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

Narcotic Addiction Treatment And Rehabilitation Programs In San Francisco And Alameda Counties, California

B-164217

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

JULY 24, 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 San Francisco and Alameda Counties, Calif., and at the Veterans Administration Hospital at Palo Alto, Calif. This is the third in a series of five reports to be issued pursuant to this request. Other reports issued or to be issued cover Washington, D.C.; New York City; Chicago, Ill.; and Los Angeles, Calif.

We discussed this report with the appropriate Federal, State, county, and city officials, but we did not obtain their formal written comments. Oral comments received have been considered 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 after your agreement has been obtained or public announcement has been made by you concerning its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

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

Contents

ABBREVIATIONS

BCMP	Berkeley Community Methadone Program
GAO	General Accounting Office
GROUP	Growth Reorientation Opportunities Unlimited Project
LEAA	Law Enforcement Assistance Administration, Department of Justice
OEO	Office of Economic Opportunity
VA	Veterans Administration
VAHPA	Veterans Administration Hospital at Palo Alto, Calif.

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 frequently lacking. Results of varying methods of treatment are debated by experts. Information on numbers of addicts in the Nation is based on educated guesses at best. Data on people in treatment throughout the country are 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 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, Ill.; and Los Angeles and San Francisco, Calif.--and that separate reports be prepared for each. This report concerns programs in San Francisco and Alameda Counties, Calif., and at the Veterans Administration Hospital in Palo Alto, Calif. (VAHPA).

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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 addict treatment and rehabilitation programs, numbers of addicts being treated by each modality, program goals and criteria used to measure program accomplishments, and efforts being made by program sponsors to measure the effectiveness of their programs. 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.

Estimates of the number of addicts in San Francisco[1] ranged from 4,500 to 7,200, and Alameda County estimates indicated that a minimum of 5,000 narcotic addicts resided in the county. The number of persons arrested in San Francisco for all categories of drug violations, including sale, possession, and use of all dangerous drugs and marihuana, were 6,408 in 1970 and 7,147 in 1971. In Oakland, Alameda County's largest city, arrests for narcotic law violations totaled 3,583 in 1970 and 2,063 in 1971.

A study based on interviews with 1,700 narcotic addicts at San Francisco's Haight-Ashbury Medical Clinic during 1970 by the clinic's epidemiologist showed that the addicts had obtained during 1 year $29 million to acquire heroin. The $29 million was obtained in the following ways:

Source	Amount (millions)
Thievery and burglary ($21 million in goods sold at one-third value)	$ 7
Cash robbery	3
Prostitution and pimping	4
Welfare	2
Jobs	7
Selling drugs	5
Other	1
	$29

[1]As used in this report, San Francisco refers to both the city and the county, which are coterminous.

The study indicated that the overall cost of heroin addiction in the San Francisco Bay Area would be about 10 times this amount, or approximately $290 million.

Alameda County estimated that (1) the direct costs of arrests, confinement, probation, hospitalization, and other expenses as a result of drug use exceeded $5 million in 1971 and (2) $100 million had been spent each year to purchase heroin.

CHAPTER 2

TREATMENT AND REHABILITATION PROGRAMS IN SAN FRANCISCO AND ALAMEDA COUNTIES

Narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties were funded by the local governments (city and county), by State and Federal agencies, and by private sources. The budgeted fiscal year 1972 financial support from Federal, State, and local governments for drug treatment and rehabilitation programs[1] in these counties was as follows:

		Amount	
San Francisco:			
City and county		$ 693,815	
State		962,857	
Federal:			
National Institute of Mental Health, Department of Health, Education, and Welfare		1,030,373	
Law Enforcement Assistance Administration (LEAA), Department of Justice		61,555	
Total			$2,748,600
Alameda County:			
Local:			
County	$ 25,749		
City of Berkeley	62,500	88,249	
State		517,377	
Federal:			
Office of Economic Opportunity (OEO)	274,783		
Model Cities Program, Department of Housing and Urban Development	126,049		
National Institute of Mental Health	18,000		
LEAA	146,123		
		564,955	
Total			1,170,581
Total San Francisco and Alameda Counties			$3,919,181

FEDERAL PROGRAMS

As shown in the above table, the Federal Government provided funds for treating and rehabilitating narcotic addicts in San Francisco and Alameda Counties through the National

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[1] We were unable to identify narcotic rehabilitation and treatment program costs since most programs offer services to abusers of all drugs.

Institute of Mental Health, OEO, the Model Cities Program, and LEAA.

In Alameda County the OEO-funded program was not fully operational as of March 1972, and the program, which received Model Cities funds, had been in operation approximately 6 months as of that time.

In addition, VAHPA provided narcotic treatment and rehabilitation for veterans in the San Francisco Bay area. (See p. 50.) This program maintains a satellite methadone maintenance center in San Francisco to dispense methadone and provide supportive services.

STATE PROGRAMS

California provided funds for narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties through the Department of Mental Hygiene, the California Council on Criminal Justice, and the California Department of Corrections.

Department of Mental Hygiene

The department operated State hospitals for the mentally ill and provided funding for mental health services under the Short-Doyle Act. The Lanterman-Petris-Short Act, which amended the Short-Doyle Act, established a 90-percent-State and a 10-percent-county financing formula for mental health services rendered to patients treated in State hospitals or community programs.

Each county with a population of over 100,000 was required to have a plan for mental health which established priorities of services. The county plans were forwarded to the State Department of Mental Hygiene for approval. Drug abuse programs were included as one of the authorized mental health services, but the amount of money spent on any service was left to the county's discretion.

California Council on Criminal Justice

The council, a 29-member board chaired by the attorney general of the State of California, administers LEAA grants

for California and determines which programs will be granted LEAA funds. Membership on the council was established on a regional basis. There were 23 regions, each with one to four participating counties. Of the LEAA funds the council receives, 75 percent must go to local units of government, such as city councils or county boards of supervisors.

California Department of Corrections
civil addict program

This program provides institutional and outpatient care to narcotic addicts committed for treatment and rehabilitation by the courts. Inpatient treatment and rehabilitation is provided at the California Rehabilitation Center facilities in Corona and at Patten Hospital near San Bernardino. Region II of the Parole and Community Services Division of the Department of Corrections administers the outpatient program in San Francisco and Alameda Counties. Our report on narcotic treatment and rehabilitation programs in Los Angeles included additional information on this program. However, problems which may be unique to the San Francisco and Alameda outpatient treatment programs are discussed later in this report. (See p. 59.)

LOCAL GOVERNMENT PROGRAMS

Drug abuse treatment and rehabilitation in San Francisco was primarily the responsibility of the county's Department of Public Health. The department either operated facilities which provided narcotic addiction treatment and rehabilitation or contracted with private local programs to provide such services to community residents.

A comprehensive community drug abuse program for San Francisco was being developed by the department. The San Francisco Coordinating Council on Drug Abuse, which comprised more than 70 public and private entities, was assisting with the development of this program. When completed it will set forth the roles of the private and public sectors in the diagnosis, treatment, rehabilitation, education, and prevention of drug abuse and addiction in San Francisco.

The program will provide for an epidemiological approach to drug abuse--that is, it will utilize techniques

similar to those used for the control and elimination of an epidemic disease. The techniques are to (1) identify, diagnose, and treat cases, (2) find sources, (3) identify modes of transmission, (4) define suspects, (5) break the cycle of transmission, (6) provide educational programs, and (7) emphasize prevention programs.

The services to be provided by the drug abuse program include (1) information and referral, (2) treatment and emergency services, (3) education and prevention, (4) rehabilitative and support services, and (5) research and evaluation.

In Alameda County addicts were treated under city and county operated and contracted programs and by private programs. The need for a comprehensive program for drug abusers, including education, prevention, treatment, and rehabilitation, became a priority in the fall of 1969. As a result, a county program, called the Alameda County Comprehensive Drug Abuse Program, was developed, which had a major purpose of reducing the number of drug abusers in the county.

The policymaking board for the program consisted of the Director of the County Health Care Services Agency, the Chief Probation Officer, the District Attorney, the Sheriff, the County Superintendent of Schools, judges from the municipal and superior courts, and the Chairman of the Alameda County Drug Abuse Coalition. The Drug Abuse Coalition is an organization composed of representatives from 21 drug abuse programs and interested agencies in the county.

TREATMENT MODALITIES

We identified four basic treatment and rehabilitation approaches which the various narcotic treatment and rehabilitation programs in San Francisco and Alameda Counties were using. The four approaches, or modalities, were:

1. Outpatient methadone maintenance.

2. Inpatient methadone detoxification.

3. Residential therapeutic communities.

4. Drug abstinent detoxification, both inpatient and outpatient.

The above modalities normally include support services, such as psychological assistance, education and job-placement assistance, and referral for additional treatment or social services, in addition to the prescribed treatment.

Methadone maintenance

The outpatient methadone maintenance approach utilized a daily oral dose of methadone, normally 80 to 120 milligrams, to block the need for narcotics.

In the programs we visited in San Francisco and Alameda Counties, the length of time a patient was to remain on methadone varied. Voluntary withdrawal from methadone, with staff approval, usually did not occur until a patient had been in the program at least 6 months and had not used illicit drugs during the 6-month period.

In both counties to be eligible for admission to a methadone maintenance program, a person generally

--must have been a narcotic addict (daily user) for a minimum of 2 years,

--must have been over 18 years of age,

--must have had a history of failure of other legitimate treatment attempts, and

--must have been deemed acceptable by the program staff.

The California Research Advisory Panel, which had the authority to establish criteria and approve and evaluate methadone maintenance programs in California, placed the following requirements on methadone maintenance programs.

--No patient was to be admitted to a methadone maintenance program without a documented history of at least 2 years of narcotic addiction.

--Methadone was not to be administered except in a suitable volume of solution.

--Each take-home dose was to be labeled and was to show the name and location of the methadone treatment center, the nature of the drug, the name of the patient, the date, and an appropriate warning.

--Take-home doses were to be secured in locked containers, and take-home dosage bottles were to be returned and checked in to the program.

Methadone detoxification

Short-term inpatient detoxification from narcotic addiction using methadone is usually a 1-week program providing for decreasing daily dosages of methadone. The daily dosages are scheduled so as to ease the withdrawal from narcotics.

Therapeutic communities

Therapeutic communities are residential treatment facilities ususally offering a drug abstinent life-style which concentrates on instilling a new and positive meaning to the addict's life. Length of voluntary program participation varies from 6 months to the remainder of an addict's life. Most therapeutic communities use group confrontation or attack therapy patterned after an early therapeutic residential treatment approach for alcoholics and drug abusers developed by Synanon Foundation, along with other encounter and counseling techniques.

Nonmethadone detoxification programs

These programs provide short-term (1- to 2-week period) detoxification from narcotics by using medications, such as sedatives and tranquilizers, to assist the addict in the detoxification process. Detoxification is accomplished on either an inpatient or an outpatient basis.

METHOD OF ENTRY TO TREATMENT

In San Francisco and Alameda Counties, persons entered narcotic addiction treatment programs through the following processes:

--Voluntary submission.

--Commitment by Federal or State courts.

--Referral by local police or judicial or parole agencies.

Individual narcotic treatment and rehabilitation programs set forth various entrance requirements, such as minimum age, residence, or addiction history. The criteria for the programs that we gathered information on are discussed in chapter 3 for San Francisco and in chapter 4 for Alameda County.

PATIENTS IN TREATMENT AND SERVICES AVAILABLE

The Director of the San Francisco Department of Public Health stated that information on the total number of persons in treatment for narcotic addiction in San Francisco was not available. He stated that funds were not available, to cover the cost of gathering this type of information and that this had been listed as a priority need in the county's plan for treating drug abusers.

The Drug Abuse Coordinator, and the Director of the Health Care Services of Alameda County stated that the total number of persons being treated for narcotic addiction in Alameda County was not presently available. According to the Drug Abuse Coordinator, the county needed this information and it was hoped that in 6 months to 1 year this information would be gathered.

We contacted the major narcotic treatment and rehabilitation programs to determine the approximate number of addicts in treatment in May 1972. The following table summarizes estimates program officials made.

Estimated Number of Addicts in Treatment
in San Francisco and Alameda Counties
as of May 1972

	Program	Total patients	Modality			
			Methadone maintenance	Methadone detoxification	Nonmethadone detoxification and outpatient rehabilitation	Therapeutic community
San Francisco:						
	County	747	400	6	341	—
	State	286	—	—	286	—
	Federal	89	89	—	—	—
	Private	735	170	—	442	123
	Total	1,857	659	6	1,069	123
Alameda:						
	County	117	102	15	—	-
	State	274	—	—	274	—
	Private	722	270	—	44	408
	Total	1,113	372	15	318	408
	Total	2,970	1,031	21	1,387	531

PROGRAM ASSESSMENT EFFORTS

The Director of Public Health, who is also the coordinator of the San Francisco comprehensive drug abuse plan, stated that county-funded programs had not been evaluated. The comprehensive drug abuse plan provided that (1) when the program was fully operational, research and evaluation would be performed and (2) a research team would collect and assemble data, develop measurements, and provide information regarding drug abuse to those interested. Some of the factors to be evaluated by the team included:

1. The effects of short-term detoxification programs.

2. Followup of patients successfully detoxified.

3. Success of multimodality program in reaching the community.

4. Pre-drug-abuse education.

5. Referral efforts and feasibility of referral.

6. Cost per patient served.

In Alameda County a uniform data collection system was designed for neighborhood counseling centers, hospital detoxification, general emergency services, medical wards, and county-operated outpatient drug abuse clinics. The evaluation plan provided for by the system called for reviewing treatment modalities and their successfulness, or cure rates, at 3-month intervals once the system was instituted. Alameda County officials stated, however, that they had not evaluated or analyzed county operated or funded drug abuse programs as of December 1971.

In our opinion, the planned evaluation components of the San Francisco and Alameda drug abuse programs, once fully operational, should provide drug treatment officials with valuable information which can be used in assessing the effectiveness of the counties' efforts in treating drug addicts. We believe that Federal, State, and local authorities should give priority to implementing these planned evaluation programs.

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As requested by the Chairman of the Subcommittee, we obtained information on the following aspects of selected programs in San Francisco and Alameda Counties which were being financed with State, Federal, and local government funds:

--Program goals.

--Treatment modalities.

--Number of patients being treated and services available.

--Source of funding.

--Criteria used by programs to select patients for treatment.

--Program assessment efforts.

--Results of assessment efforts.

We also visited some programs financed with private funds and VAHPA and its satellite methadone maintenance center in San Francisco.

The information gathered on these programs is discussed in chapters 3, 4, and 5 and in appendixes II and III. Comments by program officials are discussed in chapter 6.

CHAPTER 3

INFORMATION ON SELECTED PROGRAMS IN SAN FRANCISCO

We visited eight drug rehabilitation and treatment programs in San Francisco and gathered information on them through discussions with State and San Francisco program officials, from program literature, and by observation. Information on treatment philosophies and program results was obtained from program literature or records and through interviews with program officials and staff.

Following is a list of the programs visited.

1. Center for Special Problems
2. Walden House
3. Haight-Ashbury Medical Clinic
4. The Center for Solving Special and Health Problems
5. Northeast Community Mental Health Center
6. Teen Challenge
7. Langley Porter Neuropsychiatric Institute--Youth Drug Unit
8. San Francisco Drug Treatment Program

Information gathered on the first four programs follows. Information on the other four programs is included in appendix II.

CENTER FOR SPECIAL PROBLEMS

The Center for Special Problems, operated by the San Francisco Health Department, dealt with problems related to alcohol dependency and abuse, narcotic and other drug dependency and abuse, sex, crime, delinquency, and suicide.

The treatment approach included psychotherapy, medication, social services, occupational therapy, and counseling.

The center's narcotic program was composed of an outpatient detoxification program, which did not use methadone, and an outpatient methadone maintenance program.

The administrative functions and nonmethadone detoxification services were performed at the center's main office near downtown San Francisco. The methadone maintenance program utilized an induction center in San Francisco's northeast community mental health district. Three satellite clinics for methadone dispensing were located in the northeast, westside, and mission community mental health districts.

The staffing of the center's methadone maintenance program on December 31, 1971, included eight doctors--four full-time and four part-time--22 nurses, 19 rehabilitation workers, five counselors, nine clerical workers, and five community workers. The center's outpatient detoxification service was operating in January 1972 with one medical doctor on a half-time basis.

Treatment modalities

Methadone maintenance

To qualify for treatment in the center's methadone maintenance program, which began in July 1969, the applicant must (1) have at least a 2-year documented narcotic addiction history, (2) show no evidence of being addicted to drugs other than narcotics, (3) be over 18 years of age, (4) have a history of failure at other legitimate treatment attempts, (5) be a resident of San Francisco, and (6) be accepted by the program staff. Each applicant must also go through a final screening evaluation conducted by counselors, a psychiatrist, and a nurse. In this evaluation the applicant's addiction history--including his use of drugs and alcohol, motivation, psychological stability, and employment potential and the likelihood that he could be helped by other treatment approaches--is considered.

Upon acceptance the applicant is given a physical examination. The results of two of three urine tests, taken

prior to the administration of methadone, must be positive for narcotics to confirm the applicant's addiction. The addict is required to pay a $50 advance fee for the first 5 weeks of the program before admission. He is charged a $10 fee for each week thereafter.

After acceptance into the methadone maintenance program, the patient begins a 6-week trial period during which his daily dosage of methadone is increased until a stabilized dosage is reached. He attends weekly counseling sessions with a nurse or counselor during this period.

During the first 3 months following successful completion of the trial period, a patient makes daily visits to a clinic to receive his methadone and to give urine specimens. The giving of urine specimens is observed by the center's staff to eliminate the possibility of falsified or substituted samples. Three of these specimens are tested for illegal drug use each week. Vocational guidance, psychotherapy, and referral for other services are available if considered necessary by the center staff during this period. If a patient remains clean (i.e. uses no illicit drug) for 3 months, his visits to a clinic are reduced to three a week. Daily doses of methadone can then be taken home but must be safeguarded in a locked box. If a patient remains clean for 3 additional months, his visits to a clinic may be reduced to two a week.

In January 1972, 43 percent of the active patients were visiting a clinic 5 days a week, 27 percent were visiting 3 days a week, and 30 percent were visiting twice weekly. No patient was visiting a clinic less than twice weekly.

The center's methadone maintenance program offered the following four methadone withdrawal plans for persons leaving the program.

1. If agreed on by the patient and the program staff, a patients may elect a gradual voluntary withdrawal from methadone, usually over a 1-year period, after at least 1 successful year in the maintenance program. If the patient encounters difficulty with drug abstinence after the withdrawal period, he may be immediately reinstated in the maintenance program.

The center follows up on those patients completing the withdrawal period to determine how successful they are in remaining drug free.

2. Patients requesting withdrawal against medical advice are advised to follow a 1-year withdrawal schedule; however, the schedule may be completed in less time if the patient prefers. Patients are eligible to reapply for the maintenance program if they revert to illegal drug use.

3. Patients who go to prison may be assisted in withdrawing from methadone by decreasing their methadone dosage by 10 milligrams a day over a minimum of 5 days. The methadone is taken to the jail by a nurse or physician, and the drug must be properly accounted for by them.

4. Patients may be involuntarily released from the program for illicit drug use, severe disruptive behavior, or being $50 or more in arrears and having made no suitable arrangements for payment. Involuntary removal from the program is usually preceded by a warning period and a probation period, each lasting 15 days. Warning and probation periods are supplemented by appropriate counseling or other services. If the objectionable behavior continues, the patient will be withdrawn from methadone by reducing the dosage by 10 milligrams every 10 days until a 40-milligram dosage is reached; thereafter, dosage will be reduced 5 milligrams a week.

Outpatient detoxification

The outpatient detoxification program of the center is a 5-day program for short-term narcotic users. Under this program sedatives and tranquilizers are used for detoxification purposes.

Psychiatric and other counseling services of the center are available to the patients after detoxification, but use of these services is voluntary. Psychotherapy is not offered during detoxification because the director believes that the patients would not be receptive to this therapy while experiencing withdrawal symptoms.

Funding

The fiscal year 1972 budget for the center's methadone maintenance program was $685,499 and for the outpatient narcotic detoxification program was about $16,900. Funds were provided from local tax revenues (city and county) and by the State of California under the Short-Doyle Act.

The director of the center provided us with an estimated budget for the center's methadone maintenance program which showed that the center could provide the first year of treatment for 100 addicts at an estimated cost of $180,750. According to the director, operating costs for the second year of treatment would be lower than those of the first year because of less frequent psychotherapy, fewer urine tests, and reduced equipment costs. The director of the center estimated that the average cost for the first and second year of methadone maintenance would be about $23 a week per person, or approximately $1,200 a year.

Program participants

Methadone maintenance

The center's methadone maintenance program accepted 429 persons (including only those who received at least one dose of methadone) for treatment from July 1, 1969, to December 31, 1971. The median age of the participants was 32.8 years, and the average length of narcotic use was about 14 years. Admissions to the center's methadone maintenance program from July 1, 1969, to December 31, 1971, can be accounted for as follows:

Admissions	Readmissions	Discharges	Active patients
429	12	89	352

The program expanded from 20 active patients in December 1969 to 352 in December 1971, as shown by the following schedule:

	Active patients
December 1969	20
June 1970	40
December 1970	88
June 1971	217
December 1971	352

The director of the center informed us that, as of November 1971, about 400 persons were on the waiting list for the methadone maintenance program. He added, however, that this was not a true representation of the number of addicts waiting for treatment because, when addicts learned that the program was not accepting patients, they did not apply.

As of January 1972, two methadone maintenance patients had completed withdrawal from methadone with staff approval. One had been discharged for 5 months and was still returning to the clinic to give urine specimens and discuss his progress. Information was not available on the other patient. Seven patients had voluntarily withdrawn from methadone without staff approval. One of these patients had been released from the program for 24 months and was still refraining from illicit drug use. The center had no information on the status of the other six patients.

Outpatient detoxification

We were told that the number of patients in the outpatient detoxification program averaged about 15 to 20 a month. The number of patients in the program varies, depending on the availability of medical doctors to operate it. At the time of our visit, the program was being operated by a medical doctor on a part-time basis. In the past, up to three physicians have been involved in the operation of the program and the number of patients served has been up to 15 a week.

Program evaluation and effectiveness

Methadone maintenance

The goal of the center's methadone maintenance program is the rehabilitation of narcotic addicts to a more acceptable style of living. To reach this goal patients are expected to:

--Give up the use of narcotics and the abuse of other drugs.

--Cease criminal activity.

--Realize their potentials as human beings by working productively, caring for themselves and their families, developing satisfactory interpersonal relationships, coping with the problems of daily living, and improving life-styles.

To measure the program's effectiveness, the following types of data are collected for patients:

--Drug use as determined through urinalyses.

--Criminal activity while on maintenance.

--Social productivity as determined by jobs and educational activities.

Background data on the patient's age, sex, race, education, length of narcotic addiction, and arrest history are also retained for comparative purposes.

Urine tests are used to determine the incidence of illicit drug use. Urine samples are collected during each visit, but not all samples are tested. During the period before the patient's methadone dosage is stabilized, the patient's urine is tested three times a week. After stabilization, the urine testing schedule will be determined by the center staff on the basis of the patient's drug use record, the staff's judgment, and random sampling. All methadone maintenance patients have their urine tested at least once a week.

Results of urine tests for 1 week during April 1971 indicated that 16 percent of the specimens tested were positive for illicit drug use. Of 371 urine specimens tested, 55 showed evidence of narcotic use (nonmethadone), three showed evidence of amphetamine use, and one indicated the presence of barbiturates. Program officials stated that the 16-percent rate was rather high and probably reflected the substantial proportion of new patients who were in the patient population during that week.

A July 1971 semiannual report on the center's methadone maintenance program included the results of a study of illicit drug use by patients who had been on methadone maintenance for varying periods of time. The study showed the number of patients using illicit drugs one or more times during their 9th, 45th, and 90th week of treatment. The results were as follows:

Number of weeks in treatment when tested for illicit drug use	9	45	90
Number of patients	164	65	26
Percentage of patients using illicit drugs	27	5	-

The criminal activity of methadone maintenance patients was also monitored by the center. If a patient did not come to a clinic to receive his methadone, the center staff tried to determine the reasons for his absence through discussions with others in the program or with the patient upon his return. To insure confidentiality this procedure was used in lieu of direct police contact. Information regarding the patient's past arrest history was obtained through interview when he applied to the program. The center felt that this information was relatively reliable.

During the period January 1 to June 30, 1971, 11 patients were arrested for offenses allegedly committed while they were in the program. These arrests resulted in one conviction and prison sentence for possession of narcotics and one fine for being drunk and disorderly. Charges against five of the other individuals who had been arrested were dismissed, cases were still pending for three, and the

disposition of the charge was not known in one case. As of June 1971, 217 patients were in the program. We were told that, from July 1 to December 31, 1971, 10 patients were arrested and three convictions resulted. The number of patients in the program as of December 1971 was 352.

The development of socially acceptable behavior, as indicated by the patient's employment and education record is considered by the center staff as an indicator of program effectiveness. As of June 30, 1971, according to a San Francisco Department of Mental Health report on the center's program, 65 percent of the active patients were working, were enrolled in school or training programs, or were full-time homemakers; 20 percent were unemployed but were considered to be living socially acceptable lives; while the remaining 15 percent were considered to be pursuing lifestyles unacceptable to society.

Outpatient detoxification

The center's nonmethadone outpatient detoxification program, according to the director, has a dropout rate of 75 percent by the 4th day of the 5-day program. About 25 percent of the patients complete the 5-day program. The director estimated that perhaps 8 to 10 percent of the detoxification program's graduates remain free from illegal drug use. The director advised us, however, that verification of this estimate was virtually impossible because most addicts were never heard from after they left the program. The director stated that the detoxification program's success rate was not too impressive, but he believed it was about all that could be expected from any detoxification program.

WALDEN HOUSE

Walden House is a voluntary, residential, therapeutic community which has been in operation in San Francisco since August 1969. It is a private nonprofit corporation with a program for treating persons with a variety of emotional and social problems, particularly those associated with drug abuse. Some of the persons in treatment were referred by correctional agencies.

The Walden House staff includes the clinical director, three administrative employees, four clinical employees, and three staff trainees who are Walden House graduates. None of the staff has professional medical training, but voluntary medical services from doctors not otherwise connected with Walden House are available to residents as the need arises.

Treatment modality

The Walden House residential treatment program lasts 6 to 8 months. The program uses a variety of treatment techniques to enable a resident to uncover and resolve emotional problems and fears and to develop greater personal strength and self-confidence. A prospective resident must attend a prescreening interview, during which personal data and information on the program are exchanged. The applicant is asked to take several days to contemplate the decision and commitment he is going to make and then to return for an intake interview. The intake interview, conducted by four residents and one staff member, deals extensively with the applicant's motivation, commitment, and honesty.

After the intake interview, persons accepted will be assisted in becoming settled in the program by a fellow resident called a "big brother" or "big sister." Those not accepted, because they are not appropriate for the program, are referred to an agency that more closely meets their needs.

The initial phase of the program lasts approximately 2 weeks during which new residents are restricted to Walden House. During this period, a new resident is assigned to a work crew, such as the kitchen or maintenance crew, and usually has minimal responsibility.

When he has completed the initial phase, a new resident is formally accepted into the program's family structure through a ritual involving another interview and sensitivity exercises aimed at reinforcing the individual's acceptance in the family and destroying any feeling of isolation he might have. After acceptance, the resident is given a position of more responsibility and restrictions are relaxed. He is allowed to have visitors and to leave the house with a responsible resident. After several months restrictions are eliminated; the resident is allowed to leave the house unaccompanied and to develop his social life. He may also be given a supervisory position within the house.

The treatment processes used by the program to teach and facilitate interpersonal growth include many types of therapeutic groups, seminars, oral reprimands, learning experiences, house meetings, and speaking opportunities. Residents participate as both listeners and lecturers during the seminars and therapy sessions, speaking or lecturing on any topic they desire. The goal is to gradually uncover and resolve emotional problems and fears so that the resident will develop greater personal strength and self-confidence. Education is provided through a combination of seminars, tutoring, outside education resources, and various vocational training programs.

We were told by a program official that as of March 1972 a few residents of Walden House were also in methadone maintenance programs in San Francisco on an outpatient basis.

Funding

The Walden House budget for fiscal year 1972 was $142,000. Walden House estimated that about $50,000 would be obtained from private sources, $62,000 from the California Council on Criminal Justice, and $30,000 from the San Francisco Juvenile Probation Department.

Expenditures from November 19, 1969, to August 31, 1971, were about $154,000. We were told that the average cost per day was $19 for a resident at Walden House.

Program participants

Walden House had a capacity to serve 22 residents and served 150 persons from the date of inception to December 1971. We were informed that in May 1972 there were 11 people in the house whose problems were related to narcotic addiction. Over half of the residents have been between the ages of 15 and 21, with the age range being 15 to 40. Over 40 percent of the residents have come to Walden House while on probation and 21 percent have been parolees.

Since program inception, about 90 percent of the residents have been drug abusers. Of these, about 50 percent had used heroin, and the other 50 percent had used amphetamines, alcohol, psychedelic drugs, and barbiturates. Sixty-five percent of the heroin users had used the drug for 2 years or less. At the time of our review, Walden House did not have a waiting list although they have had one in the past.

Program effectiveness and evaluation

The Walden House staff believes that 25 percent of the persons who have entered the program have made meaningful changes in the areas of work and school as a result of the program. According to the program director, a review by the staff of program data for the past 2 years showed that the program had had good results with young people. The program staff checked on the status of former participants through personal contacts on the street and through ex-residents who visited the house. We were informed that liaison was also maintained with the probation department.

At the time of our review, the Walden House staff was in the process of evaluating the program's effectiveness. We were told that initial results of the evaluation indicated that residents were showing encouraging progress after 3 months at Walden House, and as a result the program was working to shorten the overall length of the residents' stay and to extend supportive services to help residents find jobs and obtain additional education. The evaluation was not complete at the time of our review.

HAIGHT-ASHBURY MEDICAL CLINIC

The Haight-Ashbury Medical Clinic was opened in June 1967 as a volunteer-staffed crisis center. The clinic provided services for all persons seeking help through three treatment centers: (1) medical and dental, (2) psychiatric, and (3) drug detoxification, rehabilitation, and aftercare. Services were provided in three converted houses in the Haight-Ashbury district in western San Francisco.

Treatment modalities

The Haight-Ashbury drug program offered narcotic addicts outpatient and inpatient detoxification and rehabilitation services. The outpatient detoxification service involved short-term withdrawal from narcotic addiction without the use of methadone. Medications such as mild sedatives and tranquilizers were used to ease the effects of narcotic withdrawal. The program was designed to accomplish withdrawal over a maximum period of 16 days. Psychiatric counseling was available to the patient after detoxification.

An inpatient narcotic detoxification program which had the capacity to serve six patients was started on November 1, 1971. The maximum period for inpatient detoxification was 2 weeks. The program used the same medications used for outpatient detoxification. As of December 1971, 12 patients had been treated. Clinic officials told us that short-term inpatient detoxification treatment was discontinued in April 1972.

The rehabilitative services consisted of psychiatric therapy--both individual and group--and vocational counseling. These services were made available to detoxification patients, at their option, and to nonnarcotic users who sought help at the clinic. A clinic vocational counselor told us that vocational services emphasized craft skills, community services, and trades acceptable to the youths being served.

Funding

Until August 1971, the drug program operated on private funds from various sources. According to the clinic's

epidemiologist, the annual budget was about $305,000. We were told by the director of the clinic that detailed expenditure data were not available for periods prior to August 1971. On that date the program received a drug abuse service project grant from the National Institute of Mental Health. The funds awarded for the first year of the grant amounted to $296,087.

From August 1 through November 20, 1971, the drug program had charged operating expenses of $61,862 against the grant. Clinic officials estimated that the average cost per patient-day of the outpatient detoxification program was $16.70. Cost figures were not available for the inpatient detoxification program.

Program participants

Drug program patients were from various areas of San Francisco and from outside the city. The only criteria for admission were that the addicts must need help and must be at least 18 years old. Between November 1969 and November 1971, the outpatient clinic treated 1,800 narcotic addicts and developed the following statistics from interviews with these addicts.

Average age	26.5 years
" " at first narcotic use	20.7 "
" cost of narcotic habit	$48 per day
Sex	73 percent male
Race:	
White	72 "
Black	21 "
Mexican-American	6 "
Oriental and others	1 "

During the last 6 months of calendar year 1971, according to a program staff official, there were about 4,100 patient visits for outpatient detoxification services. As of March 1972 the outpatient clinic was handling about 60 visits a day. There was no waiting list for outpatient services. At May 1972 the program was treating 250 outpatients.

Program evaluation and effectiveness

Data concerning a patient's age, sex, race, birthplace, employment, drug use history, and criminal history were gathered by the clinic. The patient's addiction to drugs was verified by urine testing at the time of admission. Thereafter, urine tests were performed on every fifth patient visiting the clinic each day. In addition, more frequent tests were performed on specific patients if requested by the counselor or patient. Periodic tests of the clinic's laboratory performance were made by submitting urine samples from staff members or by having test results sent to other laboratories for verification. As of May 1972, according to program officials, laboratory results were not being summarized.

The drug program had not established stringent criteria for measuring success because clinic officials considered that there were many levels of success to be reached by an addict. For example, clinic officials advised us that, if a patient was self-sufficient and not totally drug dependent, although not entirely drug free, he would be considered successful. According to a program official, no formal patient followup was carried out. We were told by the clinic's epidemiologist that at least 50 percent of the persons detoxified returned to the clinic or went to another facility to again detoxify.

THE CENTER FOR SOLVING SPECIAL SOCIAL AND HEALTH PROBLEMS--FORT HELP

The Center for Solving Special Social and Health Problems, more commonly known as Fort Help, is a private nonprofit program designed to aid people with any type of social problem, such as drugs, sex, crime, and overweight. Fort Help started treating patients in December 1970. Its treatment techniques include psychotherapy, encounter groups, and vocational counseling. We were told that a "living room" environment was created with the intention of divorcing the program from the clinical white-coat atmosphere found in some other programs. In line with this philosophy, all patients are referred to as "guests."

The staff of Fort Help's drug program included three medical doctors, two psychologists, four nurses, and five ex-addict counselors. The program director was called the "leader."

Treatment modality

Outpatient treatment is provided for drug abusers and includes such activities as individual and group counseling, vocational counseling, recreational outings, and a methadone maintenance program. Detoxification services are available to methadone maintenance patients who wish to withdraw from methadone.

Methadone maintenance patients are encouraged to eventually withdraw from methadone. The leader of the program indicated that an attempt to withdraw from methadone should be made after about 6 months of maintenance. In an attempt to discourage persons from becoming life-long methadone maintenance patients, methadone mixed with water was given to the patients. This was in contrast to most other programs which used orange juice or a sweetened mixer. Water is used to allow the bitterness of methadone to be tasted, which supposedly reminds the patients that they are using a drug and are therefore drug dependent.

All methadone maintenance patients receive individual counseling at least once a week from a doctor, nurse, or former addict.

Funding

Fort Help receives funds from three sources--contributions, a grant from a private foundation, and fees. The fees are paid by patients in the methadone maintenance program. Each patient is required to pay $20 a week, with the exception of married couples, who pay $30 a week.

The monthly budget for the overall operation of Fort Help was about $10,000. The leader told us that more detailed cost data, such as by service and treatment modality, were not available.

According to the leader, Fort Help has not accepted any governmental funding (Federal, State, or local) in the past, nor is it likely that such funds will be sought in the future. The leader believes grant regulations hinder creativity and require bureaucratic administrative structures which adversely affect staff and patients.

Program participants

At any given time Fort Help has about 500 guests receiving treatment for various social problems. We were advised by the program leader that in May 1972 Fort Help was serving about 150 narcotic addicts and that 100 were methadone maintenance patients.

From inception of the methadone maintenance program in March 1971 to the end of December 1971, approximately 200 persons participated in the program. As of January 1972, about 600 persons were on the waiting list for methadone maintenance. Some of those on the waiting list were receiving counseling while waiting to get into the program. The leader of Fort Help believes that there is considerable duplication between the names on Fort Help's waiting list and the names on the waiting list of another program in the area.

Program evaluation and effectiveness

The leader of the Fort Help program considers the program successful if the use of, or dependency on, drugs is decreased and if social or vocational functioning is

increased. In his opinion, a person who abstains from the use of drugs for just a few months should be considered a partial success.

To verify that an individual is not abusing drugs while on methadone, all patients were subject to urinalysis once a week. A list is posted daily of those required to provide urine specimens and the patients do not know what day their names will be on the list. Specimens are to be provided under the observation of a staff member, who signs a slip stating that he has observed the specimen being provided. The patient gives the signed slip to a nurse and receives the methadone. If a patient does not have the signed slip from a staff member and his name is on the list of those required to give a urine specimen that day, he cannot receive his methadone.

Reports that could be useful in evaluating the program had not been prepared at the time of our review.

There had been no followup on the patients leaving the methadone maintenance program because the longest period any individual had been off methadone was 6 months. The leader believes that any followup at this point would result in artificially high results because an ex-addict may not go back to drugs immediately. However, followup is planned for patients once they have been off methadone for 1 year or more. To maintain contact, all patients are required to sign a consent form prior to entering the methadone program. This form is worded, in part, as follows:

> "I also understand that following termination of my treatment in the research project, I will be expected to cooperate by remaining in contact with the program for the purpose of providing follow-up information at specified intervals, in order to permit evaluation of the results of the program."

CHAPTER 4

INFORMATION ON SELECTED PROGRAMS IN ALAMEDA COUNTY

We visited six drug rehabilitation and treatment programs in Alameda County. Information on these programs was gathered mainly from discussions with cognizant program, State, and county officials; from program literature; and from our observations. Information on treatment philosophies and on the results of the programs was obtained from program literature or records and from interviews with program officials and staffs.

The following programs were visited:

1. West Oakland Health Center Methadone Maintenance Research Program.
2. G.R.O.U.P. Community Services.
3. Eden Drug Abuse Clinic.
4. Berkeley Community Methadone Program.
5. Soul Site.
6. Fairmont Methadone Detoxification Program.

Information on the first three programs follows; information on the other three programs is included in appendix III.

WEST OAKLAND HEALTH CENTER METHADONE MAINTENANCE RESEARCH PROGRAM

The West Oakland Health Center is a comprehensive health-care center operated by the West Oakland Health Council, Inc., a nonprofit community organization. A Methadone Maintenance Research Program and an Outreach Center are operated by the mental health component of the West Oakland Health Center. The Methadone Maintenance Research Program started operating in August 1971 under contract with the Oakland Model Cities Agency.

The Outreach Center, also known as "Trouble House," opened in October 1971 and provides crisis intervention, referral services, "rap" sessions, job counseling, and individual and group therapy for drug abusers. We did not gather information on the operations of the Outreach Center.

Treatment modalities

The objectives of the outpatient methadone maintenance program were to (1) reduce the high rate of narcotic addiction within the Oakland Model Cities target area, (2) combat the use of drugs by schoolchildren, and (3) reduce the crime rate within the target area.

The West Oakland methadone maintenance program has the following admission requirements for patients. They (1) must reside in the West Oakland Model Cities target area, (2) must participate voluntarily, and (3) must have had one documented episode of withdrawal.

The medical director of the methadone maintenance program told us that the program's treatment philosophy was the "modified lifetime theory." Under this theory an individual must be on methadone maintenance for at least 6 months and must not abuse drugs during this period before the program staff will approve his withdrawal from methadone and his release from the program. In addition, the participant must demonstrate a positive life-style, through participation in educational activities or employment. At the time of our review, the program staff had not approved placement of any patients in a withdrawal program.

Prior to admission an applicant for the methadone maintenance program must (1) take an intelligence and personality test, (2) take a test to diagnose organic brain damage and significant mental illness, (3) have an interview with program officials (a screening panel), (4) have a medical examination, and (5) provide a complete social and medical history. In addition, three urine samples are tested in the week following the patient's interview with program officials. All three tests must show heroin use before the applicant can be accepted. Exceptions to this requirement are made only for participants who come directly from penal institutions.

After completing the screening process, each patient is assigned to a team comprised of a nurse, a social worker or rehabilitation counselor, and a case aide. The team is responsible for the patient's total program involvement and assists the patient in his efforts to disengage from the drug culture and to move into a more productive and satisfying life-style.

Patients are given an initial daily dosage of 30 milligrams of methadone which is increased by 10 milligrams a day until a maximum dosage of 90 milligrams is reached. As of December 31, 1971, it had been necessary to deviate from this pattern 11 times because at the maximum dosage these patients experienced prolonged side effects.

The methadone maintenance program's support services include group therapy, individual counseling, vocational and educational guidance, referrals for employment, and some medical and dental services.

Funding

The West Oakland Health Center methadone maintenance program is funded by the Oakland Model Cities program of the Department of Housing and Urban Development. The Oakland Model Cities budget for the methadone maintenance program was about $120,000 for the period November 1, 1970, to March 31, 1972. The approved budget amount for the period April 1972 through March 1973 was $120,000. The budget for the methadone maintenance program was supplemented by patient fees--a $16 initial fee and $10 a week thereafter.

Program officials estimated that the cost per patient for the first year of treatment would be about $1,000 to $1,500. However, they questioned the accuracy of this estimate because the program had been operating less than a year. Program officials believed that the cost per patient could be reduced by about 50 percent for a second-year methadone maintenance patient.

Program participants

As of May 1972 the West Oakland Health Center methadone maintenance program had about 120 active patients. There

were 74 patients in the methadone maintenance program at December 31, 1971. Their median age was 35; 72 percent were black; 14 percent were white; and 14 percent had Spanish surnames. Also, 71 percent were male and 29 percent were female.

Program evaluation and effectiveness

To determine whether a patient was abusing drugs, a urine specimen was taken each time a patient visited the clinic for his methadone. For the first 2 weeks of participation in the program, the patient's urine was tested daily. Thereafter, although the specimens were still collected daily, only two per week were tested for each patient. The giving of the specimen must be observed by a program staff member.

From August 16, 1971, the date methadone dispensing began at the center, to December 31, 1971, program reports show that 2,059 urine specimens were collected for testing, an average of 32 tests per patients. Of these, 279, or about 14 percent showed illicit drug use, as follows: 169 showed heroin use, 83 showed barbiturate use, and 27 showed amphetamine use.

G.R.O.U.P. COMMUNITY SERVICES

G.R.O.U.P. Community Services (an acronym for Growth Reorientation Opportunities Unlimited Project), which began operating in the summer of 1970, is a private program for drug addicts, alcoholics, and persons with character disorders.

GROUP has three facilities--a storefront and residence quarters in a commercial area of East Oakland for the initial phase of the program, a long-term residence house (Family House) in the West Oakland Model Cities target area and a farm near Marysville, California, that, when renovated, will be used as a long-term residence facility.

GROUP's staff was comprised of ex-addict graduates of the program and residents. The East Oakland facility was staffed by a house manager and five trainees; Family House had a house manager and nine trainees; and the farm had a house manager and one trainee. Trainees are ex-addicts who are being trained for positions with GROUP.

In addition to this resident staff, the two Oakland facilities received the volunteer services of a medical doctor once a week and of a psychiatrist when needed.

Treatment modality

The treatment modality of the GROUP program is the drug-free therapeutic community concept which has three separate treatment phases and which lasts from 7 to 12 months.

A candidate enters the first phase, which lasts from 30 to 90 days, at the phase-in center in East Oakland. The first phase was generally referred to as a "tearing down" period during which an individual was exposed to his "hang-ups," bad habits, and attitudes. An addict was admitted to this phase if he demonstrated to the satisfaction of the house manager a willingness to stop abusing drugs. If admitted, the candidate spent the first 14 to 30 days "quarantined" from anyone outside the program and his only contacts were fellow candidates and the program staff.

The remainder of the time in the candidate phase was spent in developing certain qualities, such as good work habits and a sense of responsibility. The daily routine included housekeeping duties, "rap" (group discussion) sessions, critiques on the candidate's progress, seminars on such subjects as concepts of truth and honesty and fund-raising projects.

When a candidate had demonstrated to the satisfaction of the house manager and his staff a desire for total rehabilitation, he was sent to the Family House in West Oakland for phase two. An addict resides at this facility from 3 to 6 months and engages more intensely in such activities as group therapy and confrontation games. The purpose of this phase, in contrast with the "tearing down" phase, is to "build up" a person by helping him develop goals and rechannel his energies toward a positive life-style. The farm, in addition to the Family House, will eventually be used for phase two for those who wish to experience rural life.

The third phase is referred to as the "phase-out" period, during which an individual is a member of the staff at the East Oakland residence, Family House, the farm, or at a program in Berkeley called Soul Site. (See p. 67.) This phase lasts for about 3 months.

Future plans provide for an additional treatment period during which an individual would live in a GROUP residence for the first 2 or 3 months after the final phase and work or go to school. No restrictions would be placed on a resident; he would stay until he was both mentally and financially ready to settle in a place of his own.

GROUP does not detoxify anyone at the candidate center in East Oakland. Anyone who needs this service is referred to Soul Site in Berkeley (see p. 67) or to the Fairmont Methadone Detoxification Center in San Leandro, California. (See p. 68.)

Funding

GROUP receives no funds from governmental sources. Public funds have not been sought because the board of directors believes numerous conditions or restrictions on the program's

operation would be "attached" to the money. The directors want the freedom to continue to develop the type of treatment they feel is best.

GROUP's funding support comes from a variety of sources including disability payments received by some of the residents, cash and in-kind donations, and proceeds resulting from presentations before various community and civic organizations. The annual budget for the program is about $70,000.

Program participants

GROUP's staff estimated that about 50 percent of the participants in the program were narcotic abusers. At the end of February 1972, 82 patients were active in the program. The following tables show the caseload at each of the three facilities and the ethnic backgrounds of the patients.

Location	Number	Ethnic background	Number
East Oakland	27	White	53
Family House	45	Black	23
Marysville Farm	10	Mexican-American	5
		Oriental	1
Total	82		82

About 60 percent of the patients were male, and the ages of the patients ranged from 15 to 51 years. Data on the number of persons who entered GROUP since program inception were not available. The program has no waiting list.

Program evaluation and effectiveness

The primary goal or success criterion of the program was for a person to become a productive and responsible individual with the confidence to make decisions and stand behind them. The GROUP staff believes that, to instill attitudes, such as trust, honesty, and responsibility, the staff must demonstrate these concepts by trusting the patients. For example, urine samples have not been collected or tested for illicit drug use.

In the 18 months GROUP has been operating, there have been five graduates, all of whom started the program and are now the board of directors of GROUP. GROUP staff members had received information through telephone conversations with former patients and through the "grapevine" that about 25 persons who had left the program before completing the treatment phases had refrained from illicit drug use. GROUP does not compile statistics on program performance.

EDEN DRUG ABUSE CLINIC

The Eden Drug Abuse Clinic is operated by Alameda County and is located in the Alameda County Public Health Department outpatient clinic in the city of San Leandro.

The Eden clinic offers outpatient methadone maintenance, therapy and counseling for heroin addicts, and therapy and counseling for adolescents who abuse drugs other than narcotics. The services for adolescents comprise only a small part of the clinic's operations and are provided by one of the clinic's social workers.

The methadone maintenance program was started in July 1971 and is authorized to serve 110 patients.

Treatment modality

The Eden clinic is primarily a methadone maintenance outpatient clinic for heroin addicts. A prospective patient is screened by a counselor who determines whether he meets the following requirements. Patients must (1) be 21 years or older, (2) have a minimum 2-year history of addiction, (3) be a resident of Alameda County, and (4) be a voluntary patient. In addition, current addiction to heroin must be verified. After being admitted to the program, each patient is given a complete physical examination and is started on methadone. The initial daily dosage is 20 milligrams which is increased over a 2-week period to an 80-milligram maintenance level. As of December 31, 1971, most patients were receiving between 60 and 80 milligrams of methadone.

Support services offered include individual counseling and therapy, group therapy, vocational counseling, and medical followup and treatment.

Funding

The Eden clinic calendar year 1972 budget request for California Council on Criminal Justice funds was approximately $145,000, as follows:

Personnel services	$ 99,150
Travel	2,100
Consultant services	1,500
Supplies and operating expenses	39,700
Equipment	2,892
Total	$145,342

A county official told us that the final budget approved by the California Council on Criminal Justice was $80,350 and that Alameda County planned to provide an additional $35,500 which would make $115,850 available to Eden clinic during 1972. Cost allocations as listed above were not available for the revised budget.

At the time of our review, Eden clinic did not charge the patients for services. However, the clinic plans to initiate in the near future a sliding-scale fee schedule based on the patient's ability to pay.

Program participants

Approximately 300 heroin addicts have been interviewed at the clinic from program inception (July 1971) through February 24, 1972, as shown below:

	Number of patients
In program	93
On waiting list	148
Detoxified and released at patient's request	3
Detoxified and released by staff for disciplinary reasons	7
Did not meet requirements, went to other programs, never returned after reaching top of waiting list, or other reasons	50
Total	301

According to clinic officials, of the 93 patients in the program, about 15 were allowed to take their methadone dosages home. Two patients were allowed to take home enough methadone for 3 days; the remaining 13 patients were allowed to take home enough methadone for 1 or 2 days.

Program evaluation and effectiveness

The goals of the methadone maintenance program were, as follows:

--Stop heroin use.

--Develop more productive life-style (job or educational activity).

--Stabilize emotional life.

--Increase self-esteem.

--Eventually withdraw from methadone maintenance.

Eden clinic checks on heroin use by testing urine specimens from one of every five patients visiting the program daily and tests each patient at least once a week. The specimens were tested for opiates, amphetamines, barbiturates, quinine, and methadone. No tests were made for alcohol. All urine specimens were obtained under the observation of program staff. During a 1-week period in the latter part of 1971, results of urinalyses were:

Results of tests	Number of samples	Percent
Methadone only	47	76
Methadone and heroin	12	19
Methadone and amphetamines	2	3
Methadone, codeine, and heroin	1	2
Total	62	100

Patient withdrawal from methadone maintenance was the ultimate goal of the program. As of February 24, 1972, two persons were being withdrawn from methadone with staff approval; one was an outpatient and one was in the hospital as a result of an automobile accident.

CHAPTER 5

VETERANS ADMINISTRATION HOSPITAL AT PALO ALTO

VAHPA, a general medical and surgical hospital, since August 1970 has offered a drug abuse rehabilitation program to veterans through the hospital's psychiatric service. The VAHPA drug program had (1) three inpatient rehabilitation wards offering a wide variety of therapeutic services, (2) an outpatient methadone maintenance program, (3) a short-term inpatient detoxification program utilizing methadone and/or other appropriate drugs, and (4) an outpatient methadone maintenance satellite clinic. These services were provided at the Menlo Park, California, and Palo Alto branches of VAHPA and at a satellite methadone maintenance clinic in San Francisco.

TREATMENT MODALITIES

The VAHPA drug program treatment approach focuses on the biological, social, and psychological factors which initiated and perpetuated the patient's addiction. VAHPA provided its drug rehabilitative services through the following treatment facilities.

Inpatient facilities

--A short-term, 15-bed detoxification ward at Menlo Park which uses methadone and other drugs for withdrawal from heroin, barbiturates, and other addictive drugs.

--A 20-bed inpatient eclectic rehabilitation ward with a wide variety of therapeutic services including methadone maintenance for heroin addicts.

--A 20-bed inpatient rehabilitation ward which uses a drug abstinence approach.

--A 15-bed inpatient rehabilitation ward similar to the above drug abstinence approach, with the exception that the patient population is a mix of drug abusers, alcoholics, sexual deviants, and other antisocial personality disorders.

Outpatient facilities

--An outpatient methadone maintenance service located at the 15-bed inpatient, short-term detoxification ward at Menlo Park.

--A satellite outpatient methadone maintenance clinic offering the same services as the facility above but for patients residing in San Francisco and other areas.

The above facilities are described in detail below.

Short-term inpatient detoxification ward and outpatient methadone maintenance program

VAHPA's short-term, inpatient detoxification ward and the outpatient methadone maintenance program at Menlo Park offered the following services: (1) inpatient detoxification from narcotics using methadone during a 5-day withdrawal period, (2) inpatient detoxification from barbiturate dependence using phenobarital over a 1- to 2- week gradual withdrawal period, and (3) outpatient methadone maintenance.

The inpatient detoxification ward followed a 3- to 4-day detoxification program for heroin withdrawal using methadone. Methadone maintenance was also started in this ward. When a stabilization level (50 to 60 miligrams) was reached, the patient was released to the outpatient methadone maintenance program or to the inpatient maintenance ward.

The outpatient methadone maintenance program was separated into four phases.

Phase I--Daily patient visits for methadone for at least 13 weeks.

Phase II--Patients visit the clinic Monday through Friday with a weekend supply of methadone to be taken home.

Phase III--Patients visit the clinic Monday through Thursday for a 2- to 3-month period with a 3-day supply of methadone to be taken home.

Phase IV--Patients visit the clinic on Monday, Wednesday, and Thursday and take home methadone for the other 4 days.

The director of this program stated that urine samples from each patient were tested at least once a week for illicit drug use. Should illicit drug use be detected, a patient in phases II through IV would be moved back to a lower phase.

Eclectic inpatient ward

This ward had about one-third of its patients on methadone maintenance and provided a wide variety of rehabilitative treatment services, such as group and individual psychotherapy, family group sessions, and vocational and educational counseling.

Inpatient abstinence ward

The inpatient abstinence ward operated as a therapeutic community and employed such treatment techniques as: (1) small group meetings, (2) community group meetings, (3) encounter groups, (4) one-to-one counseling, (5) sports and recreational activities, (6) community drug education and prevention talks, and (7) vocational and educational counseling.

Multidisorder inpatient ward

The multidisorder ward treated persons with varied emotional disorders in a therapeutic residential treatment setting. The primary treatment modality is confrontation or attack therapy.

Satellite outpatient methadone maintenance program

The satellite methadone maintenance outpatient clinic in San Francisco started operating on November 1, 1971, as an extension of VAHPA's outpatient methadone maintenance program located in Menlo Park.

The satellite clinic was open 6 days a week for methadone dispensing. Initially, patients visited the clinic

every day except Sunday to receive their doses of methadone. A take-home dose for Sunday was given on Saturday. After a minimum of 13 weeks, the patient may be given two doses to take home for the weekend. Urine testing was used to determine whether the patient was using illicit drugs while on methadone. The clinic collects patient urine specimens three times per week without advance notice. At least one sample per patient was tested each week by VAHPA to determine whether the patients were using illicit drugs while on methadone.

FUNDING

Total drug program costs for calendar year 1971 were allocated for us by VAHPA accounting department as shown below:

Program	Personal services	All other costs	Total program cost
All inpatient care	$450,632	$38,490	$489,122
Methadone maintenance (Menlo Park)	42,607	8,623	51,230
Satellite methadone maintenance (San Francisco)	7,543	5,744	13,287
Total for 1971	$500,782	$52,857	$553,639

The total program cost incurred for all inpatient care from July 1, 1970, through December 31, 1971, was $591,772. Since the methadone maintenance programs were both begun during 1971, amounts shown above represent total program costs from inception of the methadone maintenance programs.

PROGRAM PARTICIPANTS

VAHPA limited its drug rehabilitation services to veterans who had better than dishonorable discharges and who did not have pending criminal charges. Of the patients in the drug rehabilitation programs, approximately two-thirds were Vietnam veterans and one-third were World War II and Korean War veterans.

As of December 1971 VAHPA did not have a waiting list for any of its drug rehabilitation services. On January 14, 1972, as a result of closing certain buildings at the Veterans Administration (VA) hospitals in Livermore and Los Angeles, which was part of a plan to structurally upgrade VA facilities, a ceiling or quota was placed on the number of patients allowed in each ward at VAHPA, including the drug treatment wards. This action did not result in creating waiting lists at that time.

The following table shows, by treatment program, the number of patients treated since inception.

Program	Date of inception	Number of patients treated: Since inception	Number of patients treated: Jan. through Nov. 1971
Detoxification ward	9-1-71	158	158
Multidisorder ward (data on drug patients only)	8-1-70[a]	40	29
Abstinent ward	8-1-70	121	104
Eclectic ward	8-1-70	188	128
Outpatient methadone maintenance	9-1-71	62	62
Satellite methadone maintenance (San Francisco)	11-1-71	70	70

[a]Data available from this date on drug-dependent persons; this is not the date of program inception.

A VA official advised us that the above figures included patients treated by more than one program and that

eliminating the overlap resulted in a net figure of 381 separate patients treated from January through November 1971.

PROGRAM EVALUATION AND EFFECTIVENESS

The goal of VAHPA's drug program is to help the patient learn to live without drugs or to function satisfactorily on methadone maintenance. Each treatment component sets forth slightly different criteria for evaluation based on different goals as indicated below.

--The eclectic ward set forth as criteria for evaluation: (1) abstinence from drugs, (2) occupational rehabilitation, (3) stable living situation, and (4) better relationships with the family.

--As measurements of program effectiveness the drug abstinence ward looked for: (1) drug abstinence, (2) lack of problems with police, (3) a stable living arrangement, and (4) a goal-directed activity such as school, work, or training.

--The detoxification ward inpatient program measured its effectiveness by the number of patients involved in a rehabilitation program.

--The outpatient methadone maintenance program set the criteria of effectiveness as the number of patients still in the program.

The director of the drug program stated that VAHPA did not have the staff that would be required to perform evaluations on program results. However, in December 1971 a pilot followup study of the first 40 patients admitted to the eclectic ward was made. The patients were residents of the ward between August 1, 1970, and January 1, 1971. Thirty-five of the 40 patients were narcotic addicts, and the remaining five abused other drugs. Thirty-one of the 35 patients who were admitted as narcotic addicts were interviewed by a drug counselor who was a former patient of the eclectic ward. Contact was made entirely by phone, although some information was verified by checking with public agencies and families of the patients. Percentage responses to the six questions asked follow:

	Percent Yes	No
1. Have you used any narcotics since you left the program?	23	77
2. Have you been arrested since you left the program?	19	81
(a) Have you been convicted since you left the program	6	94
3. Have you been employed since you left the program	68	32
(a) Are you now employed?	52	48
4. Have you had education (enrolled in an institution) since you left the program?	23	77
5. Have you been in another treatment program since you left the ward?	19	81
6. Did you serve in Vietnam?	55	45

The pilot study was being used by a VA psychologist in an attempt to secure funds from the VA for a research project to evaluate the relative effectiveness of the drug programs at VAHPA.

The proposed research project would utilize background information on the patient's drug use, employment, education, arrest and convictions, and interpersonal relations collected during treatment and through mailed questionnaires at regular intervals for 4 years after the date of admission. These data would be supplemented by records and information from public agencies and by surprise visits with the patient after hospital discharge. Statistical analyses would be employed to determine which treatment modality was most effective.

CHAPTER 6

COMMENTS BY PROGRAM OFFICIALS ON NARCOTIC TREATMENT AND REHABILITATION PROGRAMS

We discussed the treatment and rehabilitation programs in San Francisco and Alameda Counties with representatives of State and local governments and county drug abuse coordinating groups to obtain information of problems being encountered, operational needs of the programs, and ways in which the narcotic treatment programs could be improved. We were informed that (1) narcotic treatment programs needed to be registered and licensed, (2) standards as to the type of data that should be gathered for use in measuring program results needed to be developed, and (3) State-operated facilities in the San Francisco-Oakland area were lacking which was hampering the effectiveness of the State's program for the civil commitment of narcotic addicts.

We noted that San Francisco officials were experiencing difficulty in obtaining patient arrest information from the State because State officials believed that furnishing arrest information to the San Francisco Methadone Research Program violated the State penal code.

REGISTERING AND LICENSING OF NARCOTIC TREATMENT PROGRAMS

County officials in both San Francisco and Alameda Counties advised us that registering or licensing narcotic treatment programs would be beneficial.

The director of the San Francisco Department of Public Health, who was also the coordinator for San Francisco's Drug Abuse Control Plan, advised us that registering or licensing would permit the licensing agencies to exercise control over the quality of care given to addicts. Also, the director stated that licensing could result in more stable treatment and rehabilitation programs which would avoid interruptions in treatment caused by curtailment or discontinuance of services. The director stated that in a number of instances programs had been curtailed or discontinued because funds could not be obtained or for other reasons.

A third advantage of licensing or registering mentioned by the director was the establishment of a standard means for evaluating the results of a program or treatment modality. The use of a standardized evaluation system approved by the licensing agency could be made a condition of licensing or registering.

The director, Alameda County Health Care Services, told us that licensing would provide the county with the means for obtaining data on the number and types of drug abuse programs in operation. In addition, it would enable the county to know more about the programs in the area, such as the number of persons in treatment and the type of modality being used. He stated that, although a program evaluation methodology should be made a condition of licensing, the methodology should be general in nature and should not result in burdensome reporting and evaluation requirements which would interfere with the treatment.

An official in the State's Office of Narcotics and Drug Abuse Coordination informed us that State legislation requiring licensing by the State of certain drug abuse treatment programs is anticipated. However, he stated that there would probably be many exclusions, such as Federal, State, or county programs; programs affiliated with churches; and facilities such as hospitals and clinics which have other licensing requirements. He also said that, while the State would license certain programs, the contemplated legislation would require virtually all drug programs to register with the county.

STANDARDS FOR EVALUATION

The Director of Public Health for San Francisco stated that assessment and comparison of the variety of treatment approaches was not possible because uniform program data were lacking. He suggested that a committee of experts on different treatment modalities from various places throughout the country should be asked to arrive at a standardized evaluation program for all treatment approaches.

The director stated also that the data-gathering requirements should be similar for all programs and should provide information, such as the number of persons entering

treatment, the dropout rate, length of participation, extent of continued drug abuse and criminal activity, social productivity or employment, and patient activities and status after program completion. He stated further that the requirements for data gathering, followup, and public disclosure would have to apply to all programs--public or private--to add credence to the plan. The director advised us that the patient's confidentiality should be maintained at all times.

PROBLEMS OF THE STATE CIVIL ADDICT PROGRAM

Officials of the State Region II Parole and Community Services Division, which covers San Francisco and Alameda Counties, told us that there were not enough local methadone maintenance and detoxification programs to effectively treat outpatients of the State's civil addict program. We were told that if an outpatient returned to drug use and services either did not exist or were not available locally, the patient must be returned to the California Rehabilitation Center. (See p. 12.) This move not only disrupts the outpatient's family, homelife, and overall rehabilitation, but is costly.

The officials stated that they had attempted at various times to develop or to assist with the development of community-based facilities, but without success primarily because of funding restrictions. In addition, these officials stated that more former addicts should be hired to work with the outpatients from the center.

PATIENT ARREST INFORMATION

In a March 7, 1972, letter to the Chief of the State's Bureau of Identification, the director of the San Francisco methadone maintenance program explained that, for the past few months, the program had been obtaining arrest records of program participants from State parole officers but that recently the parole officers had stopped supplying these records on the basis that they were not authorized to do this.

The director explained in his letter that arrest information on applicants would assist the program in determining whether the applicant had a history of at least 2 years of narcotic addiction--a requirement for admittance to a methadone maintenance program (see p. 15)--and would be useful for program evaluation purposes. The director also explained that the program always obtained written consent from the patient to obtain arrest information and consequently felt that this practice was not a violation of the patient's confidence in any way.

The bureau's reply dated March 13, 1972, stated that it could not furnish arrest information to the program because such action was not permitted by section 11105 of the State penal code. This section of the code specifies those persons, organizations, and institutions to which the attorney general is authorized to furnish data about persons for which there is a record in the State's attorney general's office.

The bureau's reply indicated that the written consent obtained from the patient would have no bearing on the release of the information since it would not relieve the bureau of obligations imposed by statute. The bureau concluded that specific legislation authorizing the release of the information to the program would be necessary.

This matter had not been resolved as of June 1972.

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

INFORMATION ON OTHER PROGRAMS IN SAN FRANCISCO

In addition to the narcotic treatment programs in San Francisco discussed in chapter 3, we gathered information on the following programs.

NORTHEAST COMMUNITY MENTAL HEALTH CENTER

The San Francisco Northeast Community Mental Health Center provides comprehensive mental health services for alcoholics, the mentally disturbed, geriatric cases, and drug abusers. The staff consisted of about 125 members, of whom about 20 were directly involved in the drug abuse treatment services.

The outpatient program provided methadone maintenance to patients who were enrolled in a program operated by the Center for Special Problems. (See p. 20.) Counseling and referrals were provided to outpatient drug abusers as part of the overall Center program. In addition, the outpatient services included visits to the city jails by a psychiatrist who, as one of his responsibilities, assisted in the withdrawal treatment of addicts with or without the use of nonnarcotic medication.

The amount budgeted for drug abuse treatment, excluding the methadone maintenance program for fiscal year 1972, was $266,374. This consisted of $147,756 of Federal funds from the National Institute of Mental Health, $106,756 from the State (Short-Doyle Act), and $11,862 from San Francisco.

A residential drug detoxification program with a capacity of 12 persons started in January 1971 but closed down in November 1971. During the 10-month period about 250 persons, primarily heroin addicts, were treated by the program. This program was terminated because staff evaluations showed that the treatment methods employed were not very successful. Coordination with other programs was minimal. A new residential program was started in February 1972 and was designed to serve about 12 persons who could be amphetamine, barbiturate, or heroin users.

TEEN CHALLENGE

Teen Challenge, a private, nonprofit program under the sponsorship of a religious organization--Assemblies of God Church--is a therapeutic community designed to provide inpatient treatment to an addict for about 9 to 12 months. Heroin addicts, who comprise 60 to 70 percent of the participants in Teen Challenge, must withdraw from their addiction without medication. In May 1972 there were 25 residents at the therapeutic community we visited. The staff consisted of a director, two vocational counselors, three supervisors, and five resident trainees who were ex-addict graduates of the program.

Emphasis is placed on rehabilitation and prevention of drug abuse through religious activities, counseling, vocational guidance, and other activities. Each resident is helped to develop qualities such as self-discipline, Christian character, and a sense of responsibility.

Expenditures were $76,000 for calendar year 1971 and $211,000 for the 3-year period 1969 through 1971. All funding was from the church and from private donations. During the 3-year period, 439 persons entered the program. Program officials estimated that about 59 of these were not abusing drugs.

The program had no accurate information on program completions and results because a means for complete patient followup did not exist.

LANGELY PORTER NEUROPSYCHIATRIC INSTITUTE--YOUTH DRUG UNIT

This program provides for (1) psychiatric research into drug culture and drug history, (2) the residential treatment of drug abusers, and (3) staff training in the Langley Porter Neuropsychiatric Institute of the University of California Medical Center. Inpatient treatment consisted of group and individual therapy using techniques of counseling and "rap" or discussion sessions. According to program officials, optimum benefit from the program is derived if a patient remains in treatment for 3 to 6 months.

The institute's drug unit has a capacity to treat 14 persons, most of whom were referrals from law enforcement agencies and probation departments. The residents must be adolescents or young adults with a drug problem. About 25 percent of the patients treated are opiate users. The drug ward is staffed by a psychoanalyst, a psychiatrist, a clinical psychologist, an occupational therapist, and ward nurses.

Funding has been provided exclusively by the California Department of Mental Hygiene. We were told by the institute's Assistant Director that data on expenditures were not available but that the estimated patient cost had been about $100 a day. Since inception of the program, about 5 years ago, about 300 persons have been treated by the drug unit.

There had been no followup and evaluation of treatment results until about June 1971. For a 1-year period from that date, information was obtained on 11 heroin addicts who had been in the program. Five of the 11 had dropped out of treatment, three had returned to the use of drugs after completing the program, and three had not used drugs for at least 6 months. These results were considered to be good by the institute's Assistant Director--the psychiatrist in the program--because, in his opinion, it would be unusual for addicts who leave or complete a drug program to not continue the use of some drugs.

SAN FRANCISCO DRUG TREATMENT PROGRAM

This clinic offers an outpatient counseling program for drug abusers, about 90 percent of whom are heroin addicts. Therapy and counseling are used in attempts to alter the individual's behavior pattern in the use of drugs. Usually an addict makes between five and 10 visits to the clinic to complete the counseling treatment. There is a detoxification program utilizing nonnarcotic medications to reduce physical discomfort during the withdrawal period. The staff consisted of 11 persons (full and part time).

The budget for fiscal year 1972 provided for the receipt of funds from the National Institute of Mental Health, from the State (Short-Doyle Act), and from San Francisco.

The staff estimated that, of the 609 patients served during the period January 1, 1971, to November 17, 1971, about 62 percent continued to use drugs while in the program and about 38 percent may have been clean (i.e., no illegal drug use) upon leaving treatment. We were told that regular patient followup, as an integral part of the program, was initiated in early 1972.

APPENDIX III

INFORMATION ON OTHER PROGRAMS IN ALAMEDA COUNTY

In addition to the narcotic treatment programs in Alameda County discussed in chapter 4, we gathered information on the following programs.

BERKELEY COMMUNITY METHADONE PROGRAM

The Berkeley Community Methadone Program (BCMP), which started in May 1971, was one of 13 organizations in a consortium of drug addiction treatment agencies in Berkeley. BCMP also coordinated its program with the methadone maintenance programs in Oakland and San Leandro through monthly staff meetings in which common ideas and problems were shared. These meetings were also used to verify that patients were not enrolled in more than one local methadone maintenance program.

BCMP is an outpatient methadone maintenance program; its long-range goal is the detoxification of patients. It provides such ancillary services as group therapy, individual counseling, legal counseling, other group activities, and vocational rehabilitation through the California State Department of Vocational Rehabilitation.

The BCMP staff consisted of (1) a principal investigator--a medical doctor who was professionally and administratively responsible for the program, (2) a director, who was a medical doctor and who performed psychiatric evaluations of all patients, (3) an ex-addict, who was the program supervisor, (4) a registered nurse, who dispensed methadone and kept records, (5) a part-time registered nurse, who dispensed medication on weekends, (6) a part-time secretary, and (7) two ex-addict aides whose duties included collecting urine specimens and supervising discussion groups.

BCMP received funds from weekly patient fees and from the city of Berkeley. Although a weekly fee of $15 to $19 per patient was charged, no one had been refused admittance or had been discharged because of his inability to pay. To be eligible, an individual must meet the following criteria: (1) be over 21 years old, (2) have 2 or more years of documented addiction, (3) reside in Berkeley or Albany for at least 6 months (except for transfers from other methadone

maintenance programs), (4) have failed in previous efforts to detoxify, (5) show evidence of current use of opiates as confirmed by three consecutive positive urinalyses, except that this criterion may be waived for persons coming from penal institutions, and (6) be motivated to give up drugs.

The program had a capacity of 165 patients. As of January 13, 1972, 101 patients were in the program. About 40 percent of these persons were employed--the remaining 60 percent were unemployed.

Urine tests determined whether patients were remaining drug free. Random-sampling methods were used to determine which specimens would be tested. Also, specimens were given under the observation of a member of the program staff. We were told that there were plans to evaluate the program annually. The criteria established to measure patient progress were the extent to which patients (1) remained in the program, (2) remained drug free, (3) avoided arrest, and (4) were employed. The effectiveness of the program will be evaluated on the basis of the percentage of patients who successfully withdraw from methadone and do not return to drug use. Those who finally withdraw from methadone will be asked to periodically review their activities with program staff and to periodically have their urine tested for at least 2 years.

SOUL SITE

Soul Site, located in the city of Berkeley, is primarily a neighborhood counseling and drop-in information center. Soul Site's primary function is to refer drug abusers and addicts to various drug treatment programs. Soul Site also makes medical, educational, and employment referrals for nondrug users. An inpatient detoxification facility was opened in December 1971 primarily for heroin users. This facility had a capacity to treat 25 patients.

The detoxification program is scheduled to last 7 to 14 days. Such medications as tranquilizers are used for detoxification purposes. Soul Site's detoxification program had treated 120 patients from its inception to February 17, 1972. The Director stated that a study of the first 27 patients indicated that 13 discontinued treatment before

completing detoxification and that 14 completed the program. Of those completing the program, 10 went on to residential treatment programs and four returned to heroin use.

The staff of Soul Site consisted of a director and his assistant, both of whom worked part time, and volunteers from the community. The detoxification unit had a paid staff of three full-time counselors and one part-time counselor.

Soul Site had received $15,000 from the California Council on Criminal Justice through the county of Alameda. In addition, $15,000 for the detoxification program was provided by the city of Berkeley for the initial period (6 months) of operation. We were told that expenditure data were not available.

Soul Site's Director believes that persons in treatment can be considered successes if they stop using narcotics and other dangerous drugs, are productive in employment and education, and establish meaningful family relationships. The staff was developing a followup technique to determine whether the program was helping drug abusers. As of February 1972 the staff estimated that, of those clients contacted by phone, about 17 percent had refrained from heroin use and about 15 percent had used heroin occasionally. The remainder were back on drugs, were in jail, or could not be located.

FAIRMONT METHADONE DETOXIFICATION PROGRAM

The Fairmont Detoxification Program is operated by Alameda County under the direction of a medical doctor who is also in charge of the Eden Drug Abuse Clinic. (See p. 46.) This short-term inpatient methadone detoxification project, located in Fairmont Hospital at San Leandro, began operations on January 31, 1972.

The program staff consisted of about 20 medical doctors, nurses, ex-addict counselors, and social workers on a full- or part-time basis. The budget for fiscal year 1972 was about $154,000, of which $139,000 was from the State (Short-Doyle Act) and $15,000 was from the county.

The program had a capacity of 23 patients; the average daily patient census was 15. Detoxification from heroin was completed in 4 to 7 days depending on the extent of the patient's habit. Methadone was administered twice daily in decreasing amounts. At the time of our review, after 24 days of operation, about 70 addicts had been treated and 23 patients had completed the program.

In addition to short-term detoxification, the program staff attempted to place detoxified addicts in an aftercare program. We were told that this phase of the program had not been very successful because only three patients had been placed in aftercare programs. As part of a followup program, it was planned to have former patients return periodically for visits and to have the staff contact programs to which detoxified patients had been referred to see how they were doing.