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

Narcotic Addiction Treatment And Rehabilitation Programs In Chicago, Illinois B-166217

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

NOV. 16, 1972

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

B-166217

Dear Mr. Chairman:

In accordance with your October 15, 1971, request, the General Accounting Office has obtained information on narcotic addiction and treatment in Chicago, Illinois. This is the fourth in a series of five reports issued or to be issued pursuant to this request. Other reports cover Washington, D.C.; Los Angeles and San Francisco, California; and New York City.

We discussed this report with the appropriate Federal, State, county, and city officials, but we did not obtain their formal written comments. We did consider oral comments received in preparing this report.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only if you agree or publicly announce its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

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

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Contents

ABBREVIATIONS

BNDD	Bureau of Narcotics and Dangerous Drugs
BOP	Bureau of Prisons
BRASS	Behavior Research and Action in the Social Sciences Foundation
DART	Drug Abuse Rehabilitation Treatment
FPR	Friends of Psychiatric Research, Inc.
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
IDAP	Illinois Drug Abuse Program
LEAA	Law Enforcement Assistance Administration
NARA	Narcotic Addict Rehabilitation Act
NIMH	National Institute of Mental Health
OEO	Office of Economic Opportunity
VA	Veterans Administration
WSO	West Side Organization Drug Abuse and Rehabilitation Project
YMCA	Young Men's Christian Association

COMPTROLLER GENERAL'S
REPORT TO SUBCOMMITTEE NO. 4
COMMITTEE ON THE JUDICIARY
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NARCOTIC ADDICTION TREATMENT AND REHABILITATION PROGRAMS IN CHICAGO, ILLINOIS B-166217

D I G E S T

WHY THE REVIEW WAS MADE

This is the fourth of five reports requested by the Chairman of the Subcommittee on programs for treating and rehabilitating narcotic addicts in Chicago, Illinois; Los Angeles and San Francisco, California; New York City; and Washington, D.C. The General Accounting Office (GAO) previously reported on programs in Washington, Los Angeles, and San Francisco.

In developing legislation relating to treating and rehabilitating narcotic addicts, the Subcommittee is concerned that adequate provision be made for assessing program performance so that the Congress and executive agencies will have a basis for improving treatment and rehabilitation.

GAO was asked to determine for each of the five cities:

--Amount of money being spent by governmental agencies on narcotic treatment and rehabilitation.

--Goals of the different programs.

--Methods of treatment.

--Number of patients in treatment.

--Services available.

--Costs of the different treatment methods.

--Criteria used to select patients.

--Extent of efforts to assess program performance.

--What was learned from assessment efforts.

FINDINGS AND CONCLUSIONS

Size of narcotic addiction problem

Estimates of the number of narcotic addicts in Chicago range from about 7,200 to 37,000. Although program officials stated that accurate estimating techniques are lacking, they agreed that the problem is increasing. It appears that the outlay for illegal acquisition of heroin in Chicago may exceed $100 million annually. (See p. 9.)

Funds, number of people in treatment, and programs available

In Chicago increased annual amounts of Federal and State funds have been made available since July 1967 for treating and rehabilitating narcotic addicts. By December 31, 1971, over 8,100 persons had been treated. (See p. 13.) The funds made available were about $14 million through June 30, 1972. (See p. 11.)

The State government, through the Illinois Drug Abuse Program, became involved in treating narcotic addicts in 1968. With Federal assistance this program has helped narcotic addicts through the use of several treatment modalities

(methods). The State program in Chicago provides services to addicts through 10 State-operated clinics and 10 clinics operated under contracts with private agencies. (See p. 11.)

State and Federal assistance is also provided to local agencies not affiliated with the Illinois Drug Abuse Program. In addition, the Federal Government treats veterans with addiction problems through the Veterans Administration West Side Hospital. (See p. 75.) Narcotic addicts may also be treated under the Federal Civil Commitment Program. (See p. 83.) The Bureau of Prisons, Department of Justice, assists Federal offenders who have past histories of addiction. (See p. 88.)

Treatment goals and program results

The goals of the programs in Chicago vary but are generally directed toward helping patients cease drug use and become law-abiding, socially acceptable, and productive citizens. There are a variety of treatment modalities, sources of funding, and patient selection criteria.

Evaluations of overall program effectiveness and analyses of the cost of various modalities of treatment had generally not been made for the programs for which GAO obtained information. Moreover, none of the programs reported that a significant number of the patients had met defined program goals.

Program results most frequently compiled were those relating to the extent of illicit drug use by patients as determined by urinalyses. Program results in terms of decreasing criminal activity and increasing employment and social acceptability frequently were not measured.

Problems and needs of treatment programs

As part of its review, GAO visited various program facilities and treatment centers in Chicago to obtain information on problems being encountered, operational needs of the centers, and ways in which the programs could be improved. GAO learned or was informed that:

--The overall Federal-State-local-governmental effort to develop narcotic addiction treatment and rehabilitation programs in Chicago was not well coordinated. (See p. 89.)

--Most of the programs visited had difficulties in securing facilities for treatment purposes. Frequently there was negative community reaction to locating a treatment center in a residential neighborhood. (See p. 90.)

--Many programs experienced problems in training staff members, particularly counselors. A corollary problem was the shortage of funds to employ specialists for basic supportive services, such as job training and placement and vocational rehabilitation. (See p. 91.)

--Most treatment programs reviewed did not routinely compile and disseminate program results as they relate to established goals and criteria, and programs did not undertake comparative

evaluations of the various treatment modalities being used. (See p. 92.)

--Most agencies sponsoring drug treatment programs did not have cost accounting systems which would permit the development of accurate data on the cost of various modalities of treatment. (See p. 93.)

Information on selected narcotic addict treatment programs

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

NAME OF PROGRAM	DATE STARTED	TREATMENT METHOD	NUMBER OF PATIENTS
Illinois Drug Abuse Program (see p. 14)	Jan. 1968	Inpatient: --Methadone withdrawal. --Therapeutic community. Outpatient: --Methadone maintenance.	Jan. 1968 through Dec. 1971--5,266 patients served. As of Dec. 30, 1971--2,412 in treatment.
Gateway Houses Foundation, Inc. (see p. 38)	July 1968	Inpatient therapeutic community.	July 1968 through Dec. 1971--about 800 served. As of Dec. 30, 1971--156 in treatment.
Behavior Research Action in the Social Sciences Foundation (see p. 44)	May 1970	Outpatient methadone maintenance.	As of Dec. 30, 1971--353 in treatment.
West Side Organization (see p. 49)	Jan. 1970	Outpatient methadone withdrawal.	Jan. 1970 through Dec. 1971--about 500 served. As of Jan. 10, 1972--272 in treatment.
St. Leonard's House (see p. 54)	July 1967 (terminated Dec. 1971)	Inpatient: --Detoxification. --Abstinence. Outpatient: --Abstinence.	July 1967 through Nov. 1971--983 patients served.
Near North Family Guidance Center (see p. 63)	Jan. 1969	Outpatient: --Withdrawal. --Abstinence.	July 1970 through Dec. 1971--561 admitted for treatment. As of Dec. 31, 1971--179 in treatment.
Drug Abuse Rehabilitation Treatment Program (see p. 69)	Jan. 1971	Abstinence beginning as inpatient, prior to release from institution, and continuing as outpatient.	During 1971, 122 inmates at the Joliet Branch and 34 at the Vienna Branch of the Illinois Penitentiary participated in group therapy sessions. Of these 26 voluntarily withdrew from the program and 52 transferred to the postrelease phase. The status of these at Dec. 31, 1971, was as follows: Remaining in postrelease status: 23 Returned to prison or absconded: 9 Returned to therapy phase at the penal institutions: 2 Paroled: 18 Total: 52
Veterans Administration West Side Hospital (see p. 75)	July 1971	Inpatient: --Detoxification. --Rehabilitation. Outpatient: --Methadone maintenance. --Methadone withdrawal. --Abstinence.	July through Dec. 1971: --292 admitted as inpatients. --209 admitted as outpatients. As of Dec. 31, 1971: --48 inpatients. --152 outpatients.

PROGRAM COSTS	PROGRAM EVALUATION CRITERIA	PERTINENT PROGRAM RESULTS
1972 budget--$5,103,717.	Extent to which patients are: --Law abiding. --Employed or are in educational or training programs. --Drug free. --Emotionally stable.	Results of urinalyses for the week of Dec. 8, 1971, showed that: --73 percent of 1,109 patients in methadone clinics had not used narcotics. --88 percent of 393 patients in multimodality centers had not used narcotics. During the last 6 months of 1971, 339 of a group of 450 active patients had not been arrested; 119 of the 339 were also drug free; 28 of the group had not been arrested, were drug free, and were employed.
Funding for fiscal year 1971--$654,394.	Changed lifestyle.	A study of 160 randomly selected patients who left the program prior to Feb. 1, 1971, showed: --49 resumed drug use. --15 were in jail. --36 were not using narcotics. -- 9 died or were in the hospital. --51 could not be reached.
Projected costs for 1972--$300,300.	Extent to which patients are: --Crime free. --Employed or in educational or training programs. --Drug free. --Emotionally stable.	Results of urinalyses for week of Dec. 8, 1971, showed 68 percent of 361 patients were drug free.
Funding for July through Dec. 1971--$154,920.	Patients who: --Remain in treatment 2 years. --Are drug free or maintained on methadone. --Are arrest free. --Are employed or in training.	For a 2-month period ended Jan. 23, 1972, urinalyses showed that 53 percent of patients had used narcotic drugs.
Expenditures for treatment of narcotic addicts totaled $1.2 million during the 4-1/2-year life of the program.	Drug-free and self-supporting patients.	One contractor reported on problems in data collection and concluded he was unable to make an overall assessment of program effectiveness. Another contractor concluded that most of the program's stated objectives had not been met.
Funding for June 1969 through Dec. 1971--$125,098.	Extent to which patients are: --Abstinent. --Arrest free. --Stable in the community.	Of 115 withdrawal patients served between Feb. and Dec. 1971, only 10 completed the program.
Budget for 18 months beginning in Aug. 1970--$449,870.	Extent to which participants are: --Drug free. --Crime free. --Employed. --Socially adjusted.	During 1971 two of 52 were returned to prison for illicit drug use and three absconded.
Fiscal year 1972 allocation--$582,526.	Extent to which patients: --End drug dependence. --Develop emotional stability. --Obtain employment.	Results of 1,655 urinalyses from Aug. through Dec. 1971 showed: --17-percent heroin use. -- 4-percent barbiturate use. -- 4-percent amphetamine use.

Tear Sheet

CHAPTER 1

INTRODUCTION

Our Nation today is faced with a serious narcotic[1] 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."

Throughout the Nation questions are being asked as to what is the most effective way to deal with this problem. Criteria setting forth the results expected from treatment and rehabilitation programs are vague or are frequently lacking. Experts debate results of varying methods of treatment. Information on numbers of addicts in the Nation is based on educated guesses at best. Data on people in treatment throughout the country is generally lacking, as is information on program costs and results achieved.

Because of the seriousness of this problem and the need for information to arrive at rational decisions, the Chairman, Subcommittee No. 4, House Committee on the Judiciary, requested us to assist the Congress in obtaining information on the progress being made in rehabilitating narcotic addicts by various modalities (methods) of treatment. The Chairman asked that our review include narcotic addiction treatment and rehabilitation programs receiving Federal, State, or local funds in five cities--Washington, D.C.; New York City; Chicago, Illinois; and Los Angeles and San Francisco, California--and that separate reports be prepared for each. Previous reports have been issued on Washington, Los Angeles, and San Francisco.

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

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

EXTENT OF NARCOTIC PROGRAM

Estimates of the number of narcotic addicts in Chicago range from 7,190 to 37,000. As explained in appendix II, estimates are based on indicators of the size of the problem, such as police arrest records and overdose deaths.

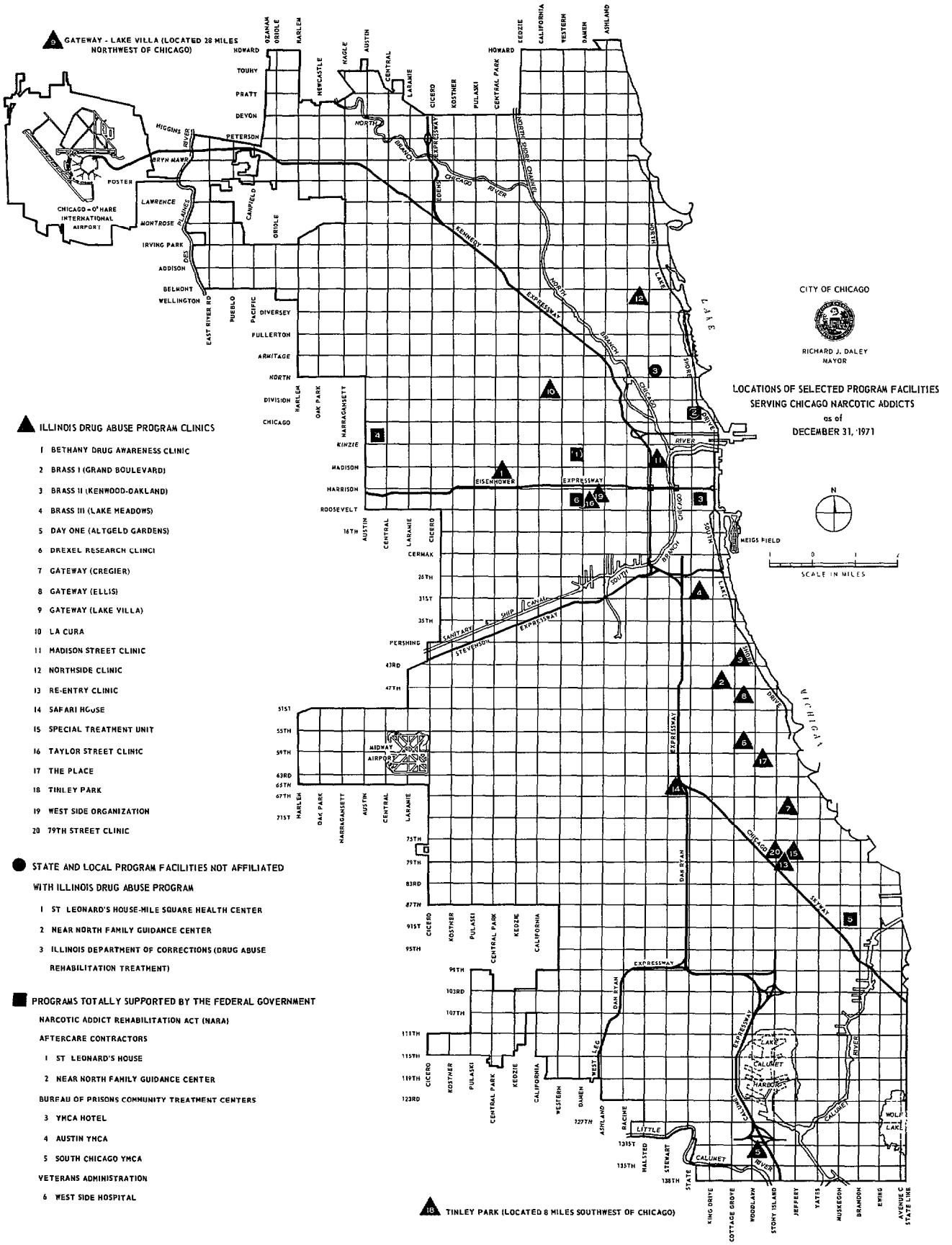
TREATMENT AND REHABILITATION PROGRAMS AND RELATED COSTS

Narcotic treatment and rehabilitation programs in Chicago are generally of recent origin. Reports commenting on the lack of such programs from 1965 to 1967 stated that the only available way for an addict to be detoxified (removed from physical dependence on drugs) was to be arrested, usually on a disorderly conduct charge, and taken by the police to Cermak Memorial Hospital, a unit of the Cook County Department of Corrections.

As far as we know, no estimate of the annual cost of narcotic addiction in Chicago has been made. On the basis of piecemeal data, it appears that narcotic addicts in Chicago cost the criminal justice system at least $4.4 million annually and that the outlay for illegal acquisition of heroin in Chicago exceeds $100 million annually. Indicators of the size of Chicago's addiction problem are discussed in appendix II.

State and Federal funds made available for treating and rehabilitating narcotic addicts in Chicago, since inception of the first program in July 1967 through the current budget period (generally June 30, 1972), are shown below.

Program name	Federal	State	Total
Illinois Drug Abuse Program (IDAP)	$4,924,025	$6,124,222	$11,048,247
IDAP affiliates:			
Gateway House	269,744	-	269,744
West Side Organization	211,576	-	211,576
St. Leonard's House	1,125,609	-	1,125,609
Near North Family Guidance Center	170,674	99,782	270,456
Drug Abuse Rehabilitation Treatment	200,000	249,870	449,870
Veterans Administration West Side Hospital	582,526	-	582,526
Total	$7,484,154	$6,473,874	$13,958,028



▲ ILLINOIS DRUG ABUSE PROGRAM CLINICS

1 BETHANY DRUG AWARENESS CLINIC
2 BRASS I (GRAND BOULEVARD)
3 BRASS II (KENWOOD-OAKLAND)
4 BRASS III (LAKE MEADOWS)
5 DAY ONE (ALTGELD GARDENS)
6 DREXEL RESEARCH CLINIC
7 GATEWAY (CREGIER)
8 GATEWAY (ELLIS)
9 GATEWAY (LAKE VILLA)
10 LA CURA
11 MADISON STREET CLINIC
12 NORTHSIDE CLINIC
13 RE-ENTRY CLINIC
14 SAFARI HOUSE
15 SPECIAL TREATMENT UNIT
16 TAYLOR STREET CLINIC
17 THE PLACE
18 TINLEY PARK
19 WEST SIDE ORGANIZATION
20 79TH STREET CLINIC

● STATE AND LOCAL PROGRAM FACILITIES NOT AFFILIATED WITH ILLINOIS DRUG ABUSE PROGRAM

1 ST LEONARD'S HOUSE-MILE SQUARE HEALTH CENTER
2 NEAR NORTH FAMILY GUIDANCE CENTER
3 ILLINOIS DEPARTMENT OF CORRECTIONS (DRUG ABUSE REHABILITATION TREATMENT)

■ PROGRAMS TOTALLY SUPPORTED BY THE FEDERAL GOVERNMENT

NARCOTIC ADDICT REHABILITATION ACT (NARA)

AFTERCARE CONTRACTORS

1 ST LEONARD'S HOUSE
2 NEAR NORTH FAMILY GUIDANCE CENTER

BUREAU OF PRISONS COMMUNITY TREATMENT CENTERS

3 YMCA HOTEL
4 AUSTIN YMCA
5 SOUTH CHICAGO YMCA

VETERANS ADMINISTRATION

6 WEST SIDE HOSPITAL

State funds of $6.1 million available for IDAP represent a net contribution after certain Federal reimbursements. A relatively small amount of these funds, which we have been unable to segregate, is for areas outside of Chicago. The table excludes funds available to the Bureau of Prisons (BOP), Department of Justice, for activities serving Federal offenders with past histories of addiction. The location of these latter activities, as well as the sites of the other programs in Chicago, are shown on the map on page 10.

Municipal and county governmental agencies had no readily identifiable programs for direct services to narcotic addicts, and these levels of government, with Federal financial assistance, appeared to be directing their resources primarily to soft-drug abusers.[1]

The State government is the principal sponsor of programs for treating and rehabilitating narcotic addicts in Chicago. The State's program, IDAP, began operations in January 1968 under the Illinois Department of Mental Health. The program has gained national recognition, and the former director is now head of the President's Special Action Office for Drug Abuse Prevention. Originally started as a pilot program focusing on heroin addicts, the program has a philosophy of helping addicts, through the use of several treatment modalities, become law-abiding, gainfully employed, drug-free and emotionally mature members of society who require no additional medical or social support.

Treatment and rehabilitation services are provided at 10 IDAP clinics and at 10 private clinics operated under contract with IDAP. Seven of the 10 private clinics were being operated by three agencies--Gateway Houses Foundation, Inc., West Side Organization Drug Abuse and Rehabilitation Project (WSO), and Behavior Research and Action in the Social Sciences Foundation (BRASS).

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[1] Soft-drug abusers include those using marijuana, amphetamines, and barbiturates.

We identified three other local programs, not connected with IDAP, as being supported with public funds. These were:

--St. Leonard's House, which began operation in July 1967 and has received Federal funds under a grant from the Office of Economic Opportunity (OEO). The OEO grant was terminated as of December 1, 1971, and the OEO program was being transferred to a neighboring comprehensive health center.

--Near North Family Guidance Center, a private agency which began operation in early 1969. The program is funded in part by the Illinois Department of Mental Health.

--The Drug Abuse Rehabilitation Treatment (DART) program, which began operation in January 1971 and received Federal funds from the Law Enforcement Assistance Administration (LEAA), Department of Justice, and State funds from the Illinois Department of Corrections.

In addition to providing financial assistance to local agencies, the Federal Government is directly involved in serving narcotic addicts in Chicago. The Veterans Administration (VA) West Side Hospital in Chicago started a drug treatment program in July 1971. Narcotic addicts committed for treatment and rehabilitation under the Narcotic Addict Rehabilitation Act of 1966 (NARA) (28 U.S.C. 2901) receive aftercare in Chicago from St. Leonard's House and the Near North Family Guidance Center.

BOP has, since 1961, operated a Community Treatment Center at a Young Men's Christian Association (YMCA) facility in Chicago as part of its Federal correctional system release program. Custodial care and general supportive services are provided to persons who are released from Federal correctional institutions, including those who have past histories of addiction.

NUMBER OF PERSONS IN TREATMENT

The following table shows the number of patients, by treatment modality, as of December 31, 1971, and the number of patients served since inception of the various programs. Problems being experienced by the programs are discussed in chapter 6.

	IDAP	Other State or private agencies	Federal agencies or contractors	Total
Patients in treatment as of December 31, 1971:				
Outpatient:				
Abstinence	158	196	180	534
Methadone maintenance (note a)	1,994	26	56	2,076
Acetylemethadol maintenance (note b)	28	-	-	28
Total	2,180	222	236	2,638
Inpatient or in residence:				
Short-term (less than 6 months):				
Abstinence	26	23	48	97
Methadone	117	-	-	117
Long-term abstinence (several years)	89	-	-	89
Total	232	23	48	303
Total in treatment as of Dec. 31, 1971	2,412	245	284	2,941
Treated since program inception through Dec. 31, 1971	5,266	2,421	414	8,101

[a]See p. 17 for explanation.

[b]See p. 33 for explanation.

CHAPTER 2

THE ILLINOIS DRUG ABUSE PROGRAM

IDAP began with the passage of the State's Drug Addiction Act of 1965, which created the Narcotic Advisory Council. The council (designated as the Dangerous Drugs Advisory Council in August 1971) was to study the abuse of narcotics and other dangerous drugs and develop proposals for designing and implementing a comprehensive program for rehabilitating drug abusers.

The program that evolved was, for the most part, based on the recognition that narcotic addiction was the most serious drug abuse problem and that focusing on the treatment of narcotic users was an appropriate beginning. Also, given the diverse nature of the addict population and the existence of several distinct treatment and rehabilitative modalities, the council called for a multimodality approach to allow patients to find the modality that worked best for them.

IDAP became operational in January 1968. The State's Department of Mental Health, in cooperation with the University of Chicago's Department of Psychiatry, operates the program. The Department of Mental Health is responsible for treatment and rehabilitation services; the university performs programs evaluation and research and trains program personnel.

Operating as a pilot program, IDAP initially concentrated its treatment facilities on the south side of Chicago. As IDAP expanded, it established treatment facilities throughout Chicago, in some suburban communities, and in other large cities within the State. Also treatment facilities have been established for young people who abuse nonopiate drugs. Approximately 40 percent of the program staff of 245 are former addicts, some of whom are still under treatment in the program. For the most part, these ex-addicts are counselors. Other staff members include lawyers, doctors, nurses, psychologists, psychiatrists, researchers, technicians, administrators, and a clerical staff.

PROGRAM GOALS

IDAP goals, in order of expected attainment, are as follows:

1. The minimum expectation--patients are law-abiding citizens, even if not drug free.

2. Patients are law abiding and productive[1] even though they may use drugs occasionally.

3. Patients are law abiding, productive, and drug free.

4. The maximum expectation--patients are law abiding, productive, and drug free, and are making some progress toward emotional stability.

In establishing the goals, it was recognized that some patients may stop using illegal drugs and work at legitimate jobs but continue to engage in illegal activities while others in the same treatment modality or other modalities may not use drugs or engage in illegal activities but remain unemployed.

Standards by which the relative effectiveness of the various treatment modalities could be judged were not established. Presumably such standards could differ for each modality depending upon the characteristics of patients (e.g., young or old, new users or long-time users) and the treatment modality (methadone maintenance or detoxification).

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[1] Generally gainfully employed but in some cases in educational or vocational training.

TREATMENT MODALITIES

The multimodality approach of IDAP initially consisted of:

--Standard periods of hospitalization for withdrawal from narcotics, followed by group therapy in an outpatient community. Patients in this setting could volunteer for use of a nonaddictive drug (cyclazocine) which blocks the effects of heroin.

--Use of oral methadone, a synthetic narcotic that suppresses withdrawal symptoms and eliminates the hunger for heroin, as part of an outpatient rehabilitation program.

--Long-term residence in a therapeutic community modeled after Synanon in California or Daytop Village in New York City. Patients were required to remain drug free in a highly structured setting where intense group therapy was used.

As IDAP became fully operational, the original treatment modalities were modified and expanded. Hospital-based withdrawal was replaced with residential-based withdrawal because the former was too expensive. Also the use of cyclazocine in treating patients withdrawing from narcotics was discontinued due to its undesirable side effects. (See p. 32.)

A variety of treatment modalities has evolved, and, while individual treatment units initially utilized one modality, some units, multimodality centers, now offer two or more treatment modalities, including some residential services. As of December 30, 1971, the principal treatment modalities available to IDAP patients in Chicago were pretreatment methadone medication, methadone maintenance, methadone withdrawal, and therapeutic communities which provide abstinence treatment.

Pretreatment methadone medication

To reduce the numbers of persons waiting entry into the methadone maintenance program, two pretreatment clinics offering only daily doses of oral methadone medication were

opened in Chicago during 1971. Pretreatment is not considered a substitute for facilities that offer full therapeutic services. Thus a patient remains in pretreatment only until an opening develops at a methadone maintenance clinic in his neighborhood. Further details of the operations of a pretreatment unit are in chapter 3. (See p. 36.)

Methadone maintenance and withdrawal

Methadone, a synthetic narcotic, is considered useful in rehabilitating narcotic addicts because:

--It suppresses withdrawal symptoms and reduces or eliminates narcotic hunger.

--It can be taken orally, reducing the risk of disease.

--It effects last a whole day and it does not usually produce euphoria or lassitude.

--It wholly or partly, depending on the dose, blocks the effects of heroin.

The basic difference between the methadone maintenance and methadone withdrawal modalities is that under the withdrawal modality the dosage of methadone is gradually reduced to eliminate dependence on all drugs whereas under the maintenance modality the dosage is administered daily in stable amounts indefinitely.

Methadone maintenance is the primary treatment modality of IDAP. Weekly peer group therapy is part of IDAP's methadone maintenance treatment process, and other services, such as medical service, legal aid, and educational and vocational counseling, are provided when needed.

When a patient stabilized on methadone (one who receives uniform daily doses) voluntarily decides to become free from all drugs, he may be withdrawn from methadone on an ambulatory basis or in short-term (less than 6 months) residential facilities of the program.

Several other IDAP treatment facilities in Chicago offer variations of the basic methadone maintenance approach. Briefly, these include:

--A reentry clinic serving narcotic addicts who previously left treatment before completion.

--A special treatment clinic serving addicts with additional problems, such as pregnancy, major medical conditions, and psychiatric disorders.

--A research clinic where a series of studies comparing the effectiveness of methadone with other drugs in treating narcotic addicts has been conducted.

Drug-free therapeutic communities

Gateway Houses Foundation, Inc., operates three such communities. Both narcotic and soft-drug abusers are accepted. First, the narcotic addict is admitted to the residential facility where he goes through withdrawal without medication. He then proceeds through three phases of treatment. During the first phase the patient lives in the residential facility and is given in-house work assignments of increasing responsibility. During the second phase, he continues as a live-in but works or attends school in the free community. In the final phase, he both lives and works in the free community but returns to the therapeutic community for group therapy until it is no longer needed.

PATIENTS IN TREATMENT AND SERVICES AVAILABLE

In Chicago IDAP has treated 5,266 patients from its beginning in January 1968 through December 1971. The largest number of persons entered the program during 1971, when 12 new treatment facilities were opened and about 2,700 patients were admitted.

The number of patients served by the program by treatment modality at the end of December 1971, is shown below.

Modality	Number of units	Number of patients
Pretreatment methadone	2	547
Oral methadone:		
Ambulatory methadone maintenance	9	1,023
Reentry	1	82
Special treatment	1	91
Halfway house	1	29
Research	1	204
Multimodality	2	347
Therapeutic community	3	89
Total	20	2,412

Program data showed that, at the end of December 1971, 89 percent of the narcotic addict patients were receiving some form of oral medication, primarily methadone, as part of the delivered services. Of the narcotic addicts being treated, 90 percent were outpatients. Of the 5,235 persons expected to be served in fiscal year 1973, about 90 percent are expected to be outpatients.

Most of the treatment facilities which opened during 1971 operate under contracts between IDAP and community organizations. At the beginning of 1972, almost 50 percent of the IDAP patients were being treated in contract facilities. IDAP plans to expand the program primarily through this means.

Ancillary services

IDAP operates a number of components which offer key supportive services to the treatment facilities. The components include:

--A toxicology laboratory where urine specimens are tested to detect the presence of heroin and other drugs, such as amphetamines and barbiturates.

--A vocational rehabilitation component established in February 1971, which functions primarily as a referral point, engages in some job-placement activity, and sponsors seminars for employers to urge them to hire former addicts.

--A legal services unit which represents IDAP in dealing with addicts on probation referred by the courts or in need of legal assistance.

--A pharmacy which supplies bulk methadone to clinics daily and maintains dosage records for each patient.

--An epidemiology unit which conducts studies of the incidence and prevalence of drug addiction.

SOURCES OF FUNDING

The program has been financed primarily by the Illinois Department of Mental Health and by a 5-year grant from the National Institute of Mental Health (NIMH), Department of Health, Education, and Welfare (HEW), to the University of Chicago. Additionally financial support for 50 staff positions was provided in fiscal year 1972 through the Department of Labor's Emergency Employment Act program (42 U.S.C. 4871). Veterans of the Vietnam conflict are given priority under this employment program. The epidemiology research unit of IDAP has been partially financed by a separate NIMH grant.

Most of the program expenditures to date have been for treating and rehabilitating narcotic addicts residing in Chicago. The following table shows actual and estimated program expenditures for fiscal years 1968 through 1972.

Fiscal year	Federal: NIMH treatment and rehabilitation grant (note a)	Federal: NIMH epidemiology grant (note b)	Federal: Department of Labor	State Department of Mental Health	Total Government expenditures
1968 and 1969	$ 434,639	$ -	$ -	$1,002,876	$ 1,437,515
1970	491,080	85,991	-	1,172,730	1,749,801
1971	469,450	67,166	-	2,220,598	2,757,214
	1,395,169	153,157	-	4,396,204	5,944,530
1972 budget	444,110	34,357	204,550	4,420,700	5,103,717
1968 through 1972	$1,839,279	$187,514	$204,550	$8,816,904	$11,048,247

[a]The grants covered the fiscal year period June 1 to May 31. Part of the grant money is used by the University of Chicago's Department of Psychiatry for program evaluation and research and for training program personnel.

[b]Figures represent amounts awarded--expenditure reports had not been completed as of December 31, 1971.

Effective October 1, 1970, the State receives from the Federal Government reimbursement of a substantial portion of the State's expenditures for treating and rehabilitating narcotic addicts under the authority of title XVI of the

Social Security Act.[1] The reimbursement resulted from the approval by the Secretary of HEW of an amendment to the Illinois plan under title XVI. The amendment was submitted to the Secretary during the fourth quarter of 1970. Under the approved amendment, the Federal Government reimburses the State for 75 percent of the cost of social and rehabilitation services furnished by IDAP to current, former, and potential public aid recipients.

Reimbursements are made directly to the general revenue fund of the State and consequently are not reflected in the tables on pages 9 and 21. The amount reimbursed for services provided to narcotic addicts by IDAP during the period October 1, 1970, to September 30, 1971, was $1,360,682. The amount estimated to be reimbursed for the remaining three quarters of fiscal year 1972 is $1,332,000, or $444,000 each quarter.

A State-sponsored survey showed that 77 percent of the IDAP patients qualified as current, former, or potential welfare recipients. A drug addict is considered a potential recipient of aid to the permanently and totally disabled under the Illinois title XVI plan, as long as his family income is below a specified amount.

COST OF VARIOUS TREATMENT MODALITIES

Due to the lack of a cost accounting system, IDAP had not developed information relating to per patient costs by treatment modality. Past estimates of costs per patient by program officials ranged from $800 per year for some

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[1]Title XVI authorizes (1) financial assistance to the needy aged, blind, and disabled, (2) medical assistance on behalf of those listed in (1) who do not receive financial assistance but whose income and resources are insufficient to meet the costs of necessary medical services, and (3) rehabilitation to help persons in (1) and (2) attain or retain self-support or self-care. Also, a State can elect to provide special services to certain persons, including low-income narcotic addicts, who were former, or are likely to be future, recipients of financial assistance.

outpatient clinics to $3,120 per year for a therapeutic community. We were informed that these were rough estimates and were not supported by accounting records.

IDAP records showed that a public accounting firm had calculated some per patient costs in connection with Federal reimbursements under title XVI of the Social Security Act. This firm calculated, on the basis of direct IDAP costs, a per diem cost for a special treatment clinic and an average daily cost per patient for the other IDAP-operated outpatient clinics and for the two multimodality centers.

Using this firm's calculations, we allocated indirect costs and certain Federal and State expenditures not considered by the public accounting firm and arrived at the following costs by type of treatment facility.

Facility	10-1-70 to 9-30-71 Cost per patient	
	Per day	Per year
Special treatment (see p. 18)	$ 8.55	$3,120
Outpatient clinics (generally methadone)	5.51	2,012
Multimodality centers (see p. 16)	14.13	5,157

CRITERIA USED TO SELECT PATIENTS FOR TREATMENT

Program officials informed us that all addicts, except those with severe psychological disorders, are acceptable for treatment. To be eligible for any form of methadone treatment, the applicant must use narcotics regularly and must have made at least one attempt at detoxification and suffered a relapse. Addicts accepted for treatment by IDAP in Chicago can choose their treatment modalities. About 85 to 90 percent of the accepted narcotic addicts elect methadone outpatient treatment, either maintenance or detoxification.

A central intake unit, opened in May 1971, handles admissions for all IDAP's Chicago treatment facilities except those operated for IDAP under contracts with three private agencies. At the intake unit each applicant is interviewed to provide IDAP with general information regarding his residence, employment, income, type of drugs used, and illegal activity. After this initial interview, an applicant is requested to come for a medical examination. There was a 3-week waiting period between the initial interview and the medical examination at the time of our review. We were told that the following types of applicants are processed without this waiting period:

--Court referrals under direct order from judges.

--Vietnam veterans not eligible for the Veterans Administration (VA) drug program.

--Medical emergencies as determined by the medical director.

--Persons under 20 years old.

--Pregnant women.

--Persons who are the legal or common law spouses of other patients.

Using the results of the patient's examination and urine test, as well as information about his background,

IDAP assigns the patient to a treatment facility which offers the modality he has chosen. The program attempts to assign methadone patients to outpatient clinics in their neighborhoods.

Between May and December 1971, the central intake unit processed 2,200 applications. Of those applicants making initial contact, 1,350 entered treatment. An IDAP official told us that about 50 percent of the applicants do not appear for the required medical examination. The director of central intake told us that some applicants move without leaving forwarding addresses, some are incarcerated, and others simply lose interest in the program. As of January 20, 1972, 47 persons were awaiting entry into the program through the central intake unit.

PROGRAM ASSESSMENT EFFORTS

Each IDAP patient, at time of admission and each week thereafter, must fill out a standardized questionnaire relating to program goals. This questionnaire, called a weekly activity summary, covers such matters as living arrangements, employment, earnings, illegal activities, arrests, and drug and alcohol use. The patient's counselor is required to insure that all questions are answered and to verify employment by checking pay stubs. Self-reported arrest information is not regularly confirmed with police records. A urine specimen from each outpatient is obtained at least once a week. The urine samples are required to be obtained under direct staff observation and are tested at the IDAP toxicology lab for the presence of heroin and other illegal drugs.

The above weekly data on active patients becomes part of an automated data bank and is available for assessing patients' progress in meeting the first three program goals. (See p. 15.) IDAP does not periodically test patients' progress toward emotional stability, the last of the goals the patients are expected to attain. Formerly, the Minnesota Multiphasic Personality Inventory was administered to some patients at time of admission and at intervals thereafter. However, the IDAP Director of Clinical Evaluation informed us that testing for emotional stability was of very low priority and that money would be better spent on measuring the other goals.

Although weekly data is accumulated on active patients, no followup data is accumulated for patients who drop out of the program. Finally, under the terms of the NIMH treatment and rehabilitation grant to the University of Chicago, IDAP is obligated to submit bimonthly, to Texas Christian University, admission and status evaluation reports on patients being treated in seven south side Chicago facilities. The data reported to the university, which is under contract to NIMH to make evaluations of drug treatment programs, is similar to the data included on the IDAP weekly activity summaries and urinalysis reports. The tabulations of individual admission data and evaluation reports compiled by the university from information furnished by IDAP are not used by IDAP for program evaluation purposes.

RESULTS OF ASSESSMENT EFFORTS

Although IDAP's Clinical Program Evaluation Section has data on a large patient population which could be used for program evaluation, comparative analysis of the effectiveness of treatment approaches has been very limited. Most of the changes in program direction and treatment approaches have resulted from clinical observations and experiences, supplemented to some extent by the data on patients.

Assessment results by IDAP in terms of program goals

Program results based on established goals have not been routinely compiled and disseminated. IDAP officials acknowledged the results that had been compiled were of little value in terms of judging the effectiveness of the overall program or any one modality.

The only results recurringly reported were those which pertained to the goal of becoming drug free. Weekly reports of urinalysis results showed the number of patients, by clinic, who were clean (did not use narcotics). The Director of the Clinical Program Evaluation Section stated that these reports were of limited value because they did not show the length of time patients had been in treatment nor the number and percent of patients who were consistently clean.

Inpatients are not tested for drugs unless they temporarily leave the residential treatment facility. The results of urine tests for narcotic use by outpatients, as reported by IDAP for 2 weeks in 1971, were as follows.

	Week of 11-9-71		Week of 12-8-71	
	Number tested	Percent clean	Number tested	Percent clean
Pretreatment clinics (See p. 16)	349	41	448	33
Methadone clinics (See p. 17)	977	71	1,109	73
Multimodality centers (note a)	365	85	393	88

[a]A multimodality center is one which offers several types of treatment (maintenance, abstinence, withdrawal).

Program results in terms of the employment goal have not been routinely reported. The most recent program results available at the time of our review were provided by a special study of the employment status of all patients in treatment as of July 4, 1971. This study showed that 31.6 percent of the patients were employed at time of entry and 33.3 percent were employed as of July 4, 1971.

The Director of the Clinical Program Evaluation Section discounted the value of the employment study because it included many patients who had been in the program less than 6 months, which was, in the director's opinion, too short a period to expect a change in employment status.

In response to our request the director prepared a report on the change in employment status of 1,198 outpatients who had been in the program at least 6 months as of December 15, 1971. This report showed that 408, or 34 percent, of the 1,198 patients were employed when they entered IDAP's program. The number reported as employed in December had increased to 478, a net increase of 70, or 6 percent. The report noted that 238 patients had become employed since entering the program and 168 patients had apparently lost their jobs since entering the program. Program officials stated that employment opportunities for patients must be greatly increased before any significant progress could be made toward accomplishing the program's employment goal.

Program officials stated that they had not reported any results on patients' continued illegal activities. They did, however, engage the University of Chicago Center for Studies in Criminal Justice to study changes in patients' arrest rates after they entered IDAP. The researchers, in their June 1971 report to IDAP, concluded that patients' arrest rates dropped significantly after participation in the program and that arrest rates decreased as the length of time of participation in the program increased. The researchers were not sure, however, whether this was due to the treatment or to the gradual elimination of arrest-prone addicts from the program.

An assessment of the program's holding power was included as part of a March 31, 1971, progress report under the NIMH treatment and rehabilitation grant. This report

showed that, at the end of 1 year, approximately 20 percent of the patients who entered a therapeutic community were still in treatment and approximately 60 percent of those who began as outpatient methadone patients were still in treatment.

Assessment results by GAO in terms of program goals

Statistical information reported by IDAP on active patients has been in terms of the number and percentage of patients meeting one of the program goals.

To determine the extent to which the program goals of being law abiding, gainfully employed, and drug free were collectively being met, we developed a statistical summary from IDAP's program records. The summary showed the extent to which patients who entered the program in 1969 achieved the three program goals during the last 6 months of 1971. The year 1969 was chosen at the suggestion of program officials because those patients would have had at least 2 years of treatment available to them, which should have provided sufficient time for changes in their antisocial behavior.

Our analysis showed that 1,054 narcotic addicts entered treatment during 1969. We selected for analysis the records of 450 patients who were active for 23 or more weeks during the last 6 months of 1971. The table on page 30 shows the results of our analysis.

The extent to which patients were law abiding and employed was determined from information provided voluntarily by the patients. Program officials summarized weekly the information provided. To determine the percentage of time patients were law abiding, we divided the number of weeks during which patients reported they were law abiding by the number of weeks they participated in the program. Similarly, to determine the percentage of time patients were employed, we divided the number of weeks during which patients reported they were employed by the number of weeks they participated in the program.

The extent to which a patient was drug free was determined by urinalysis reports. We determined the percentage

of time patients were drug free by dividing the number of weeks during which test results showed no evidence of illicit drug use by the number of weeks the patients participated in the program.

Patients were classified in the last four lines of the table on the basis of the individual goal that they were least successful in achieving. The table shows the maximum percentage of time the patients could have actually met the combined goals.

	Patients meeting goals			
	100% of time	80 to 99% of time	50 to 79% of time	Under 50% of time
Law abiding	339	89	12	10
Employed	73	72	50	255
Drug free	140	197	78	35
Law abiding and employed	60	81	51	258
Law abiding and drug free	119	206	85	40
Employed and drug free	32	89	65	264
All three goals	28	90	65	267

The table shows that 255 out of 450, or 56 percent, of the patients reported legitimate employment less than half the time. Analysis of the table indicates the significance of the employment record of patients as related to overall goal accomplishment. For example, the data shows that, at the 80-percent-or-more level of goal attainment (the first two columns combined), of the 450 patients, 428 were law abiding, 325 were law abiding and drug free, but only 118 were law abiding, drug free, and employed.

For 1,041 inactive patients who had been treated in Chicago, IDAP's records showed that 830, or 80 percent, either left the program against medical advice or failed to show up for treatment. Another 113 of these former patients were discharged from treatment because they had been incarcerated, had continued illegal activities, or had illicitly

used drugs. Only 12 of the 1,041 persons completed treatment. Program officials presumed that most patients who leave the program before completing treatment revert to illicit drug use.

Other assessment efforts

IDAP has made considerable additional research and evaluation efforts, and the results have been published in such periodicals as the Journal of the American Medical Association and The International Journal of the Addictions or presented at various conferences and symposiums, such as the annual national methadone conferences.

Following is a resume of the major research and evaluation studies conducted under IDAP's direction that were related to treatment approaches. Most of these studies involved a comparison of treatment approaches.

Hospital-based withdrawal of narcotic addicts found unnecessary

An IDAP study concluded that the general hospital was not the optimal location for specialized addiction withdrawal units. Researchers found that few patients required the expensive services and facilities of a general hospital. They concluded that routine withdrawal could be carried out for the majority of patients in a nonhospital, residential setting at a reduced cost. The study was the basis for the decision to replace hospital-based withdrawal with residential-based withdrawal.

Minimal methadone support found helpful for addicts awaiting entry into treatment

IDAP undertook research in 1969 to determine whether maintaining large numbers of addicts on oral methadone, without group therapy or other supportive services, would be beneficial. The research involved 62 heroin addicts seeking entry into the program. Thirty-one were put on the waiting list. The other 31 were placed in pretreatment and given daily doses of methadone.

Researchers found that the pretreatment group reported less illegal activity than those on the waiting list and

decreased their illicit drug use whereas the other group continued to use narcotics at about the same level. Neither group showed significant change in employment status. As a result of this research effort, two pretreatment clinics were opened during 1971.

Research on use of cyclazocine

Cyclazocine is a long-acting drug that, when taken orally, blocks the actions of narcotics and helps patients abstain during the first few months following withdrawal. IDAP undertook research because previous studies of this drug had not involved control groups.

The study involved 186 narcotic addicts who entered a treatment center for withdrawal from narcotic use. Of these, 33 volunteered for treatment with cyclazocine. Study results showed that cyclazocine caused serious side effects in some patients and could also produce severe withdrawal symptoms if administered to a patient not free from narcotics. Moreover, withdrawal from cyclazocine itself could be accompanied by various types of discomfort.

The researchers concluded that the drug has potential for patients seeking help in achieving immediate abstinence but that further controlled experiments were needed.

Inconclusive rehabilitative effects of high and low doses of methadone

IDAP has conducted two studies comparing the rehabilitative effect of high doses of methadone (approximately 100 mg. a day) with relatively low doses (approximately 35 mg. a day). Over specified periods control groups of patients receiving high and low doses of methadone were compared with respect to arrest rates, social productivity, illicit drug use, program discharge rate, and rate of transfer to abstinence programs.

The researchers concluded:

--Lower dosages did not result in a significant increase in the number of patients seeking or achieving abstinence.

--There was no significant difference in the overall dropout rate between the high-dose and low-dose groups.

--The illicit use of narcotics was higher in the low-dose group. During the 20th week, 18 percent of the low-dose group and 12 percent of the high-dose group engaged in illicit drug use.

--For both groups self-reported arrest rates were substantially lower than pretreatment rates.

--The immediate apparent advantages of low doses are the reduced frequency of side effects and a reduction in the potential for redistribution of methadone to nonpatients.

Although final conclusions were not drawn from the studies, it should be noted that the IDAP program is a low-dose methadone program.

Acetylmethadol shown to have promise as replacement for methadone

Acetylmethadol, a synthetic narcotic similar to methadone, suppresses narcotic withdrawal symptoms for periods of 72 to 96 hours as compared with only 24 hours for methadone. IDAP undertook a study to determine whether acetylmethadol was as safe and effective as methadone in aiding social rehabilitation of narcotic addicts.

The study found that the two drugs produced about the same results with respect to reduction of illicit drug use and increase in legitimate employment. The results were also about the same with respect to required clinic attendance and medical safety. The researchers concluded that the advantages of acetylmethadol--reduction in visits and the possibility of more effective control over its administration and illegal redistribution--outweighed any problems detected under study conditions. However, the acceptability of the drug in treating narcotic addicts has not been widespread, and IDAP was performing further research on its use at the close of our review.

CHAPTER 3

FACTORS CONTRIBUTING TO RAPID GROWTH OF THE ILLINOIS DRUG ABUSE PROGRAM AND THE MULTIMODALITY APPROACH

During 1971 IDAP (1) improved its relationship with the courts and thereby provided service to an increased number of court-referred patients, (2) adopted a methadone pretreatment approach to alleviate the problem of addicts' having to wait long periods before any services are provided to them, and (3) increased the number of contracts with private agencies to provide services to addicts. These three actions have resulted in the delivery of treatment and rehabilitation services to hundreds more narcotic addicts in Chicago. Also the contractual arrangements have been, and continue to be, a primary factor in maintaining the multimodality treatment approach of IDAP.

We examined the results of the above actions, including the operations of three agencies having contracts with IDAP. These agencies utilize different treatment modalities and, in total, account for seven of the 10 clinics under contract to IDAP in Chicago. The three agencies, two of which received Federal grants, were:

--Gateway Houses Foundation--a nationally recognized proponent of the therapeutic community approach.

--BRASS--one of IDAP's first contract agencies, which was serving the largest number of methadone maintenance patients in Chicago at the time of our review.

--WSO--an agency whose goal is the gradual withdrawal of patients from methadone.

ADDED COURT REFERRALS

In February 1972 IDAP reported to the Dangerous Drug Advisory Council of Illinois that the number of referrals made to the IDAP program from the courts had increased continually during the last 8 months of 1971. The increase

reportedly reflected a greater willingness of the courts to make use of the program and the ability of the program to absorb all court-referred patients.

Under the State's Dangerous Drug Abuse Act, persons charged with or convicted of nonviolent crimes, excluding the sale of narcotics, are eligible for treatment if a court determines an individual is an addict and is likely to be rehabilitated through treatment. The court can:

1. Order the person to IDAP for treatment in lieu of criminal prosecution. Criminal charges can be continued without disposition up to a maximum of 2 years. At that time, the charges will be dismissed if the person has successfully completed the treatment program. Prosecution may be pursued on those patients who fail to participate in the program.

2. Place convicted persons on probation and under IDAP supervision for a period not to exceed the maximum sentence that could be imposed, or 5 years, whichever is less. Failure to remain in treatment may be considered a probation violation.

Under the Illinois statute, acceptance of treatment for narcotic addiction may also be made a condition of parole, and failure to comply with such treatment may be treated as a violation of parole.

IDAP performs an examination to determine whether a person is an addict and likely to be rehabilitated. The IDAP court liaison officer informed us that, although IDAP rejects fewer than 5 percent of those examined, the court does not commit for treatment about 20 percent of those persons found acceptable by IDAP. He was unable to explain why.

The following table shows the status at the time of acceptance by IDAP of those patients who were still in treatment as of February 18, 1972, as reported by IDAP's court liaison officer.

Status at time of acceptance	Patients in treatment
Continuance of charges	152
Probation	653
Parole	86
	891

Summary information was not available on the progress of the above patients or on the 419 additional patients who, according to program officials, left treatment after being accepted. The court liaison officer advised us further that 407 of the active patients were on probation and had entered the program voluntarily without court orders. IDAP is not required to report to the court on these patients' progress, lack of progress, or departures from the program.

METHADONE PRETREATMENT APPROACH

During 1971 IDAP responded to the problem of a growing waiting list by opening two pretreatment units which offered only methadone medication. An IDAP research project had shown that the pretreatment approach was preferable to no treatment. (See p. 31.) As of December 30, 1971, of 547 pretreatment patients, 313 were being served by the pretreatment unit of the Taylor Street Clinic.

Originally, the Taylor Street Clinic, which opened in September 1971, offered only methadone medication. Recently, however, the staff was increased through the assistance of the Emergency Employment Act[1] program, and each patient is now assigned to a counselor for a minimum of individual therapy.

At the Taylor Street Clinic, methadone is dispensed 6 days a week and urine specimens are taken on 3 of these days. The patients generally are started at low methadone

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[1]The act provides unemployed or underemployed persons with transitional jobs and training in needed public service positions during periods of high unemployment, so that these persons can move into positions not supported under the act.

doses and, if they experience withdrawal problems, the dosages are increased. The mean dosage is about 40 milligrams per day; the highest is 110 milligrams per day. The results of urine tests for 2 weeks, one in November and one in December 1971, showed that 58 percent (70 out of 121) and 37 percent (83 out of 224) of the patients tested were not involved in illicit drug use during the respective test weeks.

Complete cost data on the pretreatment services delivered by the Taylor Street Clinic was not available. We noted, however, that the other pretreatment unit--which was under contract to IDAP--received $8 a week per patient from IDAP for pretreatment services.

Program officials advised us that the length of pretreatment varies depending on the patient's place of residence. Pretreatment may range from 3 to 4 weeks for a resident of the south side of Chicago to an indefinite period for a resident of the west side of Chicago, where there is an insufficient number of full-treatment methadone clinics.

INCREASED USE OF CONTRACTS

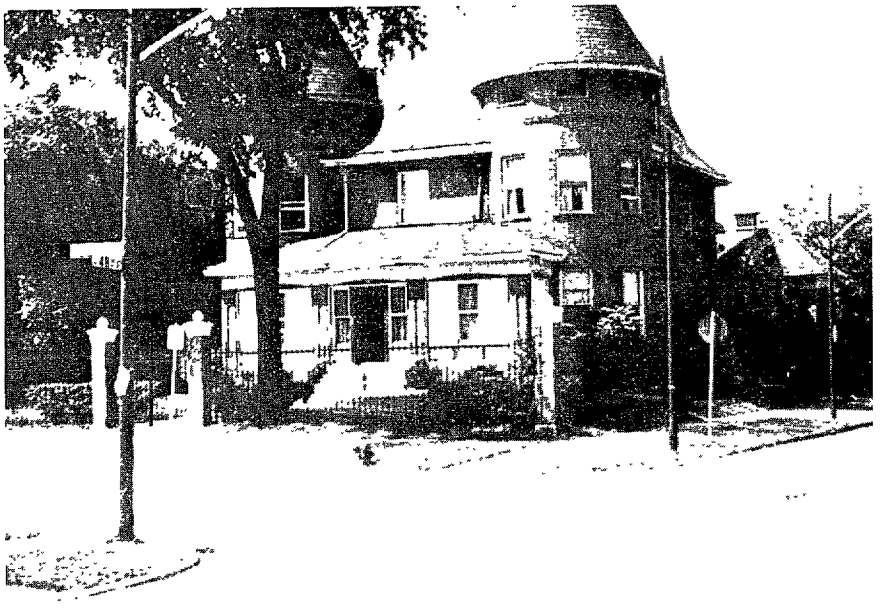
IDAP grew dramatically during 1971 with the opening of 12 new treatment facilities, nine of which were contractor operated. By December 30, 1971, approximately 50 percent of the IDAP patients were served in a contractor-operated facility. Moreover, additional methadone maintenance clinics planned for opening during a 12-month period ending June 30, 1973, are to be operated under contracts.

IDAP contractors, (community agencies) furnish a facility and a trained staff and receive a set fee based on the number of patient-weeks of treatment provided. Contractors operating methadone maintenance clinics agree to adhere to the IDAP standard methadone protocol which requires that monitored urine specimens be obtained at least once a week from each patient for testing at an IDAP laboratory. IDAP has also issued guidelines for staffing an outpatient methadone maintenance clinic. The guidelines recommend that, for each 50 patients in treatment, a staff of six comprising a project director, a part-time medical director (physician), a full- or part-time licensed practical nurse, a part-time social worker, and two full-time rehabilitation counselors.

The activities of the three agencies which operated seven of 10 clinics under contract are discussed below.

GATEWAY HOUSES FOUNDATION, INC.--
THERAPEUTIC COMMUNITY

Gateway, a Chicago-based nonprofit organization, offers residential therapeutic community (drug-free) treatment for rehabilitating drug abusers. At the time of our review, Gateway operated three facilities, two on the south side of Chicago and one in suburban Lake Villa, that were opened in July 1968, November 1968, and August 1970. One of Chicago's facilities is shown below.



GATEWAY (ELLIS) HOUSE THERAPEUTIC COMMUNITY LOCATED ON CHICAGO'S SOUTH SIDE.

Gateway reported to IDAP in 1971 that its staff consisted of 16 persons, 13 of whom were former drug addicts. The only staff members who were not ex-addicts were the executive vice president, the administrator, and a registered nurse. Of the 13 ex-addicts, 10 were graduates of the Gateway program and three were graduates of Daytop Village, a similar therapeutic community in New York City.

Program goal

The aim of the Gateway program is to change the life-style of the drug abuser so that he adopts realistic personal goals for himself and acquires the maturity to work toward these goals. Gateway expects that the program graduates will be free from illicit use of drugs.

Treatment modality

The Gateway program accepts both narcotic and non-narcotic drug users. Each new resident is given a medical examination. Once accepted, a narcotic addict is detoxified within 72 hours without medication. Barbiturate users are detoxified in a hospital with medication, while users of other drugs are simply required to cease using them.

The residents are expected to discontinue their previous behavior patterns and adopt those which are adult, responsible, and compatible with society. One of the ways that this is accomplished is through a succession of work assignments ranging from the most menial task to highly responsible work. Another way is through group therapy, which uses methods of confronting addicts with their problems to increase self-knowledge and assist them in personal growth.

The program is divided into three phases. During the first phase, the patient lives and works in the house. He is allowed to leave only if accompanied by a staff member or a senior resident. During the second phase, he lives in the house but works or attends school in the community. In the third phase, he both lives and works in the community but returns to the house for group therapy sessions. There is no specific length of time for any phase. However, the average total time in treatment for the Gateway graduates has been about 16 months. The Gateway program is patterned after Synanon, a similar program in California. The basic difference is that Gateway graduates return to society after treatment, but at Synanon people are not encouraged to leave the institution.

Patients in treatment

From program inception in July 1968 to the end of 1971, about 800 persons had enrolled at Gateway's facilities in Chicago. About three out of every four of these persons had, at the end of 1971, left the program against the advice of staff and residents and not returned.

The active population of all three houses as of December 30, 1971, was 156. Of these, 131 were in phase I, 19 in phase II, and six in phase III.

As of December 30, 1971, 22 had graduated, i.e., completed all three phases. Of these, 17 were narcotic addicts. Gateway officials informed us that the status of the 22 graduates at the time we inquired was as follows:

Drug free:	
On the Gateway staff	11
On staff of other drug programs	4
Returned to college	3
Employed in private industry	2
Using drugs	2

Sources of funding

Gateway received funds through a contract with IDAP and under a grant from the Illinois Law Enforcement Commission, the State planning agency which receives Federal financial assistance under the Safe Streets Crime Control program administered by LEAA.

Other funds, as well as all noncash contributions (food, clothing, furniture, etc.), were obtained from individual donors, businesses, and foundations. A breakdown of the sources of funds for fiscal years 1970 and 1971 is shown in the following table.

	Fiscal year 1970	1971	Total
Cash:			
IDAP	$194,069	$219,990	$ 414,059
Illinois Law Enforcement Commission	-	112,667	112,667
Contributions	52,839	71,147	123,986
Fees for speaking engagements	-	19,907	19,907
Other	3,656	5,583	9,239
	250,564	429,294	679,858
Noncash contributions	149,976	228,100	378,076
Total	$400,540	$657,394	$1,057,934

Gateway has had a contract with IDAP since July 1968. Under the contract, Gateway receives $8.50 per patient-day up to a maximum of 2 years in phase I, $4.50 per day up to a maximum of 1 year in phase II, and $25 per month per patient in phase III.

Financial support of Gateway continued at a high level during fiscal year 1972--the fiscal year 1972 contract between Gateway and IDAP was for up to $260,000, and on August 31, 1971, Gateway received a second-year grant of $140,450 from the Illinois Law Enforcement Commission.

Cost of treatment modality

Fiscal year 1971 financial reports on Gateway operations showed that the agency had cash and noncash expenditures of $653,973. By using cost information in these reports and by allocating the applicable indirect IDAP costs of $101,301, we arrived at the following costs of treatment per patient.

	Per day	Per year
Direct costs only	$15.57	$5,683
Direct plus indirect costs	18.80	6,862

Criteria used to select patients for treatment

Abusers of any drug, as well as other people whose association with the drug culture causes them to seek help, are accepted into the program. As of December 30, 1971,

nearly 60 percent of the residents were narcotic users, more than one-third were soft-drug users, and 6 percent had not been drug users.

Before an addict is accepted at Gateway, he is questioned by a group of five to seven residents to force him to admit the facts about his way of life. Although very few who apply are rejected, the number of people who leave the program before completing treatment is substantial. (See last paragraph on this page.)

Program assessment efforts

As part of the contract with IDAP, weekly activity summaries are prepared for all residents. The data from these summaries is included in overall IDAP reports; Gateway patients are not reported on separately.

In January 1972 a consultant issued a report on a study of the first 3 years of operation of the Gateway program. The study was funded by the Illinois Law Enforcement Commission, and the report contained a description of the program and information (age, sex, race, drug use, etc.) on patients. In addition, the report contained the results of a study of persons who left the program without completing treatment.

Results of assessment efforts

Of the 787 persons who had been admitted to Gateway by November 30, 1971, over 77 percent left before completing treatment. Many left within the first 15 days of residence. For the study on persons who left the program before completing treatment, the consultant selected a random sample of 160 patients who left the program prior to February 1, 1971. The following table shows the status of this sample group as of February 1, 1971.

	Number	Percent
Continued drug problems:		
Resumed drug use	49	30.6
In jail	15	9.4
In hospital	5	3.1
Died	4	2.5
Total	73	45.6
Not using dangerous drugs as of 2-1-71:		
Remained drug free	21	13.1
Had used for only a short time	7	4.4
Using marijuana only	8	5.0
Total	36	22.5
Unable to reach	51	31.9
Total	160	100.0

Those persons in jail were there primarily because of the continued use of drugs. Four of the five reported as being in hospitals were in State mental hospitals. Three of the four who died were reported to have died from overdoses of drugs.

Heroin was reportedly used by 40 of the 49 persons who resumed drug use. In addition, 20 of the 49 persons reported illegal activities as a means of support for their addiction and 12 of them had charges pending against them at the time of the study.

BEHAVIOR RESEARCH AND ACTION IN THE SOCIAL SCIENCES FOUNDATION--METHADONE MAINTENANCE

BRASS, a nonprofit corporation, operates three outpatient methadone maintenance clinics under contract with IDAP. BRASS I, BRASS II, and BRASS III were established in May 1970, December 1970, and July 1971, respectively. Two of the three clinics are storefront operations. (See photograph of BRASS II on p. 45.)

At the time of our review, the BRASS staff consisted of 26--19 of whom were ex-addicts. The ex-addicts served in such capacities as counselors, unit directors and maintenance personnel. The other staff members included the executive director, the medical director, licensed practical nurses, and clerical staff.

Program goal

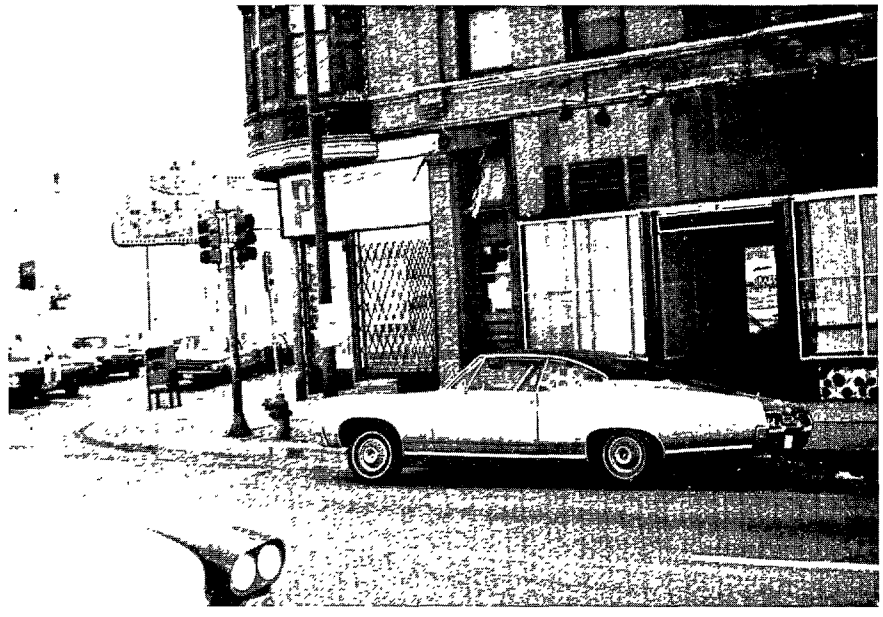
BRASS clinics provide rehabilitation and treatment to drug addicts residing primarily in the Chicago community areas of Grand Boulevard, Kenwood-Oakland, and Lake Meadows. BRASS officials stated that they subscribe to the same goals for patients as IDAP, namely being drug free, employed, crime free, and emotionally stable.

Treatment modality

BRASS, like all other IDAP outpatient methadone maintenance clinics, must abide by the IDAP methadone standard protocol, which requires methadone to be dispensed by mixing it with fruit juice. The amount of methadone given to each patient is determined by a physician and depends upon the dosage needed to eliminate compulsive narcotic craving.

The IDAP protocol also provides that all patients initially come to the clinic 6 days a week to take methadone under direct observation. Dosage for the seventh day is taken home. As treatment progresses, patients are required to report less often; eventually they may report once each week and be given methadone to last until they return to the clinic.

BRASS, under the terms of the contract with IDAP, is to provide patients with at least one group therapy session



BRASS II CLINIC HOUSED IN STOREFRONT IN MID-SOUTH CHICAGO AREA

per week and at least one-half hour per week with a social worker or rehabilitation counselor.

BRASS officials stated that, in addition to the services required by the IDAP contract, they have assigned one of their staff members to provide vocational counseling.

Patients in treatment and services available

As of December 30, 1971, the combined population of the three clinics was 353 patients--175 at BRASS I, 124 at BRASS II, and 54 at BRASS III.

In response to our inquiries, BRASS officials advised us that the program served 762 persons during the period November 1, 1970, through March 31, 1972, and that 347, or about 46 percent, were still patients. They also advised us that, of the remaining patients, 80 percent left BRASS for other treatment programs, 15 percent left against medical advice, and the rest were incarcerated (3 percent) or died (2 percent).

Sources of funding

BRASS officials stated that most of the financial support for their program is received from IDAP. BRASS told us that, apart from a small amount of donations, the only other source of funds was fees of $15 per week paid by 36 patients at BRASS II. In December 1971 BRASS officials informed us that many of their patients were unable to pay the fees, and in March 1972 the officials told us that they had discontinued charging fees.

Under the fiscal year 1972 contract with IDAP, BRASS is authorized to treat 350 patients. Reimbursements are to be $15 per patient-week for as many as 200 patients at BRASS I and $18.50 per patient-week for a maximum of 100 patients at BRASS II and 50 patients at BRASS III. The additional amount allowed for BRASS II and III is to compensate for startup costs. The following table shows the current maximum allowable reimbursements for fiscal year 1972 and the actual reimbursements for the 18-month period ended November 14, 1971.

	BRASS			
	I	II	III	Total
Maximum reimbursements for fiscal year 1972	$156,000	$96,200	$48,100	$300,300
Actual reimbursement for 18-month period ended Nov. 14, 1971	110,685	76,122	18,463	205,270

Cost of treatment modality

BRASS told us that the cost per patient-week of treatment was about $19, or about $993 a year for each patient. Also, an official stated that, if startup costs were considered, the cost was from $25 to $28 per patient-week, or from $1,300 to $1,456 a year for each patient.

Criteria used to select patients for treatment

BRASS clinics are located in and serve narcotic addicts from the south Chicago community areas. The IDAP central intake refers most patients. (See p. 24.)

BRASS officials stated that they have not established contact with the criminal justice system in Chicago. They advised us that some of their patients might be under court pressure to remain in treatment but indicated that they do not know how many.

Program assessment efforts

As part of the contract with IDAP, weekly activity summaries are prepared for all patients. IDAP accumulates the data from these summaries but does not routinely summarize it and make it available to BRASS. BRASS officials informed us that the only data routinely furnished by IDAP is the results of urinalyses which are required for each patient at least once a week.

BRASS officials stated that they have not conducted any independent research or program assessment. They agreed that followup information on addicts who leave the program would be interesting but stated that they have no plans to obtain such information due to a shortage of funds and personnel.

Results of assessment efforts

IDAP analyzes the required weekly urine specimens to determine whether the patients are engaging in illicit drug use. The results of urine tests for BRASS patients for the week of December 8, 1971, were:

	Number of patients tested	Percent of patients that were drug free
BRASS I	183	68
BRASS II	124	57
BRASS III	54	93
Total	361	68

BRASS III is the smallest clinic and was the last to open. The higher percentage of drug-free patients at BRASS III apparently was the result of a transfer of some of the patients making the most progress at the other clinics to BRASS III.

WEST SIDE ORGANIZATION--METHADONE WITHDRAWAL

WSO, a private, nonprofit corporation, operates an outpatient methadone program. As a community-based organization it relies heavily on the community grapevine for recruiting addicts. WSO differs from other IDAP methadone clinics in that it has an independent intake unit and its aim is to withdraw patients from all drugs and provide only temporary methadone support in an outpatient setting.

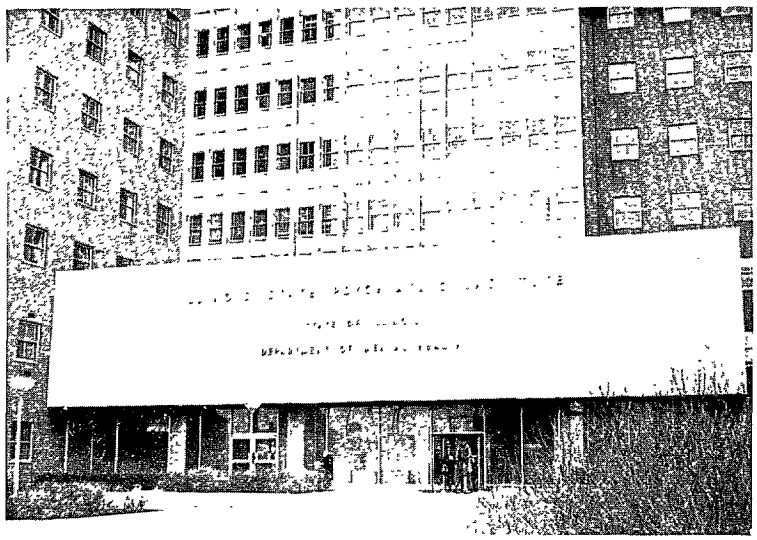
WSO began treating narcotic addicts in January 1970. Most of the financial support which enabled professional staff to be hired and program services to be strengthened and expanded was obtained during the last 6 months of 1971. (See p. 51.) At the time of our review, 31 persons staffed the program, 21 of whom were ex-addicts. The ex-addicts served primarily as counselors. Except for the WSO administrative offices, the program was housed on the 11th floor of the Illinois State Psychiatric Institute on Chicago's west side. (See photograph on p. 50.)

Program goals

WSO officials stated that they agreed with the overall goals of IDAP, namely to enable addicts to become law abiding, drug free, and gainfully employed. According to WSO officials, successful patients are those who continue in the program and, for 2 years, are free from illict drug use, are employed or are in training, and have no arrests.

Treatment modalities

The aim of WSO is to withdraw narcotic users from all drugs through decreased methadone dosages in an outpatient setting which will involve the patients' families and provide the patients with weekly group therapy, vocational counseling, and basic education. Program officials recognize that some persons with long histories of heroin addiction may need methadone support idefinitely. However, total drug abstinence is still the primary aim of the program.



ILLINOIS STATE PSYCHIATRIC INSTITUTE WHICH HOUSES THE WEST SIDE ORGANIZATION DRUG ABUSE AND REHABILITATION PROJECT

Methadone is initially dispensed under supervision to a patient 6 days a week. The dosage is tailored to the individual patient's needs, with emphasis on providing a patient with the lowest possible dosage necessary to prevent severe withdrawal symptoms. In general, after 6 months, a patient who is employed and has made satisfactory progress visits the clinic only three times a week to receive his methadone under supervision. When a patient reaches this stage, counselors encourage him to withdraw from all medication. However, each patient is allowed to make the final decision regarding when to begin withdrawal and at what rate.

Patients in treatment and services available

By the end of 1971, the program had served about 500. Those served were, on the average, 30 years old, black, male, and had long histories of addiction. As of January 10, 1972, 272 patients were in treatment.

As of January 10, 1972, 174 patients were on methadone maintenance, and daily dosages ranged from 8 to 95 milligrams. Twenty were being withdrawn from methadone. The average daily dosage of methadone for these patients was 22

milligrams. The remaining 78 patients in treatment were not receiving any medication.

Program officials stated that most of the patients who left the program did so against medical advice. They acknowledged that the dropout rate was high and stated that this was due in part to the lack of a full staff complement prior to August 1971.

In addition to receiving methadone support, patients were also participating in weekly group therapy sessions. Emergency medical treatment and legal assistance were available. Moreover, program officials stated that vocational and basic education services were being provided and were being improved.

Sources of funding

The major sources of funds for the WSO program have been derived from a Federal grant from the Social and Rehabilitation Service to the State Department of Public Welfare and an IDAP contract. We were told that the only other sources of funds were patient fees of $10 per week and initiation fees of $13. Patients pay these fees on the basis of their ability to pay.

The Federal grant funds from the welfare department for the 12-month period ended June 30, 1972, amounted to $211,576. Under the 1972 IDAP contract, WSO could serve as many as 100 patients per week and receive $15 a week per patient from IDAP. The following table shows the amounts received by WSO for the last 6 months of calendar year 1971.

Month	Patient fees	IDAP	Federal grant	Total
July	$ -	$ -	$ -	$ -
August	2,026	-	18,425	20,451
September	2,057	6,945	10,683	19,685
October	2,128	5,790	22,433	30,351
November	1,931	5,970	7,450	15,351
December	2,057	7,500	21,567	31,124
Total	$10,199	$26,205	$80,558	$116,962

In addition WSO received $37,958 of in-kind contributions (primarily space and laboratory services) from the Illinois State Psychiatric Institute during the same 6-month period.

Treatment cost

WSO officials had not made an analysis of the cost of treating patients. Using expenditure data provided by officials of WSO and the Illinois State Psychiatric Institute, we arrived at a total cost of $161,334 for the 6-month period ended December 31, 1971. Assuming full participation by the average number of patients who were in treatment during this period, the cost per patient-day in the WSO program would be $4.39, or $1,602 per patient-year. These costs do not include any indirect or direct IDAP costs allocable to the WSO program.

Criteria used to select patients for treatment

The WSO program serves an area with a population of about 100,000 on the west side of Chicago. Officials stated, however, that all addicts who come to WSO are accepted for treatment. As a result, WSO had patients from all over Chicago, as well as from several suburban areas.

We were advised that during November and December 1971 WSO program representatives met with officials of the Cook County Narcotics Court and the Cook County Jail in an attempt to have persons on parole or probation assigned to their program. WSO officials advised us that they will establish special therapy groups for such persons.

During a 4-month period ended December 31, 1971, 61 WSO patients charged with crimes appeared in court. Three of the 61 patients were put in jail, 20 were put on probation with the provision that they remain in the WSO program, and the remaining 38 were awaiting disposition of their cases while still receiving treatment.

Program assessment efforts

WSO provides IDAP weekly patient activity summaries for WSO patients covered by the IDAP contract. The weekly summaries submitted to IDAP are only support claims for reimbursement and are not otherwise used by IDAP.

Under the terms of a grant from the Social and Rehabilitation Service, success of the program in terms of stated goals is to be objectively measured. The research director of the WSO program advised us in March 1972 that he was preparing an evaluation report but that the collection and tabulation of evaluative data had not been completed.

Results of assessment efforts

WSO officials provided us with summaries of the urinalyses performed by IDAP. For the 2-month period ended January 23, 1972, IDAP tested urine specimens for an average of 54 patients per week. The results of these tests indicated that on the average 53 percent of the patients were using narcotics.

CHAPTER 4

STATE AND LOCAL PROGRAMS NOT AFFILIATED WITH ILLINOIS DRUG ABUSE PROGRAM

We obtained information on three other programs in Chicago, in addition to the programs directly affiliated with IDAP, which were supported with public funds and whose operations were directed principally to treating narcotic addicts. The three are St. Leonard's House, the Near North Family Guidance Center, and the DART program.

St. Leonard's House was funded primarily by OEO to provide the black ghetto addict with inpatient detoxification services and outpatient assistance and counseling directed toward abstinence and employment. The Near North Family Guidance Center, a nonprofit private agency funded by various governmental and local sources, operates as an abstinence outpatient clinic providing counseling and therapeutic services to the adolescent drug abuser and his family. The DART program, initiated as a pilot program and funded by a grant from LEAA, provides a continuum of services for the ex-addict offender as he progresses from incarceration to parole. Information obtained on the three programs follows.

ST. LEONARD'S HOUSE--OEO PROGRAM

St. Leonard's House, an agency of the Episcopal Diocese of Chicago, is known primarily for its halfway house which assists ex-prisoners in their transition from prison life to the free community. From July 1967 through November 1971, St. Leonard's also operated a narcotic addiction treatment center which provided hospital detoxification, employment and therapeutic counseling, short-term residency, and outpatient aftercare.

St. Leonard's outpatient services were provided from a storefront facility in a predominately black poverty area on the near west side of Chicago. Nearby residential facilities housed the administrative offices and provided short-term residency. (See photographs on p. 56.) The program was staffed by 26 persons, five of whom were either ex-addicts or ex-convicts.

The St. Leonard's treatment program was funded primarily by an OEO grant. The grant, which was channeled through the Chicago Committee on Urban Opportunity, the city's Community Action Agency, was terminated on December 1, 1971.

Concurrently with our review, the OEO program was being transferred to a neighborhood comprehensive health center, the Mile Square Health Center, which had received OEO grants since 1966. OEO officials informed us that the transfer was being made primarily because of limited progress made by St. Leonard's in treating and rehabilitating narcotic addicts. As of March 8, 1972, the new program had no active participants and the health center had not treated any narcotic addicts since assuming program responsibility in December 1971.

Program goals

To meet the OEO criteria of success, program participants were to become drug free and self supporting. In furtherance of these goals St. Leonard's outlined the following program objectives.

During the 14-month period ended September 30, 1971, St. Leonard's intended to (1) deal with the immediate problems of 500 addicts, (2) orientate and detoxify 250 addicts for rehabilitation, and (3) provide extensive rehabilitative care to 125 addicts selected from the latter group.

In addition, the agency intended to (1) provide services to the addict and his family as needed, (2) train ex-addicts as rehabilitation counselors, (3) stimulate and assist in developing added community resources, and (4) evaluate the program quantitatively and qualitatively in terms of the services offered.

Treatment modalities

The St. Leonard's program offered a continuum of services for those applicants who exhibited a commitment and motivation toward treatment without any drugs and rehabilitation.

STOREFRONT NARCOTIC ADDICTION CENTER OPERATED BY ST. LEONARD'S HOUSE WITH FUNDS FROM THE OFFICE OF ECONOMIC OPPORTUNITY AND LOCATED ON THE NEAR WEST SIDE OF CHICAGO

TWO RESIDENTIAL STRUCTURES OPERATED BY ST. LEONARD'S HOUSE AS A HALFWAY HOUSE FOR EX-ADDICTS AND FOR THE NARA AFTERCARE PROGRAM. THE FACILITY ON THE LEFT IN THE BOTTOM PHOTO CAN BE SEEN ON THE FAR RIGHT IN THE UPPER PHOTO.

The program staff scheduled orientation and counseling sessions for selected patients prior to their detoxification in a hospital to (1) test their motivation, (2) collect data on their social, vocational, and medical problems, and (3) develop an overall rehabilitation plan.

Detoxification was provided primarily by two nearby private hospitals, each of which had reserved two beds for use by St. Leonard's patients. A patient was hospitalized for up to 14 days. During this time his medical needs were assessed and treated and program counselors visited him and continued developing an overall rehabilitation plan.

After detoxification, a patient was expected to stay at the St. Leonard's residential facility for 2 weeks. This permitted close observation of the patient in a structured environment, and, if he was not employed, this period provided an opportunity for more extensive vocational counseling and added time to work out job placement, living arrangements, and related problems. The treatment provided during this period included intensive group therapy sessions.

The outpatient phase of the program began with the patient's full-time employment or participation in a training program. A patient was also expected to participate in group therapy meetings twice a week for 4 to 6 months.

Patients in treatment and services available

St. Leonard's records showed that the program served 983 addicts from July 1967 through November 1971. During 1971 the program served 264 patients. Fewer than 75 were treated in November 1971, the final program month. Ancillary services provided to patients included employment and legal assistance; medical, psychiatric, and social services; and referrals for financial assistance.

Overall program data on the number of persons who completed treatment or precise data on the number of persons who participated in each of the various phases of the program was not readily available. The data which was available indicated that about 200 addicts had been detoxified since the program began.

The relatively low number of persons detoxified, as compared with the total number served, was attributed, in part, by program officials to the lack of sufficient hospital beds for detoxification. We were told that during 1970 addicts spent an average of 10 to 12 weeks waiting for an opening for detoxification at one of the two hospitals used by the program.

Sources of funding

As an agency of the Episcopal Diocese of Chicago, St. Leonard's received funds from the Episcopal Church. Funds were also obtained from organizations such as the Community Fund of Chicago and Goodwill Industries and through private contributions. The Department of Justice and HEW provided funds in addition to the OEO funds. (See p. 86.)

Financial reports and records at St. Leonard's showed that the agency had received over $2 million during the 5-year period ended December 1971 for all its activities, including its narcotic addict treatment program. OEO provided $901,120 of this amount for the narcotic program.

Cost of various treatment modalities

The total reported expenditures for St. Leonard's narcotic program during its 4-1/2 years of operation were $1,161,911, including the OEO funds.

A 1970 OEO review of St. Leonard's operations noted that an average of 50 people were in treatment at any one time. Using this average enrollment and the average annual OEO costs of $263,076, we computed a treatment cost of $5,262 per patient-year, or a cost of about $14 a day for each addict in treatment.

From data supplied by the two hospitals which provided the facilities and services to detoxify St. Leonard's patients, we determined that 194 addicts were detoxified during the program period July 1, 1967, through September 30, 1971. The following table shows the number of patients detoxified by the two hospitals and the costs incurred for this purpose.

Hospital	Number of patients detoxified	Total costs	Average detoxification cost per patient
Rush-Presbyterian-St. Luke's	150	$138,900	$926
Walther Memorial	44	20,400	463
Total	194	$159,300	$821

We were told that the hospitals were reimbursed directly through the Cook County and Illinois Departments of Public Aid for most of these services, but we were unable to readily identify the total amount paid by these agencies or the amount included in St. Leonard's expenditures previously cited.

We were informed that because the Rush-Presbyterian-St. Luke's hospital is a teaching hospital, its per diem rate is higher than Walther Memorial, which is a general hospital. Also we noted that the length of the detoxification treatment period at Rush-Presbyterian-St. Luke's was slightly longer than at Walther Memorial.

Criteria used to select patients for treatment

St. Leonard's applicants came to the program either through word-of-mouth communication or by referral from various community social agencies.

Applicants had to be employable and, as previously explained, exhibit motivation for treatment and rehabilitation. If it was immediately apparent that the program could not meet the addict's needs, he was referred to other programs. Also the practice of testing a participant's motivation for treatment and rehabilitation while he was waiting for hospital detoxification undoubtedly discouraged narcotic addicts with limited motivation.

Program assessment efforts

Under OEO guidelines, both St. Leonard's and the Chicago Committee on Urban Opportunity were responsible for

evaluating the program, and both agencies collected data on patients and program operations. In addition, St. Leonard's was required to provide data on patients to the Friends of Psychiatric Research, Inc. (FPR), which, under contract to OEO, evaluated seven OEO projects. FPR's final report was issued to OEO in June 1970.

As a followup to the work performed by FPR, OEO contracted with Arthur D. Little, Inc., to conduct a comprehensive analysis of drug rehabilitation programs, including the one operated by St. Leonard's. A final report on this analysis was issued to OEO on June 30, 1971. Results of the work performed by FPR and Arthur D. Little, Inc., are discussed on page 61.

Local assessment efforts

St. Leonard's had not evaluated the efficacy of its treatment approach. Results of urinalyses made available to us were fragmentary and did not show either the number or percentage of drug-free patients. Other summarized data was available on the number of persons served, on their demographic characteristics, and on the type of services provided.

The Chicago Committee on Urban Opportunity's assessment efforts were limited primarily to administrative reviews and accumulation of data on program activity. In March 1969 committee personnel determined that St. Leonard's had served 489 narcotic users since inception of the program in July 1967 and that over 93 percent of these persons had not been in contact with the program for at least 2 months. The committee determined also that the program had placed over 50 persons in jobs at annual salaries ranging from $2,522 to $7,800.

The Executive Director of St. Leonard's recognized that the narcotic program generally had not met its stated objectives. The lack of hospital beds for detoxification, insufficient local employment opportunities, and inadequate housing, as well as problems in training personnel and turnover in staff, were cited as primary factors which adversely affected the program's ability to serve patients.

Evaluation by Friends of Psychiatric Research

FPR tabulated statistical data on 348 patients who were in the program sometime during a 2-year period ended March 1970. FPR reported on problems in data collection and concluded that it was unable to make an overall assessment of program effectiveness.

Notwithstanding the above qualification, FPR reported that St. Leonard's patients remained in treatment for an average of 134 days and that the use of narcotics declined significantly as patients continued in the program. For example, FPR reported that over 80 percent of the patients were using narcotics often, or almost daily, at admission and that this dropped to 16 percent after 5 months of treatment.

Due to the lack of adequate program data, FPR requested that St. Leonard's rate the relative success achieved by patients who were in treatment for at least 3 months. FPR reported the following ratings.

	Patients	Percent
Unimproved or worse	32	24
Slightly improved	66	50
Moderately improved	23	17
Markedly improved	9	7
Complete success	2	2
Total	132	100

The report cautioned that the reliability and validity of the ratings were open to question and stated that there was no way of determining to what extent any improvement in a patient's status was a function of the treatment efforts.

Study by Arthur D. Little, Inc.

Arthur D. Little, Inc., concluded in its report that most of St. Leonard's stated objectives had not been met. For example, the program established contact and provided information, service, and referral for the solution of immediate problems to only 225 persons instead of the

500 proposed to be served annually. The report stated that, instead of providing extensive rehabilitation to 125 persons following detoxification, only 75 to 90 patients received anything close to extensive rehabilitation during 1970.

The report also stated that the improper use of urine-testing techniques and poor record maintenance precluded a determination as to the length of time and degree to which patients were free from illicit use of drugs. Finally, only 19 of a possible 70 to 75 St. Leonard's patients were placed in employment during the first three quarters of 1970.

NEAR NORTH FAMILY GUIDANCE CENTER

The Near North Family Guidance Center, a nonprofit organization incorporated in October 1968, operates two mental health clinics which are primarily concerned with treating and rehabilitating narcotic addicts. The clinic we obtained information on is located in the near north--Rush Street--area of Chicago. The other clinic is located in a northern suburb of Chicago. The Chicago clinic is located in a 92-year-old, three-story, former private residence. (See photographs on p. 64.)

As of December 31, 1971, program staff assigned to the Chicago clinic totaled 11. The clinic director and the social services director devoted part of their time to the suburban clinic, whereas the other nine individuals, including two ex-addicts who worked as counselors, were full-time staff members at the Chicago clinic.

The Chicago clinic is primarily an outpatient clinic, specializing in providing both counseling and therapeutic services to drug abusers, who are considered the primary patients. Services are also available to patients' families.

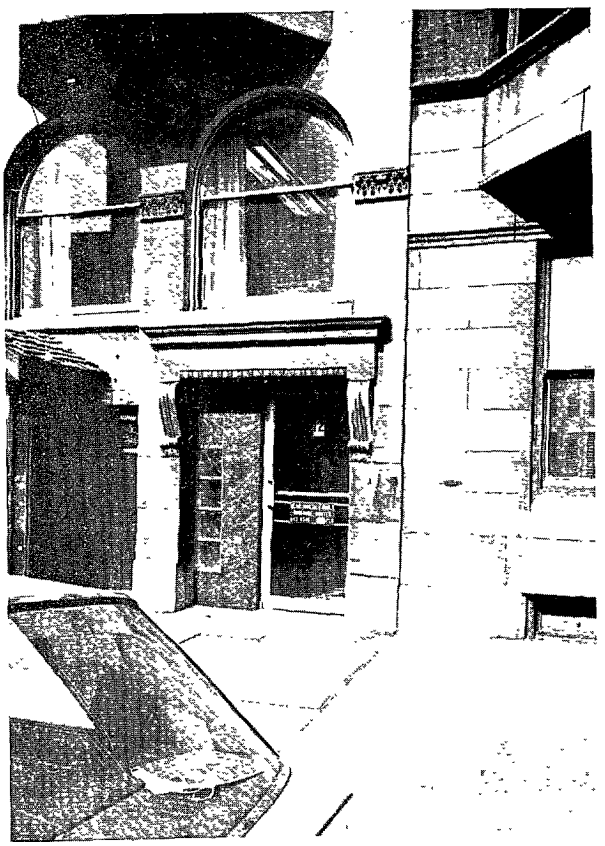
Program goals

The Chicago clinic's treatment goal is drug abstinence. Program officials stated, however, that success or failure cannot be determined on the basis of a single relapse to drug use and that the program utilizes the following criteria as measures of program success.

--Abstinence from drugs as determined by urine tests. Patients who abstain from drugs for 120 days are considered successes. Those who use drugs occasionally are considered partial successes.

--Change in community adjustment and illegal activity. Successful patients are those from whom there is no indication of misconduct or violation of the law.

--Integration into a conventional segment of the community. Factors include job stability and performance, appropriate schooling and vocational training, and stability in relationship with family and associates.



FACILITY AND ENTRANCE TO THE NEAR NORTH FAMILY GUIDANCE CENTER LOCATED IN THE NEAR NORTH (RUSH STREET) AREA OF CHICAGO.

Treatment modalities

The clinic's drug treatment program is primarily an outpatient program directed principally toward helping the adolescent drug abuser become abstinent and solve his family-related problems. In addition, the clinic provides methadone as a temporary supportive measure to narcotic addicts with the goal of total withdrawal from all drugs. The methadone support treatment resulting in withdrawal is scheduled over a period not exceeding 6 months, and a maximum fee of $15 per week is charged each patient in this program. When other forms of treatment have not been successful, a patient will be placed on methadone maintenance.

The services provided on an outpatient basis include individual, group, and/or family counseling; psychotherapy; educational and vocational training; employment placement; temporary housing; and 24-hour emergency assistance.

Inpatient detoxification services are also available at two local hospitals.

Patients in treatment and services available

We could not accurately determine the number of patients that had been served by the clinic, because complete records had not been maintained from inception of the program in January 1969. Program staff estimated, however, that from inception of the adolescent and family mental health program to June 30, 1970, about 410 drug abusers had been served. Clinic records showed that, from July 1, 1970, to December 31, 1971, 561 drug abusers were admitted to the program. The records showed 179 active drug patients as of December 31, 1971.

We found, however, that not all the patients reported to be active in the program were actually in contact with the clinic. For example, information available showed that only 39 percent of the reported active drug patients had visited the clinic in October 1971.

The methadone withdrawal program, which started in February 1971, had served 115 patients by December 31, 1971, 25 of whom were still in the program as of that date.

Records were not maintained for patients who were detoxified at the two local hospitals. Program staff estimated that about 60 patients had been referred to the two hospitals for detoxification.

Sources of funding

A summary of the funds provided to support the Near North Family Guidance Center from June 1, 1969, to December 31, 1971, is presented below.

Source of funds	Period ending 5-31-70	5-31-71	12-31-71	Total
Illinois Department of Mental Health	-	$36,596	$39,766	$ 76,362
Methadone program fees	-	16,781	19,583	36,364
Contributions	-	-	2,048	2,048
Private patients of staff	$2,465	3,326	1,901	7,692
Speaking engagements	110	40	819	969
Other income	-	1,663	-	1,663
Total	$2,575	$58,406	$64,117	$125,098

Cost of various treatment modalities

Presented below are our computations of per patient costs for the 7-month period June 1, 1971, to December 31, 1971, based on available program records and discussions with program personnel.

Program	Program costs	Patient-days of care provided	Cost per patient Per day	Per year
Methadone treatment	$41,514	6,502	$6.38	$2,329
Adolescent and family mental health	28,277	22,847[a]	1.23	449

[a]Based on average number of active patients in the program at the end of the month.

The above costs do not include hospitalization costs for those patients who were referred to the local hospitals for detoxification. Also the costs per patient-day for the adolescent and family mental health program appear unusually low and are probably understated since they are based on the average number of reported active patients at the end of each month rather than on the actual cases seen by program staff during the period. Cases are reported as active although the patient may not have been in contact with the clinic for as long as 90 days.

Criteria used to select patients for treatment

Patients admitted for treatment on a voluntary basis include both narcotic addicts and soft-drug abusers. Only narcotic addicts are eligible for methadone treatment. Narcotic addiction is determined during the intake process through interview, urine and blood tests, and a physical examination.

To remain in the outpatient program, the patients must attend individual and/or group-counseling sessions at least once a week, submit urine specimens three times per week, and pay weekly fees of $15 if they are receiving methadone.

Program assessment efforts

Near North has made some effort to evaluate its success on an individual patient basis, but the results of such efforts have not been summarized. The extent to which stated program objectives (see p. 63) were being met on an overall program basis could not be determined.

Results of assessment efforts

Our review of the clinic's current methadone withdrawal program showed that, of the 115 patients who had participated in the program from February 1971 through December 1971, only 10 had completed the program. These 10 patients were on methadone for periods ranging from 42 to 237 days prior to withdrawal. The status of the 115 patients as of December 31, 1971, is shown in the following table.

	Number of patients	
Terminated because of:		
Consistent absence	65	
Poor behavior and/or attitude	5	
Hospitalized	3	
Reason not cited	2	75
Transferred to other programs		5
Completed program--detoxified		10
Active in program as of 12-31-71		25
Total		115

DRUG ABUSE REHABILITATION TREATMENT PROGRAM

The DART program, sponsored by the State of Illinois Department of Corrections, is a pilot program for treating prospective male parolees with past histories of narcotic addiction who are to be released from Illinois State penal institutions. The approach of the DART program, which became operational in January 1971, is to support and encourage the reintegration of criminal offenders, with known drug addiction histories, into a community of parolees and/or ex-inmates. Participants are offered a continuum of services while they are in the penitentiary, in the correctional facility within the community, and living in the private community.

The DART program is staffed by 24 full-time employees and two part-time consultants. Nine members of the DART staff are paid from Federal funds, and 17 are paid by the Illinois Department of Corrections. The entire DART program staff, as well as the resident participants, are housed on the fourth floor of the Isham YMCA, adjacent to the Old Town area of Chicago. (See photographs on p. 70.)

Program goals

Basically the DART program has two stated goals. Program participants must not (1) engage in illicit drug use or (2) commit crimes. Failure to meet the second goal is measured in terms of conviction of a crime; the presumption is that a participant is innocent until proven guilty.

Employment and social adjustments are also objectives of the program. Participants' vocational and educational needs are assessed, and job opportunities are provided. A counselor monitors participant employment status weekly, and social adjustment ratings are completed weekly.

Treatment modalities

Treatment consists of four phases. Phase I involves orientation-therapy meetings held inside the prison. Progression from phase I into phase II (outside prison) is based on psychological tests, interviews, and satisfactory progress in group therapy. Participants help select candidates for

THE ISHAM YMCA, LOCATED ADJACENT TO THE NEAR NORTH (OLD TOWN) AREA OF CHICAGO, HOUSES THE DRUG ABUSE REHABILITATION AND TREATMENT PROGRAM (DART).

FOURTH FLOOR HALL OF NORTH WING OF ISHAM YMCA WHICH CONTAINS RESIDENT ROOMS AND THREE OFFICES OF THE DART PROGRAM.

phase II to give them some responsibility for the success of the program.

At the phase II facility, each resident undergoes a medical examination and evaluation and is required to provide daily urine samples. Individual, group, and family therapy sessions are provided the resident, either daily or weekly, by the psychologist. In addition, the entire clinical staff participates in individual, group, and family encounter sessions which may include informal confrontations with a resident by one or more of the staff. Informal confrontations occur in hallways, in the dining area, and in the staff offices and deal with the resident's individual problems as they may exist or occur at the time. During phase II a resident is allowed to leave the facility on an unsupervised basis for gainful employment. Additionally, many residents have participated in a work-study program at Malcolm X College.

The third phase of the program was to include a community halfway house where parolees could live while making a gradual supervised transition to the private community. As of mid-March 1972, DART had not obtained a facility nor implemented this phase of the program, and therefore residents completing the phase II program are paroled directly to phase IV.

Phase IV involves placing a person under "independent parole supervision" and allows him to live in the private community. This outpatient status requires that the parolee report to the phase II facility an average of three times each week for counseling and giving urine specimens, depending on the need of the individual as determined by the clinic staff.

Patients in treatment and services available

Once admitted to phase I, the inmate is assigned for several months to an orientation therapy group which meets at the penal institution, generally once each week. During the first year of phase I operations (Jan. to Dec. 1971), 122 inmates participated in group therapy sessions held at the Joliet-Stateville Branch, Illinois State Penitentiary, and at the adjoining honor farm.

At the Illinois State Penitentiary, Vienna Branch, 34 inmates participated in phase I, which was conducted by volunteers from Southern Illinois University. During the first year, 26 inmates voluntarily withdrew from this phase and 52 transferred to the phase II facility in Chicago.

Intake for phase I has been limited, according to the program director's annual report, due to the lack of funds to hire trained professionals to run group sessions and staff to administer, score, and evaluate the battery of psychological tests given the participants. Statistical data regarding the number of requests received for admission to phase I and not acted upon or rejected was not maintained. Also, the number of applicants in phase I is restricted since the phase II facility accommodates a maximum of 40 residents.

As of December 31, 1971, the statuses of the 52 residents admitted to phase II of the program were as follows:

	Number of residents
Remaining in phase II	23
Returned to prison or absconded	9
Returned to phase I	2
Paroled to phase IV	18
Total	52

From June 1 through December 31, 1971, 100 group therapy sessions were held for participants of phase IV and 520 urine specimens were tested for drug use. Two parolees were found to have returned to using narcotics, but both were subsequently detoxified and were free of drugs at the end of the first program year. Also, one parolee is on methadone maintenance under medical supervision.

Source of funding

A Federal grant for the DART program was awarded in August 1970 by LEAA under the Safe Streets Crime Control Program. The grant was for $200,000, and the grantee's contribution was to be $249,870.

Cost of various treatment modalities

DART financial reports showed that as of December 31, 1971, Federal funds expended amounted to $148,000 and local or State funds expended amounted to $157,700. Costs of the various phases of treatment had not been computed. However, we were able to determine and allocate the annual salary costs and other expenses incurred during 1971 on the basis of staff estimates of time spent and services provided in each of the treatment phases.

Our computations showed that the cost of each phase I group therapy session held at the Joliet-Stateville Branch of the Illinois State Penitentiary was $198.

Under phase II, 52 participants were in residence in the work-release facility 6,344 patient-days during the first year of operations. The cost per day was about $40. In phase IV, 18 participants were in an outpatient status 1,348 patient-days at a cost per day of about $27.

We did not compute any overall cost per patient because no participants had completed all phases of the program.

Criteria used to select participants for treatment

State regulations and administrative criteria applicable to the program provide that, to be eligible, an inmate must:

1. Plan to live in the Chicago area after parole.

2. Have a hearing scheduled before the parole and pardon board in not more than 10 months.

3. Not have been convicted of murder, kidnaping, or treason.

4. Have served at least one-half of his minimum sentence.

5. Have a history of illicit drug use.

Criteria for progression from phase I through phase IV are based in large part on the participant's progress.

However, before an inmate is paroled to phase IV, he must sign, as a condition of his parole, a stipulation that he will return to the phase II center for either individual and/or group therapy and that he will provide urine specimens an average of three times per week, if considered necessary by center staff.

Program assessment efforts

In its first year of operation, the DART program assessment efforts consisted primarily of monthly statistical data assembled and published by the Illinois Department of Corrections. Data collected included employment status and incidence of illicit drug use. Also reports by the project director provided information on the extent of drug use, as determined by urinalyses, and criminal activity, as measured by the number of convictions for crimes committed by inmates after their admission to the program.

Results of assessment efforts

Urine specimens are collected daily. During the first year of operation, 6,269 were collected. According to the director's annual report, laboratory results showed that only seven specimens, involving two persons, were positive for the presence of illicit drugs. Urinalyses for both men disclosed the presence of opiates, and both were returned to phase I at the Illinois State Penitentiary at Stateville.

Although none of the participants had been convicted of a crime during the first year of the program, three participants absconded. Of these three, one returned voluntarily. As of December 31, 1971, the other two had not been apprehended.

All 23 phase II residents were employed at December 31, 1971, and data available showed that weekly earnings averaged $85.33 from April through July 1971.

The project director's annual report concluded that the program's first-year efforts were highly successful. Success was attributed, in part, to the program's informal confrontation therapy techniques. (See p. 71.)

CHAPTER 5

PROGRAMS TOTALLY SUPPORTED BY THE FEDERAL GOVERNMENT

Federal agencies provide or contract for services for specific categories of persons in Chicago who have current narcotic addiction problems or past histories of narcotic addiction, including (1) veterans who are narcotic addicts, (2) narcotic addicts committed under NARA (28 U.S.C. 2901), and (3) certain Federal offenders who have past histories of drug addiction.

Treatment and rehabilitation services for veterans and NARA patients are of relatively recent origin. These specialized services result from a 1971 VA decision to provide narcotic treatment services to veterans on a nationwide basis and from the mid-1967 implementation of NARA, which is administered by NIMH and the Department of Justice.

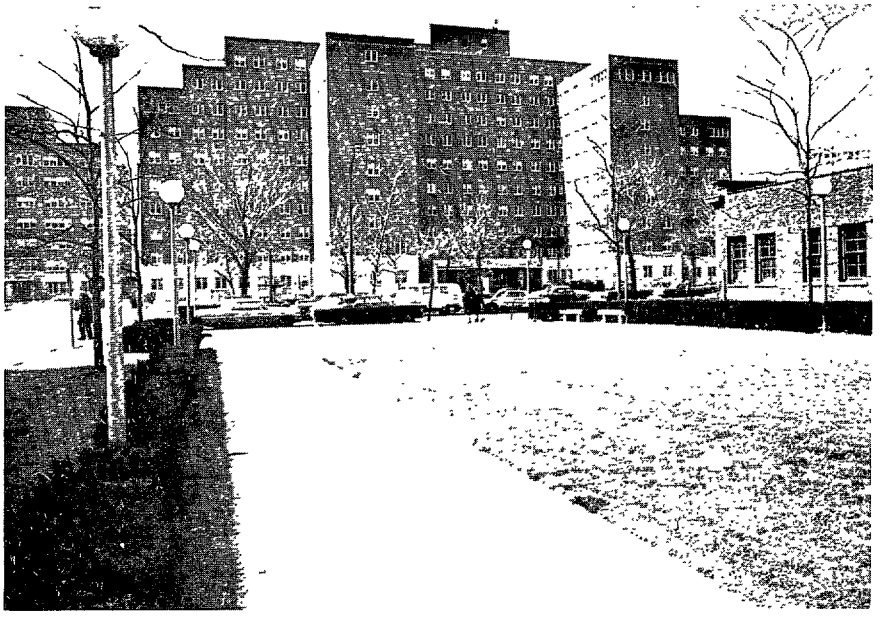
Custodial and supportive services for Federal offenders, including offenders who have past histories of addiction, have been provided in Chicago since 1961 by BOP as part of the Federal corrections system.

Details on each of these Federal programs follow.

VETERANS ADMINISTRATION WEST SIDE HOSPITAL

A drug treatment center at the VA West Side Hospital in Chicago was opened in July 1971. The center's program, as initially proposed, was patterned in part after the VA Palo Alto, California, treatment program but was subsequently modified to meet local needs.

The hospital, in Chicago's West Side Medical Center complex, is a 545-bed general medical and surgical hospital staffed by over 1,200 full- and part-time employees. (See photograph on p. 76.) The drug treatment center is in the hospital's 105-bed psychiatric and neurological department and provides both inpatient and outpatient services.



THE VETERANS ADMINISTRATION WEST SIDE HOSPITAL LOCATED IN CHICAGO'S WEST SIDE MEDICAL CENTER COMPLEX.

As of December 31, 1971, the drug treatment center staff included 39 full-time and 47 part-time medical and administrative personnel.

Program goals

The drug abuse program as developed by the VA West Side Hospital is directed toward offering the veteran an opportunity to overcome his drug dependency. In general the goals of the program are to have the patient (1) end his dependence on illicit drugs, (2) develop emotional stability in order to participate in meaningful social and family relationships, and (3) obtain legitimate and gainful employment.

Treatment modalities

The drug abuse program is directed primarily to the narcotic user and consists of five treatment and rehabilitation modalities. These are:

--Inpatient detoxification.
--Inpatient rehabilitation.
--Outpatient abstinence counseling.

--Outpatient methadone maintenance.
--Outpatient methadone withdrawal.

The period of hospitalization for detoxification is as brief as possible, generally from 3 to 5 days. To assist the patient in detoxification, drug counselors and medical staff are available continuously.

After detoxification the patient may elect to transfer to one of the other modalities. Patients who are judged "motivated to quit drugs" are candidates for the inpatient rehabilitation program. A screening committee consisting of a staff physician, three staff members, and three patients selects these candidates. Generally, all types of drug abusers are accepted into the inpatient program, although narcotic addicts are given preference.

The 24-bed inpatient rehabilitation program consists of a small community of patients who want and need further support to meet the ultimate goal of rehabilitation. The initial phase of the program lasts at least 2 weeks, during which the patient is on probation and is restricted to the immediate area while his motivation and capacity for a change in lifestyle are tested.

The second phase takes at least 4 weeks and deals with the patient's emotional problems through individual and group-counseling sessions. Regular evening sessions are also held, with family members in attendance. Also during this phase the patient is expected to assume some responsibility in operating and managing the inpatient community. At the end of the 4-week period, if the patient has made satisfactory progress, he is advanced to phase III.

In phase III, which lasts at least 2 months, the patient is expected to orient himself to the demands of the outside world. Personal relationships are nurtured and solidified, and the patient looks for employment or furthers his training opportunities, as well as continues in individual and group therapy sessions.

It is the hospital's general policy to provide a continuum of outpatient services to all patients. Patients are transferred to an outpatient status either after participating in the program as an inpatient or after being admitted to the hospital on an emergency basis. Outpatients receive counseling and participate in either an abstinence, a methadone maintenance, or a methadone withdrawal treatment modality. We were informed that the choice of modality is made primarily by the patient.

Outpatient services in the abstinence program consist primarily of counseling sessions. Sessions with individuals are held on both a scheduled and an as-needed basis. Weekly group sessions are held with an average attendance of seven to 10 patients.

Methadone is administered daily to patients orally by staff nurses during the first 6 weeks of treatment. Generally visits to the hospital are required only three times a week after 6 weeks of treatment and twice a week after 6 months of treatment, if the patient is consistently free from illicit drug use. The initial dosage of methadone is low, usually between 10 and 50 milligrams. Services such as individual and group psychotherapy, counseling, vocational guidance, and job and educational placement are provided to methadone patients on a scheduled basis. Also, urine samples are obtained at least two time a week during the initial phases of the program.

Patients who fail to participate in the program on the scheduled basis and who continue to use drugs may be required to participate in counseling sessions as a condition of obtaining methadone. Patients who do not remain drug free must make more frequent visits to the hospital to obtain their methadone.

Patients in treatment and services available

The drug treatment center includes a 24-bed detoxification ward and a 24-bed ward for inpatient rehabilitation. As of December 31, 1971, 24 patients were in the detoxification ward and 18 were in the rehabilitation ward. Also, six patients were being detoxified in other medical and surgical wards because of the lack of beds in the drug center.

From inception of the program in July 1971 through December 31, 1971, 394 applications were received for admission into the inpatient detoxification ward. However, 102 applicants dropped out of the program during the intake process. The remaining 292 were admitted as inpatients. Information showing the number of patients who completed the detoxification program was not available. According to hospital records, there were 209 admissions to the outpatient program during the 6 months ended December 31, 1971. The records showed that 152 of these patients remained in the outpatient program as of December 31, 1971. Since, according to VA officials, no patients sucessfully completed the program, it appears that 57 patients dropped out of outpatient treatment during the 6-month period.

Our review showed that 56 of the 152 outpatients were on methadone. Information was not available showing the number of patients in each of the two methadone modalities (maintenance and withdrawal). The remaining 96 patients were in the abstinence modality.

Source of funding

The VA Central Office in Washington allocated $582,526 to the hospital drug treatment center for fiscal year 1972. This allocation was to provide:

	Inpatient program	Outpatient program	Total
Staff	$246,250	$200,750	$447,000
Supplies	13,000	57,000	70,000
Renovation and equipment			65,500
Total			$582,500

Cost of various treatment modalities

Our review of VA records and discussions with program personnel showed that the following drug treatment costs were incurred from July 1 through December 31, 1971:

	Inpatient	Outpatient	Total
Direct costs	$162,300	$ 78,900	$241,200
Indirect costs	88,900	43,800	132,700
Total	$251,200	$122,700	$373,900

Criteria used to select patients for treatment

In September 1971 the VA Central Office classified all veterans seeking medical assistance because of drug dependence as medical emergencies. VA hospital officials infromed us that all addicts representing themselves as veterans are admitted to the hospital immediately and that there is no waiting list. A patient's eligibility is subsequently verified, and if the patient is found ineligible, he is discharged as soon as practicable and billed for the charges. Of the 292 inpatients admitted to the hospital drug program through December 31, 1971, six were found to be ineligible and were billed for a total of $6,100, which covered 100 days of inpatient care.

Admission criteria for the inpatient rehabilitation program are based primarily on the patient's motivation to quit drugs. A screening committee decides whether to admit an individual for inpatient treatment. (See p. 77.)

To be admitted to the outpatient methadone program, the patient must:

1. Be at least 18 years of age.

2. Have a history of regular narcotic use for at least 1 year and have made one detoxification attempt.

3. Not be receiving methadone medication from another program.

4. Give informed consent prior to start of treatment.

5. Wait 30 days if he had performed unsatisfactorily in, or had been discharged from, another methadone maintenance program.

Program assessment efforts

At the time of our review, an assessment of the program had not been made since it had been operational for a short period--about 6 months. In January 1972 a psychologist was hired as a consultant to develop guidelines and procedures for evaluating the program.

Results of assessment efforts

In the absence of other evaluative data, we gathered information on 1,655 urinalyses performed from August through December 1971. The results of these tests are summarized below.

	Inpatient	Outpatient	Total
Morphine (heroin):			
Tests performed	697	907	1,604
Positive results	83	191	274
Percent of tests positive	12	21	17
Barbiturates:			
Tests performed	188	364	552
Positive results	12	10	22
Percent of tests positive	6	3	4
Amphetamines:			
Tests performed	195	370	565
Positive results	9	15	24
Percent of tests positive	5	4	4

The drug treatment center staff advised us that they had suspected that some heroin had been smuggled into the detoxification ward during October 1971 and that this could account for the 12-percent rate of positive inpatient morphine tests.

Outpatients in the abstinence program were not required to provide urine specimens. Since these patients appear to be more susceptible to illicit drug use than inpatients, we

discussed this absence of testing with the program director. The director informed us that he was unaware that these patients were not required to submit urine specimens and stated that these patients would be included in future testing.

FEDERAL CIVIL COMMITMENT PROGRAM

Civil commitment of narcotic addicts is generally understood to mean compulsory confinement in a narcotic treatment facility followed by outpatient treatment under intensive parole-type supervision. The treatment regimen consists of withdrawing the addicts from their physical dependence upon narcotics and providing therapy and training to overcome their psychological dependence. Commitment is for an indeterminate period not to exceed a specified number of years set forth in the applicable statutes.

In 1966 the Congress passed NARA, which provided for:

--Pretrial civil commitment for treatment, in lieu of prosecution, of addicts charged with certain Federal crimes (title I).

--Sentencing addicts convicted of certain Federal crimes to commitment for treatment (title II).

--Voluntary civil commitment for treatment of addicts not charged with criminal offenses (title III).

NIMH administers titles I and III.

After an addict has been determined suitable for treatment, he receives inpatient treatment at either the Lexington, Kentucky, clinical research center or at a contractor facility. Following the inpatient phase the patient receives aftercare from a community organization under contract with NIMH.

BOP administers title II. A Federal correctional institution provides inpatient care. Upon the patient's release from the institution, an organization under contract with BOP provides aftercare in the community.

Under title III persons voluntarily seeking treatment for narcotic addiction file petitions with the local U.S. Attorney. The U.S. Attorney then determines whether there is reasonable cause to believe that the person seeking treatment is a narcotic addict and whether appropriate State or local treatment facilities are available. If the

applicant is determined to be a narcotic addict and if appropriate State or local treatment facilities are not available, the U.S. Attorney will petition the U.S. district court for commitment.

Aftercare under titles I, II, and III is provided in Chicago by St. Leonard's House and the Near North Family Guidance Center. (Both agencies' non-NARA programs are discussed in chapter 4.)

Continued limited use of civil commitment program

Our discussions with personnel of the U.S. Attorney's office in Chicago indicated that the basic conditions reported in our September 20, 1971, report to the Congress--"Limited Use of Federal Programs to Commit Narcotic Addicts for Treatment and Rehabilitation" (B-164031(2))--remained the same. In general, our previous report showed very limited use of title I and a high rejection of title III applicants because of their unsuitability for treatment. Also, as indicated in our previous report, the U.S. Attorney's office was not considered an appropriate intake point for persons seeking treatment under title III.

In February 1972 the Chief of the Civil Division of the U.S. Attorney's office in Chicago advised us that information was not complete on either title I or title II commitments during calendar year 1971. We were advised that there were about five title II commitments during calendar year 1970 and that in each of these cases the commitment was at the request of the defendant.

The U.S. Attorney's office provided the following information on title III activity during calendar year 1971.

Petitioned U.S. Attorney's office for commitment:		101
Not qualified	18	
Did not appear for commitment hearing	38	56
Committed to inpatient evaluation and examination:		45
Rejected during first 30 days		31
Committed to inpatient treatment		14

The Chief of the Civil Division told us that most of the persons who did not appear for the commitment hearing could be classified as lacking adequate motivation for treatment. Persons determined not qualified include those facing State or local criminal charges. Rejections during the first 30 days after commitment to examination and evaluation resulted from determinations that the individuals were unsuitable for treatment.

The Chief of the Civil Division also told us that he believed that the U.S. Attorney's office should not be the intake office for the title III program because it is a law office and not a social agency.

Aftercare agencies

Both St. Leonard's and Near North have aftercare contracts with NIMH for patients committed under titles I and III and with BOP for patients committed under title II. The title I and III programs were implemented in July 1968 at St. Leonard's and in February 1969 at Near North. The title II program was implemented by St. Leonard's in February 1969 and by Near North in March 1970.

Program goals

The goals of the programs, as stated in the act, are to restore the narcotic addict to health and return him to society as a useful member. In line with these goals, the two agencies have implemented programs to develop an individual into a non-drug-abusing, law-abiding, and socially acceptable and productive citizen. While the programs of the two agencies are based on a philosophy of complete abstinence from illicit drug use, occasional use of drugs by the patient, or "chipping," may not necessarily result in return of an addict to institutional custody.

Treatment modality and service

Both aftercare agencies provide individual, group, and/or family counseling; educational and vocational training; employment placement; temporary housing; and other assistance, such as temporary shelter and emergency residential care. In addition, detoxification on an inpatient basis is

arranged through local hospitals. Some of the patients under the title II program also receive temporary assistance, such as food, shelter, and clothing, at the BOP community treatment center, which is discussed on page 88.

Patients in aftercare treatment

The following table shows the statuses of the patients who were treated by the two agencies from inception of their programs to December 31, 1971.

	Number of patients					
	Title I		Title II		Title III	
	Near North	St. Leonard's	Near North	St. Leonard's	Near North	St. Leonard's
Admitted	-	4	6	6	26	39
Completed program	-	-	-	-	3	1
Terminated:						
Recommitted	-	-	1	1	1	10
Discharged for noncooperation	-	1	-	1	1	2
Incarcerated	-	-	-	-	-	1
No reason stated	-	-	-	-	-	2
Transferred to other programs	-	-	-	1	-	8
	-	1	1	3	5	24
In program 12-31-71	-	3	5	3	21	15

Source of funds and cost of treatment

The amounts funded for the above programs by NIMH and BOP from inception of the programs through December 31, 1971, and average costs per patient-day are summarized below.

	NIMH (titles I and III)		BOP (title II)	
	St. Leonard's	Near North	St. Leonard's (note a)	Near North (note a)
Total program costs	$170,584	$127,921	$6,239	$13,832
Number of patients treated	43	26	6	6
Average cost per patient-day of services provided	(b)	$8.22	(b)	$5.60

[a] Includes costs (about $3,700) for patients temporarily housed at the BOP center.

[b] Information on patient-days of care was not readily available.

Program assessment efforts

Monthly evaluations of individual patients' progress are made in accordance with the requirements of the contracts between these agencies and NIMH and BOP. The monthly progress reports, which include such information as results of urine tests, patients' arrest records, and employment histories, are forwarded to the appropriate Federal agencies for their summarization and use in making overall program evaluations. While both NIMH and BOP issued some nationwide reports dealing with their respective programs, officials of these agencies in Chicago had no evaluative information directed specifically to the operations in Chicago.

Results of GAO assessment efforts

Program staff at Near North informed us that all five patients in their title II program as of December 31, 1971, were abstinent from drugs and were employed. They also informed us that about 12 percent of their titles I and III patients had engaged in illicit drug use.

Our review of urine test for St. Leonard's titles I and III patients showed that an average of 20 percent of the tests were positive for illicit drug use from 1969 through 1971. The rate of positive tests for the title II patients was 11 percent for the same period.

While officials of both agencies felt that the NARA program provided a meaningful alternative to prosecution or sentencing of narcotic addicts, they felt that the inpatient services under title II were generally more effective than those provided under the other two titles. They attributed the lower rate of illicit drug use among title II patients to the fact that these individuals could be returned to custody if they did not adhere to treatment guidelines.

COMMUNITY TREATMENT CENTERS FOR FEDERAL OFFENDERS

The BOP Community Treatment Center in Chicago serves Federal offenders who have past histories of addiction. These facilities, in general, provide services similar to the DART program. (See p. 69.)

The Chicago Community Treatment Center program offers a residential program to facilitate the orderly reintegration of offenders into the community. Services available include vocational guidance and placement, food and shelter, emergency clothing, and medical care.

The center was established in Chicago in 1961. Satellite units in Milwaukee, Wisconsin, and southern Chicago were added in 1970. As shown on the map on page 10, three YMCA facilities in Chicago are utilized for program operations. As of December 31, 1971, the three facilities provided space for 37 residents.

Data for fiscal years 1969 and 1970 indicated that about 23 percent of all offenders entering the center had histories of drug abuse and that about 15 percent of these, or 57, were narcotic addicts. More current data was not available. Also, because the center has no provision for followup on former residents, it was not known how many offenders remained drug free or how many returned to illicit drug use.

CHAPTER 6

PROBLEMS REGARDING DRUG TREATMENT PROGRAMS

We visited the sites of treatment programs and spoke with program officials to obtain information on problems being encountered in establishing and operating drug treatment programs. We also talked with local officials of governmental activities which had been directly concerned with, or had provided financial support to, drug treatment programs. The problems or concerns mentioned related to

--coordination in planning;

--mobilization of resources for facilities;

--recruitment, training, and retention of staff;

--efficacy of treatment approaches; and

--reliability and accuracy of cost data.

COORDINATION IN PLANNING

Our discussions with local officials indicated that the overall Federal-State-local government effort to develop narcotic addict treatment and rehabilitation programs in Chicago was not well coordinated.

Under Illinois statutes the Dangerous Drugs Advisory Council has the responsibility, as did its predecessor, the Narcotic Advisory Council, to consult with various Federal, State, local, and private agencies to establish and coordinate a unified program for rehabilitating narcotic addicts. The chairman of the council told us that it has not fully carried out these responsibilities. He stated that the council was an advisory body without a staff and that the IDAP director and his staff had provided the principal planning and direction to the State's effort.

Although IDAP had utilized both State and Federal funds, and in turn, had provided funds to private agencies through contracts, these agencies also independently sought additional funds. In essence, the planning and direction at

IDAP was directed principally to the IDAP program and IDAP was one of several agencies competing for available government funds.

IDAP was not substantially involved in the award of State or Federal grants to WSO, St. Leonard's, Mile Square Health Center, DART, Near North, and Gateway. Also other State agencies, including the Departments of Mental Health, Corrections, and Public Aid and the Illinois Law Enforcement Commission, were involved in one or more of these grants. The involvement of these agencies was independent of any overall IDAP plans.

In addition, Illinois Law Enforcement Commission officials informed us that the commission had no overall plan for funding drug abuse programs.

NIMH is the principal Federal agency assisting local programs for treating and rehabilitating narcotic addicts. In Chicago Federal grant funds available to the agencies we reviewed included funds from NIMH, LEAA, and OEO. Regarding coordination, NIMH regional officials told us that from 1968 through 1970 they were involved in a regional committee which attempted to coordinate Federal programs in the drug abuse prevention, education, and treatment areas. An NIMH regional official advised us in December 1971 that the committee had not included representatives of either LEAA or OEO and had become dormant in early 1971 because of the limited participation by the representatives of the HEW member agencies.

NEED FOR ADDITIONAL AND IMPROVED FACILITIES

Most of the programs we examined had encountered problems in securing facilities. The problems centered around a shortage of funds, difficulties in securing working agreements to use existing facilities, and negative reactions by some of the communities about the prospective locations of treatment facilities. At the time of our review, most of the programs needed to establish additional and improved facilities.

Examples of such problems follow.

--The DART program was faced with limited funds, inadequate facilities to serve the patients entering

the second phase of that program, and no facilities for the third phase of the program.

--The VA program initially planned a 14-day inpatient detoxification stay. At the time of our review the stay was averaging 7 days and hospital officials were hoping to cut this to 5 days. The basic problem was that the hospital had not set aside enough beds for detoxification on a 14-day basis. Moreover, the hospital was utilizing 30 beds and VA Central Office was recommending that this number be reduced to 15.

--The IDAP program established the pretreatment methadone clinics to eliminate the waiting list problem. However, this is a holding operation pending the development of additional full treatment facilities.

Apart from the problems of securing funds to establish facilities, agencies, in some cases, were unable to secure working agreements with hospitals for sufficient space for inpatient detoxification of their patients. This was a major problem for the OEO-funded project operated by St. Leonard's. Also WSO officials told us in April 1972 that they were still seeking agreements for inpatient hospital care.

Finally, officials of both Gateway and DART informed us of problems involving community acceptance that had been encountered in establishing residential facilities for addicts. During the first 2 years of operation Gateway was involved in developing three residential facilities and all three were involved in litigation, which in varying degrees surfaced due to negative community reactions. At the time of our review, Gateway was considering the relocation of one of its facilities because of these problems.

RECRUITMENT, TRAINING, AND RETENTION OF STAFF

Each program on which we obtained information reported some problems in training staff members, particularly counselors. A corollary problem was the shortage of funds to employ specialists for basic supportive services, such as job training and placement and vocational rehabilitation.

Complicating these problems was the lure of new drug treatment programs, some of which were able to offer higher salaries or more prestigious positions.

The Executive Director of St. Leonard's partially attributed the demise of its OEO-funded narcotic treatment project to an inability to employ a competent staff. The constant uncertainty about the future of the program frustrated efforts to recruit and retain competent staff members.

One of the areas that has suffered because of staffing difficulties involves employment opportunities for ex-addicts and patients stabilized on methadone. For example, IDAP program statistics show that there has been very little increase in the number of patients becoming employed. IDAP's primary activity in the area of employment has been the establishment of referral services whereby patients are referred to other agencies which might be able to help them find employment.

EFFICACY OF TREATMENT APPROACHES

Program results as they relate to established goals and criteria were not routinely compiled and disseminated by most of the drug treatment programs we reviewed. Some programs--VA, WSO, BRASS, and Near North--had not developed techniques for summarizing data on active and inactive patients. Others, including IDAP, which had the largest data collection system, did not follow up on former patients to find out why they left treatment and what impact the program made on their lives. Further, IDAP officials admitted that the program results summarized to date were of little value for judging the comparative effectiveness of treatment approaches.

The Illinois Legislative Investigating Commission, in its October 1971 report to the Illinois General Assembly, highlighted the need for comprehensive program assessment efforts. The commission recommended that the State appropriate funds for IDAP to engage in comprehensive research and evaluation studies.

RELIABILITY AND ACCURACY OF COST DATA

Because most of the drug treatment programs we examined did not have cost accounting systems, we were unable to develop information on the cost of various treatment modalities. Of greater significance was the fact that some program officials do not have cost data on a recurring basis which can be used to assess the efficiency of their operations. A notable exception was the Gateway therapeutic community program, which had a system that enabled a public accounting firm to periodically develop per patient costs. IDAP officials told us that they are implementing a cost accounting system which will permit per patient cost comparisons between treatment modalities and treatment units of the same modality.

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

October 15, 1971

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

Dear Mr. Staats:

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

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

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

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

Sincerely,

Don Edwards

Don Edwards
Chairman
Subcommittee No. 4

APPENDIX II

INDICATORS OF THE SIZE OF CHICAGO'S ADDICTION PROBLEM

Various agencies contacted during our review have estimated the number of narcotic addicts in Chicago. The estimates range from 7,190 to 37,000, and, although officials stated that accurate estimating techniques are lacking, most agreed that the problem of drug abuse is increasing in Chicago.

ESTIMATES OF THE NUMBER OF ADDICTS

The Bureau of Narcotics and Dangerous Drugs (BNDD) estimated the number of addicts in Chicago to be 7,190 as of December 31, 1971. To determine the number of persons using narcotics, BNDD asks local enforcement agencies to furnish information on an arrested person when there are clear indications that he is an addict. The reporting process is strictly voluntary, and agencies use their own judgment as to whom they should report as an addict.

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.

Because of these factors, there is reason to believe that the total number of addicts reported to and by BNDD is understated. For example, during 1971, agencies in Chicago reported contacts with only 16 addicts to BNDD whereas during the preceding 4 years they reported 4,705. Moreover, our review showed that 3,874 addicts were admitted to treatment programs during 1971. In addition, the 1969 BNDD estimate for Chicago was 10,200, which would indicate that the number of addicts is decreasing, while all other indicators, as explained below, show that the number is increasing.

COOK COUNTY OVERDOSE DEATHS

While many agencies believe the addiction problem to be rising, the most alarming indication is the statistics on overdose deaths reported by the Cook County Coroner. In

1971, 310 drug overdose deaths were reported, of which 184, or 59 percent, were attributed to morphine or heroin. In 1970, 277 drug overdose deaths were reported, of which 142, or 51 percent, were attributed to morphine or heroin.

LOCAL CRIMINAL JUSTICE SYSTEM

Chicago Police Department records show 2,795 narcotic arrests for 1970, but the department makes no official estimate of the total number of addicts. The department's records, however, show a steady increase in narcotic arrests, as follows: 1,806 in 1967, 1,883 in 1968, 2,268 in 1969, and 2,795 in 1970.

The Illinois Bureau of Investigation reported a 38-percent increase in arrests made by their Narcotics Division between 1970 and 1971. The bureau reported that substantial heroin and cocaine traffic has spread throughout the State to the suburbs and smaller cities and among college students. The bureau stated that, in view of the dramatic increases in drug-related arrests, seizures, and convictions, it appears drug traffic and abuse has not yet reached a peak.

The Illinois Department of Corrections estimates that there could be as many as 1,500 inmates of the total prison population of 7,500 in Illinois with histories of drug addiction. The department has started the DART work-release program for parolees. (See p. 69.)

While we found no exact cost data being maintained for processing heroin addicts through the criminal justice system, some data was available for estimating the per diem costs of maintaining offenders. Using this data we estimated the total annual cost of maintaining addicts in the system to be $4.4 million, which included the costs of arrest, arraignment, trial, incarceration, and probation.

EFFORTS TO OBTAIN BETTER INDICATORS OF THE PROBLEM

Several steps are being taken, in recognition of the problem of estimating the number of addicts, to obtain more definitive data.

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The Illinois Legislative Investigating Commission has recommended the adoption of a Uniform Drug Arrest Form to be used by all Illinois enforcement agencies, and the Illinois Legislature has provided the statutory authority to explore the feasibility of drafting such a form.

The Chicago Board of Health is planning an epidemiology study to provide data on the nature and extent of the drug abuse problem in Chicago and to assess, evaluate, plan, and modify programs.

The Illinois Dangerous Drugs Advisory Council is conducting a study to determine the need for drug rehabilitation programs for veterans. One of the reasons for the study was the number of Vietnam veterans estimated to be addicted to heroin. The interim report of the council study group has indicated the problem is not as significant as originally anticipated.