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ABSTRACT

This report concentrates on the analysis and evaluation of programs utilized by New York State's Narcotics Addiction Control Commission (NACC) and concerned with control of narcotic drugs and with those individuals who abuse them. The three key premises, basic to the narcotic drug control programs approved by the state legislature, are: (1) there exists an effective criminal justice system to insure either compulsory commitment to NACC for treatment or the imposition of legal penalties as a sufficient deterrent to the sale or use of narcotics; (2) there are demonstrated, reasonably effective treatment procedures for narcotic addiction; and (3) there exists a tested, satisfactory curriculum plan upon which to base preventive education. This audit, which examines current efforts in these three areas, shows that none has yet been accomplished. It is concluded, however, that the New York State Program is worthy of continuance, that more time is needed to indicate what performance standards might be achievable, and that more funds are needed. (TL)

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THE LEGISLATURE - STATE OF NEW YORK

CG

Narcotic Control

PROGRAM AUDIT HIGHLIGHTS
NARCOTIC DRUG CONTROL IN NEW YORK STATE

New York State's annual operating expenditures to control narcotics and drug abuse have increased from $1.7 million in 1963-64 (under the Metcalf-Volker Act) to an appropriation over $91.7 million for the Narcotic Addiction Control Commission (NACC) during 1971-72. The total State operating expenditures since 1967 are almost $190 million, and in the same period there have been capital expenditures of almost $124 million.

The New York State effort to control the use of narcotics attacks the problem on three major fronts: increased law enforcement to reduce crime and support compulsory treatment, an extensive and expensive treatment program to rehabilitate present addicts, and a widespread education program to prevent addiction.

Three key premises were basic to the narcotic drug control programs approved by the Legislature in 1966 and thereafter: (1) there exists an effective criminal justice system to insure either compulsory commitment to NACC for treatment or the imposition of legal penalties sufficient to discourage the sale or use of narcotics, (2) there exist demonstrated, reasonably effective treatment procedures for narcotics addiction, and (3) there exists a tested, satisfactory curriculum plan upon which to base preventive education. This audit has shown that none of these important elements are accomplished facts even today.

The civil certification of addicts, whereby the addict is certified on his own petition or is certified on the petition of another, is working reasonably well.

The criminal certification of addicts on the other hand, is not working as intended in New York City.

When addicts contest the question of addiction and request a jury trial, as is their right, the district attorneys often concede non-addiction, either because they do not have the personnel and resources to litigate the question of addiction or because the evidence of addiction is insufficient. The evidence of addiction is insufficient sometimes because of delayed or inadequate medical examinations or weak medical witnesses. From a total of 15,876 misdemeanor arraignments reaching disposition in the New York City Criminal Courts in 1969 over 10,000 (66 percent) were dismissed outright, and only 3,598 resulted in direct sentences; 2,415 of these sentences (again 66 percent) were for 90 days or less, and only 194 were assigned to NACC.

The Narcotics Bureau of the New York City Police Department has followed up on 2,218 felony arrests made since July 1969 that have been disposed of in Supreme Court. There were 938 dismissals (42 percent) and not more than 827 direct sentences. Of the recorded direct sentences, 616 were for one year or less; presumably many of these were cases of "copping a plea" to a misdemeanor. Only 172 of the original 2,218 arrests received terms of more than one year; thus, only eight percent of those arrested were ultimately convicted and sentenced for felonies.

Thousands of alleged addicts are being arrested, but only a small percentage of these are certified to NACC or receive severe jail sentences. Addicts are not being taken out of circulation, and the State's efforts to strengthen deterrence are thereby undermined. These shortcomings are due to failings in the system of criminal justice that extend beyond the ability of the police to apprehend criminals.

NACC currently (January 31,1971) has more than 10,700 addicts in treatment, aftercare, and contract programs. An additional 10,400 noncertified volunteers are receiving some form of treatment in NACC supported private agencies.

The principal problem encountered in trying to evaluate treatment programs provided by the private agencies and the facilities operated or funded by NACC directly is the singular lack of what might be considered hard data. Most of the programs have been able to generate some basic demographic statistics which are highly descriptive

but are not evaluative in nature.

Private and public agencies, except for the Beth Israel Methadone Program, have not done the kinds of follow-up studies that are necessary for program evaluation. The private agencies, even those funded as long-term demonstration projects, have not been evaluated on any sort of rational basis by NACC.

Residential treatment is the most expensive part of the NACC program. For the 1970 budget year, almost $21 million was spent for operating expenditures to treat an average resident population of 2,246 addicts — an average expenditure of $9,250 per patient per year. Operating costs almost tripled between the first and third year for the residence facilities operated directly by NACC or under contract. However, the number of subjects in residence only increased by 62 percent between the end of the first and third years.

A basic deficiency of the NACC program of treatment and rehabilitation and supervised aftercare results at the interface or transition point between the two phases where more than 20 percent of assigned addicts abscond from NACC custody.

There are few major differences between treatment programs at NACC and other State institutions housing NACC certificants. There appears to be little justification for the interdisciplinary treatment programs funded by NACC, except for the utilization of excess space.

One of the principal efforts in the rehabilitation and treatment of drug addicts is the funding of private voluntary agencies located mainly in the New York City metropolitan area.

NACC has expanded the funding and the number of patients under treatment in the private programs almost as fast as the certificants in the regular NACC program.

Methadone maintenance offers the only new treatment approach. Methadone is a highly addictive drug that treats only the symptoms rather than the causes of heroin addiction.

Recent evaluative reports of the methadone program suggest that 20 percent of the addicts in the program either withdraw voluntarily or are administratively discharged for behavior problems and other drug abuse; of those who remain in the program, 85 percent are claimed to function in a socially acceptable manner as measured by arrest-free records and participation in educational programs or employment.

The State has decided to greately expand the use of methadone programming in the treatment of opiate addiction. Governor Rockefeller has stated his intent to have 20,000 addicts in methadone programs by the end of the 1971 fiscal year.

It is questionable, however, whether the highly selective criteria which were originally used in the selection of patients in the Beth Israel program can be maintained with the addition of several thousand addicts to methadone programs.

The cost of the Beth Israel program to the State has been $159.16 per patient per month for the 1969-70 year. This is slightly higher than the $146.08 average monthly cost per patient to NACC for all voluntary agencies, and is not the "pennies a day" cost quoted by some enthusiastic supporters of methadone maintenance. The maintenance cost, however, is substantially less than the $771 per patient month cost in the average NACC residential facility.

The Legislature in 1970 appropriated $65 million for NACC to provide State aid for drug abuse treatment programs that are designed primarily for 16 year olds and younger and that provide ambulatory and/or in-patient services. The initial application guidelines distributed by NACC in May did not allow eligibility for education programs. The second version of the guidelines has for all purposes set aside the treatment component specifed in the law and considers educational programs singularly eligible for funding. (Approved by Legislature, March 1971.)

Urgent programs—and *narcotics* is an example—often must be initiated before all the prerequisites are available. Such programs should continue to be regarded as *experimental*—in that controls, records, research and evaluation must be maintained continually to document the most advantageous methods and programs. In programs of this type, substantial initial outlays might be necessary to assure that fair and full tests will be available. At the same time, the continuation or extension of such outlays should be dependent upon demonstration that careful controls are being applied and that some criteria have been established and are being utilized to distinguish and select the more promising approaches.

Since the dimensions of the narcotics problem are still unknown, it does make a significant difference in a State hard pressed for revenue as to whether the same essential results can be accomplished in an outpatient program costing $56 or $146 per patient per month or a residential program costing $440 or $969 per patient month and, more importantly, if any of them are doing the job.

The New York State Program to control nar-

cotic abuse is a worthy experiment. This experiment has not yet had sufficient time to indicate what performance standards might be achievable, and it should therefore be continued. There is no evidence, however, that this experiment thus far has been hindered for lack of funds, and further increases should be conditioned upon NACC and other departments and agencies supplying plans founded on documented performance records.

PROGRAM AUDIT SUMMARY
NARCOTIC DRUG CONTROL IN NEW YORK STATE

One of the most frustrating problems that confronts the nation and particularly New York State today is the control of narcotics and other dangerous drugs. This State is currently engaged in an extensive and expensive program to meet this problem and while it may be too early to judge the eventual results, there is nothing to date to indicate that an acceptable solution is in sight.

Reliable figures concerning narcotics use and abuse are not available. Information that is available indicates that more than half the narcotics addicts in the country are residents of New York State and that 85 to 90 percent of the New York State addicts reside in New YorkYork City.

The State efforts to control the use of narcotics has been concentrated in the Narcotics Addiction Control Commission (NACC). Figures compiled during the four years of NACC operation give some indication of the scope of the State program.

Summary Statistics, NACC

	1967-68	1968-69	1969-70	1970-71
Addicted[1] N.Y.C.	5,910	5,768	9,409	11,151[2]
Bal. N.Y.S.	649	952	1,587	1,835[2]
NACC Certificants under Care	3,164	4,408	7,075	10,764[2]
Under Treatment - Accredited Agencies	3,158	6,257	6,704	10,419[2]

[1] Positive Examination by NACC

[2] To January 31, 1971

SOURCE: NACC Annual and Monthly Statistical Reports

To meet the narotics problem the State has rapidly increased its expenditure in this area.

State Narcotics Expenditures

Year	Metcalf-Volker	NACC
1963-64	$1,731,617	
1964-65	2,090,740	
1965-66	3,492,455	
1966-67	4,673,964	
1967-68		$20,739,393
1968-69		33,216,309
1969-70		49,535,390
1970-71 (Budget)		85,146,124
1971-72 (Appropriation)		91,739,000

In addition the State has expended almost $124,000,000 in capital construction funds since NACC was created.

The New York State effort to deal with narcotic addicts began with a Special Narcotic Project conducted by the Division of Parole in 1956. It provided close supportive parole supervision for approximately 600 parolee-addicts, and it has been regarded as valuable enough to be continued to the present.

The 1962 Legislature passed the Metcalf-Volker Act, which provided that as of January 1, 1963 arrested narcotic addicts who show a potential for rehabilitation and whose crimes are not serious may *elect* to receive specialized treatment at a State mental hospital rather than be committed to a penal institution. That session also affirmed a larger commitment by the State to treatment and aftercare support for voluntary patients.

The impact of these new State programs was reviewed by the New York State Commission of Investigation in 1965. This Commission found the Metcalf-Volker program was disappointing since

follow-up study revealed 80 percent of the treated addicts as rearrested, most of them more than once, and concluded that "no program of rehabilitation which relies principally on the *voluntary* application of the addict for treatment can be sufficiently broad and comprehensive to deal effectively with the total problem of addiction."[1] The revamped drug control program proposed by Governor Nelson A. Rockefeller and enacted by the Legislature in April 1966 accordingly featured provisions requiring compulsory commitment of proven addicts, even when they were not charged with a crime.

The Creation of NACC

The 1966 Legislation, comprising Article 9 of the Mental Hygiene Law, focuses almost exclusively on *narcotic* drugs. This focus is understandable. Narcotics use is the one drug abuse problem that is known to be widespread, and to feed and breed crime extensively. Planning officials within the Narcotic Addiction Control Commission are aware of non-narcotic drug use problems, and they assume their mandate includes dealing with this area. For the time being, however, they have more than they can handle just in attempting to bring heroin under control.

The basic premise of the NACC program, from the "Declaration of Purpose" in Article 9, is as follows:

> The narcotic addict needs help before he is compelled to resort to crime to support his habit. The narcotic addict who commits a crime needs help to break his addiction. A comprehensive program of treatment, rehabilitation, and aftercare for narcotic addicts can fill these needs.

Contrast this assertion with the following admission offered by a proponent of the bill in the Senate.

> We are talking about a problem for which we know no cure, about which no data tells us there is a cure and yet we must do something.

The intent of the Legislature thus appears to have been twofold: first, the expectation that the vast majority of addicts who were convicted of misdemeanors, and who had previously been released from confinement after four-month-average sentences and no parole, would now be supervised for three years; and second, the *hope* that whatever compulsory treatment and rehabilitation services these addicts received would equip them to turn (or return) to socially acceptable life styles.

Rehabilitation alone was never presumed to be the only solution to these problems. The fact that the emphasis in the 1966 Legislation was on treatment did not change the overall picture that included enforcement as a critical component. Enforcement resources are necessary both to apprehend the narcotics violator and to assure that potential and actual absconders and repeat violators are subjected to continuing pressure.

There is, in addition to rehabilitative treatment and enforcement, a third significant dimension in New York State's drug control planning. It is preventive education.

The 1966 Act charged the Narcotic Addiction Control Commission to:

> Provide public education on the nature and results of narcotic addiction and on the potentialities of prevention and rehabilitation in order to promote public understanding, interest, and support.

The rationale supporting this aspect of the program again was formulated, among other places, in the report of the Commission of Investigation. The Commission proposed the creation of a "comprehensive public education program" in light of its claim to have found that:

> . . . the education of the public to the perils of narcotic abuse *can be effective* in preventing addiction. This is especially true in the case of young people who are particularly vulnerable and susceptible to contagion. Education of parents, teachers, and others who have contact with children in methods of recognizing narcotics and symptoms of narcotic abuse is also of prime importance.

Since 1966, not only NACC, but also the State Departments of Education, Mental Hygiene and Health have received appropriations to support drug education activities.

Thus the New York State effort to control the use of narcotics attacks the problem on three

[1] New York State Temporary Commission of Investigation, *Ninth Annual Report*, February 1967, p. 49.

major fronts: increased law enforcement to reduce crime and support compulsory treatment, an extensive and expensive treatment program to rehabilitate present addicts, and a widespread education program to prevent addiction.

STATE ENFORCEMENT EFFORTS

Law enforcement officials largely agree that, since drug traffic is international and interstate in nature, the primary enforcement effort must be by the Federal government. They also agree, however, that the State must play an important role in narcotics and drug law enforcement, and that the State's proper role is an intermediate one between the Federal and local levels, especially in those communities where Federal presence is least felt and local police are not equipped to deal with the problem.

Consequently, the State has taken several steps in recent years to strengthen its enforcement effort:

- —Criminal penalties have been increased for large-scale pushers or dealers in "hard drugs." The 1969 Legislature imposed a mandatory maximum life sentence for possessing or selling 16 ounces or more of heroin, morphine, cocaine, or opium.
- —A Special Narcotics Unit was created in the Division of State Police.
- —Members of the Narcotics Unit were assigned in 1970 to participate with Federal and New York City police officers in the New York Joint Task Force on Narcotics.
- —The 1970 Legislature established an Organized Crime Task Force within the Department of Law headed by a statewide prosecutor with the rank of Deputy Attorney General, who is appointed jointly by the Governor and Attorney General.

It is crucial to recognize that the combined efforts of enforcement agencies at all levels have not yet significantly reduced the supply of narcotics available in New York State, and the prospects for a significant reduction in the foreseeable future are not encouraging. These agencies have succeeded, however, in bringing large numbers of addicts into court, thereby subjecting them to the possibility of either compulsory commitment to NACC or lengthy imprisonment.

New York State police recorded 2,081 arrests and $41 million in drugs seized in 1968, and 3,594 arrests and $47 million in drugs seized in 1969. In many of these arrests the drug involved was marihuana.

Local police are far more active in arrests for narcotics violations. The New York City police made over 127,000 narcotics arrests between January 1967 and December 1970, and in more than 85,000 of these the drug involved was heroin or morphine:

New York City	1967	1968	1969	1970
Total Narcotics Arrests	17,591	22,440	35,178	52,479
Heroin and Morphine Arrests	9,722	13,461	23,698	38,790

The 1969 *Annual Report* of the Criminal Court of the City of New York shows the following disposition of that year's misdemeanor cases:

Total misdemeanor arraignments	— 20,560
Dispositions to date	— 15,876
Outright dismissals	— 10,301
Convictions	— 5,210
Direct Sentences	— 3,508
Sentences for 90 days or less	— 2,415
Commitments to NACC	— 194

These figures show that about two-thirds of all cases are dismissed outright, and that only 23 percent of all dispositions result in direct sentences. Furthermore, 66 percent of these direct sentences are for 90-or-less days.

The actual threat of punishment under *felony* prosecution for narcotics violations is not proportionately stronger. There were 13,374 felony arraignments in New York City in 1969, and 7,090 reached disposition. Of these over 2,500 (36 percent) were dismissed outright. The Supreme Court records on the disposition of the rest of these cases have not been compiled, but representative figures on disposition of felony cases are available from the records of the Narcotics Bureau of the New York City Police Department.

The Bureau has followed up 2,218 felony arrests since July 1969 that have been disposed of in Supreme Court. There were 938 dismissals (42 percent), and not more than 827 direct sentences.

Of the direct sentences, 616 were for one year or less; presumably many of these were cases of "copping a plea" to a misdemenanor. Only 172 of the original 2,218 arrests received terms of more than one year; thus, only eight percent of those arrested were ultimately convicted and sentenced for felonies.

Thousands of alleged addicts are being arrested, but only a small percentage of these are being certified to NACC or receiving severe jail sentences. Addicts are not being taken out of circulation, and the State's efforts to strengthen deterrence are thereby undermined. These shortcomings are due to failings in the system of criminal justice that extend beyond the ability of the police to apprehend criminals.

CERTIFICATION

A major characteristic of the NACC program is the *compulsory* requirement whereby all certifications for treatment are made by a court order which certifies the addict to NACC for treatment for a period of up to three years or, in more serious criminal cases, for as long as five years. The legislation provides several procedures by which an addict can be certified by the courts to NACC:

Civil Certification

1. The addict himself may volunteer for certification.
2. The addict may be involuntarily certified on the petition of any person believing him to be an addict.
3. An addict arrested on a lesser criminal charge may "volunteer" for the NACC program in lieu of a possible penal sentence.

Criminal Certification

4. The court *must* certify an addict convicted of a misdemeanor or prostitution.
5. The court *may* certify an addict convicted of a felony.

In any of these procedures, the court cannot certify unless addiction is shown, usually by means of a medical examination conducted by NACC doctors.

Certification Findings

Program execution falters beginning with the certification process. "A comprehensive program of compulsory treatment" was a key provision of the 1966 legislation. As one proponent of the legislation stated, "He (the addict) does not want to be cured so we have to force him to be cured."

The civil certification of addicts is working reasonably well, despite a heavy caseload in Manhattan, Brooklyn, and the Bronx. Relatively few arrested addicts, however, have "volunteered" for NACC under the provision which permits addicts with minor criminal charges to choose a NACC treatment program.

The criminal certification of addicts, on the other hand, is not working as intended in New York City. During the first year of NACC's existence, arrested or convicted addicts comprised 59 percent of NACC certificants. For the third year and the first six months of 1970-71 only 40 percent of the certificants came by way of arrest. In the main, this is simply a part of the general administrative problem of the criminal courts of New York City caused primarily by the tremendous volume of cases and the consequent shortage of judges, lawyers, and other court personnel to handle the workload. This load factor, plus a generally negative attitude toward the NACC program by the addicts, their attorneys (mostly from the Legal Aid Society), and lawyers from the district attorneys' offices combine to produce few certifications to NACC. When addicts contest the question of addiction and request a jury trial, as is their right, district attorneys often concede non-addiction, either because they do not have the personnel and resources to litigate or because evidence of addiction is insufficient. The evidence of addiction is insufficient sometimes because of delayed or inadequate medical examinations or weak medical witnesses. Rather than being certified to NACC, therefore, most addicts are referred to private agencies or given a short penal sentence.

The negative attitude towards NACC mentioned above has come about for several reasons:

1. The belief that commitment to NACC is simply a substitute form of imprisonment;
2. The long wait in jail awaiting admission to NACC facilities following certification;
3. The advantage to the addict of a short jail sentence over a 3 or 5 year certification to a NACC treatment program.

TREATMENT AND REHABILITATION

For many years, the principal treatment for narcotic addiction has been a combination of detoxification, psychotherapy, and counselling. While drugs are slowly withdrawn from addicts, professional staff (primarily psychologists and psychiatrists) tried to come to grips with the complex behavioral factors believed to have caused addiction. This traditional method of treatment is still prevalent in most drug treatment centers in the nation. Although statistics indicate that the long-term success rate (patient not becoming readdicted to narcotics) has been very low, no other treatment program has proven more successful.

From the beginning, NACC's approach to rehabilitation and treatment was based on the concept that no single treatment program would be adequate and that it would be necessary to provide several programs to meet the needs of addicts. Accordingly, a number of approaches were chosen for the New York State overall program:

—The principal NACC treatment approach is interdisciplinary and offers a mix of individual and group counselling and therapy, education and vocational training, and recreation.

NACC offers its commission operated program of rehabilitation and treatment in thirteen residential facilities followed by a supervised period of aftercare which, hopefully, prepares the addict for community living on a drug free basis.

—NACC executed agreements with 14 other appropriate State and New York City agencies to utilize their expertise in th development of special treatment programs.

The Department of Mental Hygiene employed a "psychiatric" approach. The "correctional" approach of the Department of Correction offers treatment in the setting of a correctional institution for addicts convicted of serious crimes. A contract with the Department of Social Services offers a program for "youthful" addicts.

Separate contracts with the City of New York through its Addiction Services Agency provide primarily for support of the "therapeutic community" concept in the Phoenix Houses which utilize ex-addicts in the treatment program.

—NACC funds a number of private voluntary agencies located mainly in the New York City metropolitan area. When NACC was founded, it elected to fund (on a demonstration grant basis) a number of agencies whose existence preceded that of NACC. A total of 19 private programs are funded.

—A "chemotherapeutic" approach is supplied primarily by methadone maintenance. Methadone is a synthetic opiate which, given under proper medical supervision, blocks the narcotic effect of heroin without inducing euphoria or necessitating an increase in the dosage once a maintenance level has been attained. Once an addict has been stablilized, it is asserted that he is more amenable to treatment for the causes of his addiction.

In the first three years of its existence, NACC spent $98 million of its $103 million total operating expenditure for treatment and rehabilitation, and $124 million in capital expenditures for facilities.

As of January 31, 1971 NACC has more than 10,700 certified addicts in treatment, aftercare, and contract programs. An additional 10,400 non-certified volunteers are receiving some form of treatment in NACC supported private agencies.

There is every indication that NACC knows its principal assignment and has tried to execute it.

Screening

Once a person has been criminally or civilly certified to NACC, he is given a screening interview. The interview is an attempt at a broad character evaluation to determine his most appropriate treatment and rehabilitation facility or program. However, with the continuing shortage of treatment beds, actual assignment to residential facilities usually takes place on the basis of available bed space.

Some addicts may be recommended for methadone maintenance, private agency, or "instant aftercare" programs (short-term residential program in a community based center). Most certifi-

Addicts Under Treatment

Year	Residence	Aftercare	Total NACC Certificants	Total in Accredited Agencies	Total
1968	2,976	188	3,164	3,158	6,322
1969	3,405	1,003	4,408	6,257	10,665
1970	4,828	2,247	7,075	6,704	13,779
1971 (Jan.)	6,141	4,323	10,764	10,419	21,183

SOURCE: NACC Annual Reports and Monthly Census Reports

cants begin their treatment in a residential program operated by NACC or one of its contract facilities.

Residential Treatment

The NACC residential program as of October 31, 1970 provides treatment for some 3,800 patients in 13 residential facilities with approximately 1,400 patients in contract facilities of other State Departments. Another 1,000 beds are expected to be available in the near future as the Ridge Hill and Brooklyn Central facilities become fully operational.

In addition to those under treatment, as of November 1, 1970 the waiting list showed:

425 certified and not admitted;

444 detained for examination with certification probable for at least half this number (based on past experience);

300 in police custody and charged with new offenses who may be returned to NACC;

27 in policy custody pending return to NACC facilities.

The fact is that NACC has not yet had facilities to fully meet the demand.

For a period that now averages from 6 to 9 months, the patient is exposed to a program of individual and group counselling and therapy, education and vocational training, and recreation. When it is decided that sufficient progress has been made, the certificant is recommended for transfer to an aftercare center.

The residential phase is the most expensive part of the treatment program. For the 1970 budget year, almost $21 million was spent to treat an average resident population of 2,246 addicts. This is an average annual expenditure of $9,250 per resident patient.

Residential Treatment Findings

There are few major differences in the treatment and rehabilitation services offered for narcotic addicts by NACC and other state agencies. Programs do vary in the "mix" of counselling, vocational and educational training, recreation, and security but only the extremes in this treatment continuum show significant differences. It must be recognized there are two or three individual treatment facilities that have established programs that differ slightly in philosophy from the average program.

These differences are often based on operating premises developed by the program directors rather than NACC.

Program evaluation depends in part on the assumtion that a full program is being offered. With due respect to the fact that the NACC program is only three years old, there are several centers with inoperative program components. The reasons for this inactivity are several.

Some facilities are still not usable: the wiring of shop equipment was incompatible with the wiring at the facility; in other facilities that have been open for a year or more, equipment has not yet been delivered; and in still others, equipment lies idle because essential renovations in shop areas have not been completed.

The NACC operated programs are also plagued with a variety of personnel problems. Professionals are simply not available in some critical classifications: medical personnel, counsellors (especially Spanish-speaking), vocational, and educational staff.

Contract Treatment Findings

NACC's claim that special interdisciplinary programs have been developed for certain types of addicts does not appear valid.

The psychiatric treatment approach, utilizing professional psychiatrists in the therapy process, is supposed to be employed in the Department of Mental Hygiene's program at Manhattan State Hospital. In fact, Manhattan State's program now focuses on a team concept of psychologists and social workers while psychiatrists have been "phased out."

The Department of Correction, with NACC funds, operates a treatment program in its facilities at Greenhaven and Great Meadow. However, criminal certificants assigned to these institutuions are integrated with the regular prison population in every way except that they participate in group counselling sessions conducted jointly by correction officers and ex-addicts of the Reality House staff—a treatment program operated by former addicts that performs out-reach work in some prisons.

The arrangement with the Department of Social Services was established on the basis that NACC offered no special program for youthful certificants. These young addicts (i.e., under 17 years of age) are assigned to the Department of Social Services for treatment. However, there are no distinctions made between NACC certificants and others in the program. Addicts are intermixed and receive the same programming as other youthful offenders.

The findings of this study indicate there are few major differences from treatment program to treatment program at NACC and other State agency institutions housing NACC certificants. There appears to be little justification for the interdisciplinary treatment programs funded by NACC, except for the utilization of excess space in the contract facilities. At a minimum, this joint administration is causing problems among staff who are operating under NACC program guidelines, yet looking to other departments for promotions and other benefits.

Treatment Costs

Rapidly rising costs make establishment of controls, adequate records, and follow-up to determine results imperative. For example, operating costs almost tripled between the first and third year for the residence facilities operated by NACC or under contract. However, the number of subjects in residence only increased by 62 percent between the end of the first and third years.

	1967-68	1969-70	% of Increase
Subjects in Residence (as of March 31)	2,976	4,828	62
Operating Expenditures (Resident Treatment Centers)	$10,373,958	$29,298,293	188

Of equal concern must be the rising cost of facilities. The average construction cost per bed had been about $20,000. The cost of the last facility constructed at Ridge Hill was more than $35,000 per bed.

In addition to the sharp rise in overall treatment costs, there are wide variations between unit costs in NACC facilities, and between NACC costs and those of the contract agencies.

Average Cost Per Patient, NACC Residence Facilities

	Monthly	Annual
High (Queensboro)	$ 1,164	$ 13,966
Low (Woodbourne)	558	6,691
Average	771	9,249

The data indicate a difference of more than 100 percent between the lowest and highest cost per patient in NACC facilities.

NACC current operating costs per resident are also 75 percent higher than those of Correction and 30 percent higher than Mental Hygiene.

Average Resident Costs

	Monthly	Annual
NACC	$ 771	$ 9,249
Mental Hygiene	588	7,058
Correction	440	5,275

Until there are demonstrable differences in program results, such wide variations do not appear justified.

Aftercare

The NACC aftercare program consists of a continuing emphasis on the same essentials as

treatment: counselling, educational and vocational training, and recreation. This continuing aftercare is aimed at preparing addicts for life in the community. Aftercare centers consist of Reporting Centers with virtually no supportive services other than supervision, and Community Based Centers (CBC) which provide supervision and supportive counselling, educational and vocational, and recreational services.

There are two Reporting Centers (Albany, Syracuse) that provide counselling and supervision for certificants in most of the upstate area. Five of the six Community Based Centers are in New York City and one is located in Buffalo.

The typical Community Based Center provides programming for 800 addicts: 50 in residence, 150 on day care, and 600 on field service. Certificants are assigned to one of these programs depending on home and family situation, progress in programming, employment and educational potential, and amount of supportive services required. Minimum requirements during this phase of programming consist of mandatory periodic meetings with professional staff and regular urinalysis. At the end of October 1970 there were 3,691 patients in aftercare programs: 3,235 in field service, 210 in day care, and 245 in residence.

Year	Number in Aftercare	Operating Costs of CBC's
1967-68 (March 31)	188	$ 160,084
1968-69 (March 31)	1,003	1,038,056
1969-70 (March 31)	2,247	3,192,797
1970-71 (Oct. 1970)	3,691	6,502,090 (Budget)

SOURCE: NACC Annual Report and Monthly Census Reports.

Aftercare Findings

It is the so-called "aftercare" resources of NACC that are most directly involved in getting addicts back into the community and providing them with whatever support they might need in "returning to useful lives." Most centers actually offer little in supportive services to the people assigned them. Too often, elements of the program are inoperative because of a shortage of professional personnel and because of a breakdown in supervision resulting from large caseloads. As a result, it is in the aftercare phase of treatment that the vast majority of abscondences from NACC facilities take place. As of October 1970, there were 1,894 people who were on abscondence from aftercare programs. A large number of certificants have been transferred to aftercare who were apparently not ready when they were released from the security of the residential program, and without adequate supporting services they absconded in large numbers.

Private Agency Programs

One of the principal elements in the rehabilitation and treatment of drug addicts is the funding of private voluntary agencies located mainly in the New York City metropolitan area. When NACC began operating, it elected to fund a number of these agencies already in existence. In addition, it has funded new programs that claim to offer something "unique" in the treatment and rehabilitation of addicts.

The essential difference between programs operated by private agencies and those operated by NACC is the voluntary nature of the former. NACC exerts legal control over people certified to it and can issue warrants for those who escape. In the private agencies people enter programs of their own "free will" and leave when they choose to do so. Every program has a high "split rate" (i.e., people who have entered the program but who leave before they are judged to be "cured").

Private agencies indicate they do not screen people out of their programs, but the voluntary nature of the program acts as a selection process. Those who are unhappy with a particular program leave it. The result is that only a small percentage of the people who enter ever graduate from a program. According to an unpublished study covering a period from mid-1967 to February 1970, there were 2,110 cumulative admissions to the Phoenix - A.S.A. (NYC) programs. Of this total, only 79 persons (3.7 percent) completed the program.

The programs run by the private agencies can be divided into three basic types: residential, out-patient, and methadone. There is an apparent difference in the operating philosophies of the directors of residential and out-patient programs. The directors of the latter maintain that residential programs create an unreal environment for the addicts and that transition from the secure world of the treatment facility to the unstructured outside world is very difficult. These directors maintain that people in out-patient programs avoid these unnecessary stresses and are forced to deal with reality by going home and remaining drug

free in the community.

The program components employed in the treatment process differ almost as much as the agencies that emply them. In general, programs fall somewhere along a continuum with therapeutic communities that focus almost entirely on group therapy at one end and programs with interdisciplinary "mixes" that combine therapy with education and vocational training in varying proportions at the other end.

Out-patient programs, such as Greenwich Home Counseling Center and the Lower Eastside Service Center, do not have residential facilities. The specific mix of services offered in out-patient programs varies as much as in residential programs. Some stress intensive group therapy while others emphasize educational and vocational achievements as well. Participants come in as frequently as required to receive services and then return to the community. Additionally, these programs are less costly since they serve more people with the same staff and are less intense in nature.

NACC has expanded the funding and the number of patients under treatment in the private programs almost as fast as the numbers in the regular NACC program.

Volunteer Private Agency Programs

Year	No. of Patients	NACC Funding
1968 (March 31)	3,158	$ 3,252,000
1969 (March 31)	6,257	8,979,000
1970 (March 31)	6,704	9,158,000
1971 (January 31)	10,419	10,554,000[1]

[1] NACC Allocation

SOURCE: NACC Annual Reports and Monthly Census Reports

There is a wide range in the direct cost to NACC for the services of these private agencies, from as low as $55.73 per month for a program that is exclusively outpatient, to as high as $471.78 per month for a program that is predominantly residential.

The operating costs of the private agencies are less than those of facilities operated by NACC. This is due in part to NACC security needs, but can also be attributed to differences in programming methods and staffing. However, the direct cost to NACC which is used in this report may, in some cases, be only part of the actual cost. Additional operating costs that are financed from other sources are not reflected in NACC cost figures. For instance, many of the private agencies insist their patients apply for welfare. They are required to turn their checks over to a central fund to pay operating expenses. Additionally, private agencies often have several sources of financing. Most receive private contributions and several receive funds from other government agencies.

The private agencies have grown considerably in size since their original contracts with NACC were drawn. This growth has been permitted without a corresponding evalution of treatment results. Some agencies have doubled their budgets since their association with NACC, a growth that in many cases would not have been possible if they had to rely on their previous funding sources. Since there is no demonstrated "cure" for addiction, the funding of these private agencies with their varied approaches to treatment can be justified only if adequate controls, records and follow-up to determine results are included.

New York City Addiction Services Agency

The Addiction Service Agency (ASA), established in 1966, operates one of the largest municipally run anti-drug programs in the country. ASA provides a variety of services for addicts and drug users in Phoenix Houses, in other therapeutic community facilities, in neighborhood Community Centers, in Youth Centers, in Day Centers, and other programs. The State has authorized about $19 million for ASA since 1967. For fiscal 1970-71 the appropriation is $7.4 million.

The ASA funded treatment and rehabilitation programs are run on the Phoenix House therapeutic community concept, with most of the programs operated by the Phoenix House Foundation. The Foundation operates five Phoenix Houses on Hart Island for some 400 addicts, nearly three-quarters of whom are NACC certificants. Funding for this program is provided by NACC through ASA which is responsible for the coordination of the entire rehabilitation program on the island.

Methodone Maintenance Treatment Programs

The most controversial treatment concept for narcotic addiction developed in recent years is the use of Methadone Maintenance which has been funded by NACC since October 1967. The methadone treatment concept is still controversial because methadone is a highly addictive drug that treats only the symptoms rather than the causes of

herion addiction. To be successful in the long-term treatment and rehabilitation of addicts, the program must rely on the utilization of other supportive and therapeutic services.

Most methadone programs are based on the research work and model developed by Drs. Dole and Nyswander at Rockefeller University and located at Beth Israel Medical Center since 1964.

The general operating concept of the model is that under proper medical supervision, a high level daily dose of methadone will block the narcotic effects of opiate drugs without inducing euphoria or necessitating an increase in dosage once a maintenance level has been established. Once an addict has been stabilized, it is asserted that he may be more amenable to treatment for the causes of his addiction.

The largest program currently operates through the Beth Israel Medical Center and its satellite facilities. Beth Israel works on both an in-patient and ambulatory basis. There were 2,153 people in the program as of October 31, 1970.

The second largest methadone program in the state is operated by NACC at the Cross Bay Rehabilitation Center. This program is essentially a research project composed of three research protocols, differentiated by several criteria including age, criminal background, and prior treatment for addiction. Patients, after having been stabilized on methadone during a six-week period, are then assigned to one of the NACC aftercare methadone programs at community based centers. In addition, NACC operates several methadone maintenance programs for a small number of certificants at several of its rehabilitation centers. Certificants in the latter program are stabilized on methadone and are then transferred to aftercare programs at community based centers. There were some 700 under treatment in NACC facilities and several hundred in other private programs.

New York City is now in the process of establishing twenty centers operated by its Department of Health with Sate funding for the treatment of an additional 2,500 addicts.

Methadone Findings

Most of the public acceptance of methadone maintenance programs is based on the research data and analysis of the methadone treatment program at Beth Israel. Recent evaluative reports of that program suggest that 20 percent of the people in the program either withdraw voluntarily or are administratively discharged for behavior problems and other drug abuse; of those who remain in the program, 85 percent are claimed to function in a socially acceptable manner as measured by arrest-free records and participation in educational programs or employment.

New methadone programs are being rapidly established, usually with few supportive services and frequently without the evaluation and follow-up that are necessary in large-scale research programs. Further, it is clear that existing ancillary supportive services are not heavily utilized in several programs.

The State has decided to greatly expand the use of methadone programming in the treatment of opiate addiction. Governor Rockefeller has stated his intent to have 20,000 people in methadone programs by the end of the 1971 fiscal year.

As of September 8, 1970 10 contracts had been awarded to provide for treatment for up to 11,875 persons under the state's $15 million methadone program. "This combined with the program for treating up to 2,488 persons, carried out by the Narcotics Commission itself at their centers, accounts for a total services level of 14,363 persons."

The question must be asked, however, whether the highly selective criteria which were originaliy used in the selection of patients in the the original Beth Israel program can be maintained with the addition of several thousand addicts to methadone programs. If not, can it be assumed that the success rate obtained and widely publicized by Beth Israel can be maintained? There are strong indications based on observations and results obtained from programs operated by several private agencies that success rates are substantially lower when addicts are admitted on the basis of less selective criteria.

The cost of the Beth Israel program to the state has been $159.16 per patient per month for the 1969 and 1970 fiscal years. This is slightly higher than the $146.08 average monthly cost per patient to NACC for all voluntary agencies, and is not the "pennies a day" cost quoted by some enthusiastic supporters of methadone maintenance. The maintenance cost, however, is substantially less than the $771 per patient month cost in the average NACC residential facility. It must be pointed out that the methadone cost figure is based on a program that is largely outpatient in nature whereas the NACC cost is for a residential program.

In summary, the State pioneered and is now funding the rapid expansion of methadone maintenance because:

—It was the only "new" concept that has been offered recently;

—Follow-up records are being kept and treatment results can be documented by the program's statistics;
—It appears to offer an alternative for an as yet unknown segment of the addict population;
—It does not require long periods of more expensive residential care.

Statistics and Follow-Up

The principal problem encountered in trying to evaluate both the private agencies and the facilities operated or funded by NACC is the singular lack of hard data except for the Beth Israel methadone program. Most of the programs have been able to generate some basic demographic statistics which are highly descriptive but are not evaluative in nature.

The statistics from private agencies are probably less reliable and more subject to question than those generated by NACC. However, even NACC follow-up data have been limited. NACC directors do not know how their programs compare to other facilities, or whether individuals who participated in their programs are still abstaining from drug use or have become re-addicted to narcotics.

In most cases, the private agencies have not had either the resources or the inclination to gather even the most basic evaluative data. Instead, they have relied on their service orientation to justify their operations. The statistics that have been issued are often highly colored and in many cases cannot be verified.

Private and public agencies have not done the kinds of follow-up studies that are necessary for program evaluation. The private agencies, even those funded on a long-term demonstration basis, with exception of the Beth Israel methadone program have not been evaluated on any sort of rational basis by NACC, but have been allowed to increase the size of their programs. Therefore, at the present time, there is no way in which treatment programs can be compared in any meaningful attempt to determine which, if any, are more successful in the treatment and control of narcotics addiction.

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

EDUCATION

The NACC Programs

Of NACC's total budget, less than three percent is spent on "education" efforts. NACC was given responsibility for providing public education on the potentialities of prevention; it was also charged with disseminating "information relating to public and private services and facilities in the state available for the assistance of narcotic addicts and potential narcotics addicts," and it was essentially this latter drug awareness function that NACC understandably concentrated on in its first years. Most of this effort has been carried out by the staffs of the community narcotic education centers, of which there are presently 16—nine in New York City and Long Island and seven upstate. The education Centers have also served as the principal vehicle assisting applicants for civil certification.

NACC's second element for "prevention" is the Narcotic Guidance Council (NGC), which was authorized by legislation in 1968 to "develop a program of community participation regarding the control of the use of narcotics and dangerous drugs at the local level." NGCs were to "make immediately available to the community basic knowledge acquired in the field of drug use . . . and create a climate in which persons seeking assistance. . . can meet . . . with responsible individuals or agencies . . . .". Approximately 250 NGCs have already been established, and an additional 140 have been proposed. These organizations thus far have barely had time to go into action.

The State Department of Education Programs

The Laws of 1967, amended in 1970, authorize the Commissioner of Education to establish a continuing program for critical health problems in which:

> educational requirements regarding cigarette smoking, drugs, and narcotics and excessive use of alcohol become the basis for broad, mandatory health curricula in all elementary and secondary schools.

The basis of this new program was originally intended to be a curriculum on Sociological Health, Drugs, and Narcotic Education (Strand II) that was completed in 1967 and available for grades 4-12. Strand II was conceived along traditional lines — information, presumably "authorita-

tive," was to be given to students in lectures by teachers. Strand II has been applied minimally, with a current budget of $30,000 to cover the preparation of new curriculum materials. Strand II is currently being revised to allow more student participation in material dealing with drug abuse.

The Education Department in 1970 launched an extensive set of programs to prepare teachers, administrators and students for involvement in future drug education classes in which the utilization of innovative materials and student participation would be stressed. During the summer of 1970, 89 teachers received two weeks of training in one program, and 189 others completed the first course in a part-time Master's Degree sequence. Other future community teachers are supposed to come from College Volunteer and School-Community-Team programs. With the exception of pilot projects, as of January 1, 1971 there has been almost no feedback into schools from specially trained leaders.

The size and scope of the programs of the State Education Department were relatively small scale and experimental through 1969-70. The Department has proceeded slowly, apparently recognizing that it had to develop and substantiate a drug prevention curriculum, and prepare teachers to use such a curriculum before any large-scale program could be launched.

Youthful Drug Abuse Treatment Program

The Legislature in 1970 appropriated $65 million for NACC to provide State aid for drug abuse treatment programs that are designed primarily for 16 year olds and younger and that provide ambulatory and/or in-patient services. The initial application guidelines distributed by NACC in May did not allow eligibility for education programs. The second version of the guidelines has for all purposes set aside the treatment component specified in the law and considers educational programs singularly eligible for funding.[2]

Education Findings

NACC's Education Centers and Guidance Councils have provided a sense of community presence and it is reaching some of the addict population through the petitioning assistance given in the Education Centers.

Impact of the extensive public relations program — lectures, publications, etc. — is always difficult to judge. However, there is evidence of much continuing skepticism among judges, lawyers, and addicts themselves about NACC's ability to help the addict.

Underlying the spirit of the NGC legislation is the idea that the Councils would be able to communicate with the youth in the community who face the perils of drug abuse. NGCs often have a difficult time relating to individuals with drug problems because they lack youth membership and back-up treatment facilities. Both these shortcomings were items covered by amending legislation in 1970. Persons under 21 were specifically authorized as Council members, and the $65 million Youthful Drug Abuse Treatment money was originally authorized for a 50-50 state-local sharing of financing for youth treatment centers.

The preventive education efforts of the State are all so new that evaluation in terms of the relationship between costs and results is impossible; indeed, there are presently no results in terms of program implementation. Educational programs designed to influence the behavior of students over a period of years are almost always difficult to evaluate even when comprehensive records are maintained. School programs focused on drug abuse are particularly difficult to measure considering the numerous problems involved. Careful documentation and extensive use of control or pilot study groups involving a comparatively small number of students is a method frequently employed which, among other things, reduces the possibility of extensive adverse effects. It is expected that all educational programs devoted to drug abuse will have been authenticated before they are offered to large numbers of students and before sizeable amounts of money will be needed.

There is ample evidence of insistent public demand for "something to be done" in educating students regarding the perils of drug abuse. But the extent of the educational programs that can be immediately generated throughout the State and the amounts of money that can be used with appropriate effectiveness for drug abuse classes are not readily discernible.

CONCLUSION

Three key premises were basic to the narcotic drug control programs approved by the Legislature in 1966 and thereafter: (1) there exist demonstrated, reasonably effective treatment procedures for narcotics addiction, (2) there exists an effective criminal justice system to insure either compulsory

[2] Section 213-a of the Mental Hygiene Law was amended by Chapter 49, Laws of 1971, to permit these changes.

commitment to NACC for treatment or the imposition of legal penalties sufficient to discourage the sale or use of narcotics, and (3) there exists a tested, satisfactory curriculum plan upon which to base preventive education. This audit has shown that none of these important elements are accomplished facts even today.

Urgent programs — and *narcotics* is an example — often must be initiated before all the prerequisites are available. Such programs should continue to be regarded as *experimental* — in that controls, records, research and evaluation must be maintained continually to document the most advantageous methods and programs. In programs of this type, substantial initial outlays might be necessary to assure that fair and full tests will be available. At the same time, the continuation or extension of such outlays should be dependent upon demonstration that careful controls are being applied and that some criteria have been established and are being utilized to distinguish and select the more promising approaches.

Since the dimensions of the narcotics problem are still unknown, it does make a significant difference in a State hard pressed for revenue as to whether the same essential results can be accomplished in an outpatient program costing $56 or $146 per patient per month or a residential program costing $440 or $969 per patient per month and, more importantly, if any of them are doing the job.

The New York State program to control narcotic abuse is a worthy experiment. This experiment has not yet had sufficient time to indicate what performance standards might be achievable, and it should therefore be continued. There is no evidence, however, that this experiment thus far has been hindered for lack of funds, and further increases should be conditioned upon NACC and other departments and agencies supplying plans founded on documented performance records.

NOTE

These "Highlights" and "Summary" are from a Program Audit of Narcotic Drug Control in New York State which may be obtained from the Legislative Commission on Expenditure Review, 111 Washington Avenue, Albany, New York 12210.

The report concentrates on analysis and evaluation of programs concerned with control of narcotic drugs and with those individuals who abuse them. Recommendations are excluded from the report since they are outside the scope of the Commission's mandate. Also to be noted is that agency responses to the preliminary draft of the audit may be found only in the complete report.

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FOREWORD

The Legislative Commission on Expenditure Review was established by Chapter 176 of the Laws of 1969 as a permanent legislative agency for, among other duties, "the purpose of determining whether any such department or agency has efficiently and effectively expended the funds appropriated by the Legislature for specific programs, and whether such departments or agencies in the actual implementation of such programs have failed to fulfill the Legislative intent, purpose, and authorization." This program audit of Narcotic Drug Control is the second staff report accepted by the Commission.

It concentrates on the analysis and evaluation of programs concerned with control of narcotic drugs and with those individuals who abuse them. Recommendations in regard to program or policy are not included in this audit. Policy formulation is, of course, the prerogative of the Legislature and the programs which implement policy are properly within the Executive branch. The responsibility of the Legislative Commission on Expenditure Review is to aid the Legislature by providing factual information concerning State programs which otherwise would not be readily available.

A word about procedure may be helpful. After the preliminary draft of each audit is completed, copies are delivered to the agencies engaged in carrying out the particular legislative policies under scrutiny. The comments which agencies wish to make in regard to the preliminary draft are subsequently either included in the body of the report or presented in the Appendix. In this way, it is hoped that any possible errors are corrected before the report is printed, and that should the agencies involved feel that additional material is essential for an equitable presentation, it will be readily available. This is not designed to be a debate but rather an attempt to be of utmost assistance to all those concerned with State government.

The law mandates that the Chairmanship of the Legislative Commission on Expenditure Review alternate in successive years between the Chairman, Assembly Ways and Means Committee and the Chairman, Senate Finance Committee. Senator Warren M. Anderson is the chairman for 1971 having succeeded Assemblyman Willis H. Stephens.

The professional staff members who conducted the audit and prepared the report consisted of Neil Blanton (program director), Donald Bisesti, Travis Boggs, William Brooks, Anthony Esposito, Bernard Geizer, and Michael Moss.

On behalf of the commission staff, I wish to express thanks to each of the twelve commission members for assistance and understanding during the development of the report. Appreciation is noted also to Commissioner Milton L. Luger, Chairman of the New York State Narcotic Addiction Control Commission and Commissioner Ewald B. Nyquist of the State Education Department and their respective staffs for their cooperation during the course of the audit.

April 7, 1971

Troy R. Westmeyer
Director

NARCOTIC DRUG CONTROL IN NEW YORK STATE
INTRODUCTION

This audit is designed to provide information as to the status and progress of New York State's existing programs dealing with narcotics and other dangerous drugs.

The information is organized into the following categories: 1) the nature and extent of the narcotic drug "problem"; 2) the New York State effort to deal with the narcotic drug problem, and the relationship between these efforts and those of Federal and local governments; 3) assessment of New York State programs, in terms of legislative intent, costs and results.

General Findings

One of the most frustrating problems that confronts New York State today is the control of narcotics and dangerous drugs. While it may be too early to judge the eventual results of the New York drug control effort, there is little evidence this program has made a significant impact toward controlling drug abuse. Even though demonstrable results have been few, there appears little reason to fault the scope of the program, as the Narcotic Addiction Control Commission (NACC) represents the most ambitious program of any government to meet the problem.

The State effort to control the use of narcotics attacks the problem on three major fronts: increased law enforcement to reduce crime and support compulsory treatment, an extensive (and expensive) treatment program to rehabilitate present addicts, and a widespread education program to prevent new addicts.

In the legal area, penalties for pushers were increased and compulsory treatment legislated for arrested users. Detection forces have been increased. A special Narcotics Unit was created in the Division of State Police and the State participated with Federal officers and the New York City Police Department in establishing a New York Joint Task Force on Narcotics. Local police efforts have also been stepped up—in New York City arrests for opium and morphine offenses increased from 9,722 in 1967 to 38,790 in 1970.

The effectiveness of a law enforcement system, however, does not ultimately depend on an ability to arrest offenders. A swift and fair trial and adequate punishment are also considered essentials for deterrent effect. This has not occurred with enough frequency. Of the misdemeanor arrests for narcotics violations in 1969 in New York City two-thirds were dismissed, and the median sentence of those convicted was less than 90 days. The most serious threat of punishment under felony arraignments is apparently not much greater. In one sample only 172 (eight percent) of an original 2,218 felony cases were given terms of more than one year.

Certification to NACC for compulsory treatment of arrested and convicted addicts has also declined. During the first year of NACC's existence, arrested or convicted addicts comprised 59 percent of total NACC certificants. For the third year and the first six months of 1970-71, only 40 percent of the certificants came by way of certification in criminal courts.

The arrested addict has been quick to discover that the legal requirement for a jury trial to determine addiction, combined with an ineffective medical examining system and a crowded court calendar, make plea bargaining relatively easy and return to the street quicker than the three year "compulsory" treatment will permit.

In treatment and rehabilitation, NACC established a multifaceted approach utilizing their own residential and aftercare facilities and those of other State agencies. It also funded almost any reputable private agency that claimed to offer something "different" in treatment and rehabilitation. To date, inadequate controls, monitoring and record keeping have made evaluation virtually impossible, and there appear to be few major differences in the programs.

Rapidly rising costs make the establishment of

controls, adequate records, and follow up to determine results imperative. NACC operating costs have risen approximately 60 percent per year from an initial expenditure of $21 million in 1967-68 to just under $50 million in 1969-70 and an adjusted budget appropriation of $85 million for 1970-71. Capital expenditures have totalled some $124 million.

With rapidly increasing costs and little to show in demonstrable results from its variation of traditional treatment programs, the State has turned to a rapidly expanded program of methadone maintenance. The methadone maintenance program gained in acceptance because it maintained records, control, and follow up. Evidence suggests, however, that a great deal more objective research and evaluation are necessary before applicability of methadone for a more general segment of the addict population can be determined.

The informative and preventive education programs of the State are all so new that evaluation of the relationship between costs and results is impossible; indeed, there are presently few results in program implementation. Evaluation will remain difficult even after many years of experience with these programs because the outputs in educational systems are usually complex and strung out. Narcotics education as conceived and practiced by NACC is essentially a drug awareness effort. NACC uses its 16 Narcotics Education Centers and the more than 250 Narcotic Guidance Councils to encourage a community action approach to drug education. Of NACC's total operating budget, less than three percent was spent over the first three years for preventive education. The State Education Department has been concerned with developing a curriculum and teacher training program in narcotics education. With the $65 million appropriation originally made to finance a Youthful Drug Abuse Treatment Program now redirected to education, it becomes even more essential that an effective program be developed.

I DIMENSIONS OF THE DRUG PROBLEM

One of the most direct, most basic measures of the overall New York State effort to control narcotic drug abuse would be evidence that the number of narcotic addicts either is declining, or is increasing at a progressively slower rate. The plain fact is that trend data necessary to make such an evaluation have never been, and are not now, available.

Information on the prevalence and incidence of most serious illnesses in the United States has been comprehensively collected and accurately tabulated for a long time. Most people with communicable diseases receive some medical treatment, and the doctors providing treatment normally comply with the law requiring these diseases be reported to Public Health authorities. It is useful to think of narcotic addiction as a communicable disease in the sense that a person almost always first injects drugs under the guidance of an experienced user. Addiction differs from other communicable diseases, however, in that the majority of those afflicted with it do not seek medical treatment, and many of those who do happen to receive private medical attention are not reported (due to the ambiguous status of private treatment under Federal regulations). Statistical information on addiction is therefore not easy to gather.

Federal Estimates

The primary data-tabulating agency in the period since 1914 has been the Federal Bureau of Narcotics (since 1968 the Bureau of Narcotics and Dangerous Drugs [BNDD]), the organization created to implement the original and subsequent drug control laws. The Bureau from its inception has tried to develop some accounting of narcotic use, and since 1953 has maintained a File of Active Addicts, on which it issues an annual summary. The File is a record of addicts known to local, State, and Federal authorities. Most of the reports included in the File come from local police departments. The comprehensiveness of information in the File is limited to the extent that addicts do not come in contact with, or are at least not recognized by local police, and that police reporting of addicts is uneven.

A Bureau report on *Traffic in Opium and Other Dangerous Drugs* listed 62,045 active narcotic addicts in the United States as of December 31, 1967. Of these, 30,543 lived in New York City and 1,804 lived in the rest of New York State, giving the City 49.2 percent of the national total and the entire State 52.1 percent.

The statistics for 1969 are the most up-to-date that the Bureau can now supply. They indicate no significant change between 1967 and 1969 in New York City where over 90 percent of the State's addicts reside, but substantial (percentage) increases outside New York City.

Table 1

Active Narcotic Addicts in New York State and New York City, 1967-1969

Place	1967	1969	Amount Change	% Change
New York State	32,347	33,341	+994	+.3
New York City	30,543	30,119	-424	-1.3
Outside NYC	1,804	3,222	+1,418	+78.6

SOURCE: Federal Bureau of Narcotics and Dangerous Drugs

The New York City Narcotics Register

Government officials in New York recognized some time ago the need for better information than that developed by the Bureau of Narcotics. The State Legislature in 1952 mandated that physicians report "habitual users" of narcotic drugs to the State Department of Health.

In 1963, the New York City Health Code added the stipulation that habitual users be reported not only by medical sources, but also by correctional institutions, social agencies, or any other person who has given care to or has knowledge of a narcotic addict. New York City provided clerical staff to collect these reports, and a grant from the National Institutes of Mental Health in 1966 enabled a research and analysis unit to be added as a function of the Narcotics Register. The first and thus far the only formal estimate of addiction in New York City published by the Register (in conjunction with NACC) appeared in 1969, and covers the period from January 1, 1964 through December 31, 1967.

The New York City Narcotics Register, as of December 31, 1967, had records on 38,751 heroin users (who constituted 87 percent of their total known opiate users). From their data, they concluded that this number represented about 65 percent of the regular heroin users in the City, so their final estimates for the same date as that of the Bureau were *65,000* regular opiate users of which 58,500 were regular heroin users. Since both the Register and the File claim to record *known* addicts, the two figures should be aligned just by accepting the higher one.

Not until the NYC Narcotics Register tabulates and releases its data for 1968, 1969, and 1970 will it be possible to supply a meaningful update on the December 31, 1967 figure. (These Narcotics Register reports are scheduled for completion by March 1971.) The sketchy data that do exist can be cited to support either the conclusion that overall narcotic addiction has about stabilized or that it has increased; there is little to suggest it has decreased.

While they may only be used as indicators, data on narcotic users provided in the Annual Statistical Reports of the New York City Police Department may give some trends.

This would indicate a rise in both Narcotics arrests and users, but the percent of admitted users is declining. When compared with total arrests, the percent of admitted narcotics users is almost stable.

Even when some allowance is made for the multiple arrests of some users, 22,000 admitted users is a significant number. (See Exhibit XIV for further detail.) However, the almost constant percentage of admitted users to total arrests might seem to indicate a leveling off.

Youthful Drug Abuse

There is also substantial documentation of a long-term trend toward lowering the age of first experimentation with drugs and the onset of addiction. This trend is probably understandable in terms of two factors — the rise in the number of low-income youths, and the generally more rapid intellectual development (i.e., in terms of school curricula, at least) and consequent social awareness of today's children as compared with their parents. Special concern has recently developed, however, over an apparent rapid escalation in the trend toward earlier drug use. For example, if the data available from the BNDD are broken down, some aspects of the State situation, including that in NYC, appear less favorable than the overall totals suggest. The change over just a two-year period, from 1968 to 1969, in the number of active addicts under 21 years old is striking:

Another indicator is the number of teen-age heroin deaths reported in NYC.

This increasing number of deaths would seem to imply at least more experimentation with narcotics among younger people, although the number of new addicts may not be proportional to these rates

Narcotics Users Among Narcotics Arrests — NYC

	Total Narcotics Arrests	Admitted Users	% of Users
1967	17,580	9,413	53.5
1968	22,428	8,786	39.2
1969	35,178	11,784	33.5

Admitted Narcotics Users in Total Arrests — NYC

	Total Arrests	Admitted Users	% of Users
1967	163,324	16,779	10.3
1968	187,613	17,039	9.1
1969	228,175	21,786	9.5

of death, which may represent inexperience and not addiction.

The arrest figures for admitted youthful narcotics users have also risen sharply, as the following NYC Police data show:

Non-narcotic Drug Abuse

The New York State Legislature, following the lead provided in 1965 by the Congress of the United States, filed its own bill providing for the control of "depressant and stimulant drugs," which

Table 2

Active Narcotic Addicts Under 21 Years of Age, 1968-69

Place	1968	1969	Number Increase 1968-69	% Increase 1968-69
New York State	1,290	2,551	1,261	97.7
New York City	1,063	2,160	1,097	103.1
Outside NYC	227	391	164	72.2

SOURCE: Federal Bureau of Narcotics and Dangerous Drugs

Heroin Deaths NYC Age 15-19

1966 - 33
1967 - 79
1968 - 72
1969 -255*

*Includes 11 under 15 years.
SOURCE: Michael M. Baden, M.D., "Heroin Deaths in New York City During the 1960's"

Arrests — Youthful Narcotics Users
NYC

Year	Under 16	% of Increase	16-20	% of Increase	Total	% of Increase
1966	190	—	3,105	—	3,295	—
1967	293	54	3,270	5	3,563	8
1968	348	19	4,581	40	4,929	38
1969	531	52.5	6,721	44	7,252	47

were defined to include drugs with "hallucinatory effect." These control provisions closely paralleled the existing Public Health statute regulating narcotic drugs, and they were added to the Public Health Law as Article 33-A by the signature of the Governor on May 28, 1965.

Despite the fact that this action by the Legislature in 1965 demonstrated a sensitivity to growing concern about misuse of stimulant, depressant, and hallucinatory drugs, the new programs created by the 1966 drug legislation were focused almost exclusively on *narcotic* drugs. There were several reasons for this concentration of effort. It was the *narcotic* drug habit that was known to be the most expensive to maintain, and therefore the greatest inducer of crime to support a drug habit. It was the narcotic drug traffic that was known to be largely under the control of organized crime. It was narcotic drug abuse that was then believed to be most extensive.

Since 1966, there has been a tremendous increase in parental and official anxiety over the abuse by younger people of non-narcotic drugs, especially the hallucinating agents (e.g., marihuana, LSD) and, to a lesser degree, the amphetamines. This recent uneasiness is reflected significantly in the fact that the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 passed by Congress in October provides for Community Mental Health Centers to extend their 1968 authority to treat "narcotic addicts" to the treatment of "other persons with drug abuse and drug dependence problems."

Available data on the extensiveness of the use of various non-narcotic drugs are sketchy and spotty at best. Whatever assertions might be made about recent and rapid increases in the use of these drugs can therefore only be impressionistic. One of the most careful collections of information on drug abuse is the annual publication of the Drug Sciences Division of the BNDD entitled "Illicit Use of Dangeerous Drugs in the United States: A Compilation of Studies, Surveys, and Polls," and the evidence inthis report does not refute the conclusion that as of now there are no conclusive data. It is true that arrest figures for non-narcotic drug offenses have increased considerably in many localities, but these figures by themselves do not enable one to distinguish between increased enforcement activity and increased drug use.

While it is still true that a person cannot be admitted to a NACC facility for treatment of a non-narcotic drug problem (even if he desires treatment), it would be incorrect to conclude that the State has made no response to the growing concern about non-narcotic drugs. The law creating NACC, for example, empowers this Commission to "provide public education. . .on the potentialities of prevention. . ." and the matter of preventive education on narcotic use cannot be isolated from preventive education on drug use in general.

There is a very serious impediment holding up larger scale, government-sponsored, education and treatment programs dealing with non-narcotic drug abuse. This barrier, which no longer exists as an inhibiting factor in the area of narcotic drugs, is the unavailability of scientifically established and generally acknowledged (i.e., publicly accepted) information on either the implications of different levels of use of various types of non-narcotic drugs by various types of people in various circumstances, or proper "treatment" for any type of abuse that might be confronted.

The limited "knowledge" that officials now have upon which to base their actions appears to justify the current focus of the New York State program on narcotic addicts and Narcotic Law violators. *Narcotic* use is the only drug abuse problem of known *epidemic* proportions, and the drug abuse problem known both to feed and breed crime extensively. Planning officials within the NACC are not aware of non-narcotic drug use problems, nor are they assuming that their name and mandate preclude their dealing with this area. For the time being, however, they have more than they can handle just in attempting to bring heroin under control.

II EVOLUTION OF NARCOTICS CONTROL PROGRAMS

Federal Background

The program to control the use of narcotics in this country dates from the Federal Harrison Narcotic Act in 1914. The premises underpinning the Harrison Act, and virtually all other laws enacted at the Federal and State level until 1960, were (1) that the taking of narcotics so endangers the health of the individual and the community that there is no acceptable justification for this indulgence except in strictly medical circumstances, and (2) that the application of severe penalties (made increasingly more severe over the years) could satisfactorily regulate the level of use.

There is indication that this enforcement approach has had some effect—the tenuous data available suggest that approximately 1 in 500 Americans were addicted in 1920 as compared to 1 in 1,500 today. But the increase in the number of illicit addicts from about 20,000 at the end of World War II to around 60,000 in the early 1950's generated a high level of public concern and the feeling that prevailing reliance on enforcement was not, in-and-of-itself, sufficient to cope with the problem. Some people had come to view addiction as a health deficiency to be cured rather than as a criminal condition to be confined.

The first governmental manifestation of this conception was the establishment of the Public Health Service Hospitals in Lexington, Kentucky, and Fort Worth, Texas, in 1935 and 1938, respectively, where treatment was provided for some federal prisoners addicted to narcotics, and to voluntary patients admitted on a space-available basis. Ultimately the social attitude that addiction is a disease had a direct impact on legislative leaders and produced entirely new types of programs, which still had to take into account the fact that addicts more often than not enjoyed their illness and perpetrated crimes to support their habits.

The Civil Commitment Program in California

Innovation first appeared in the Civil Addict Program established by the California legislature in 1961. It provides for "civil commitment" by a state court to a special facility for rehabilitative treatment through any of the following procedures: (1) petition to the court initiated by the addict, a relative, or some other responsible person, (2) adjournment of proceedings or suspension of the imposition of sentence for a person who has been convicted of any crime in a municipal court of justice and whom the judge believes to be an addict, or (3) suspension of proceedings against a person who has been convicted for a felony and whom the judge believes to be an addict, so the suspected addict can be referred to another Superior Court to determine the issue of his addiction. The revolutionary impact of these statutes was that addicts could be committed for treatment against their will, not only when they were indicted for a criminal offense, but also when they faced no criminal charge at all. This legislation was the model for the New York State and Federal approaches adopted in 1966.

The Metcalf-Volker Act in New York State

The New York State efforts in the control of narcotics began with a Special Narcotic Project conducted by the Division of Parole in 1956. It provided close, supportive parole supervision for approximately 600 parolee-addicts, and it has been regarded as valuable enough to be continued to the present.

The 1962 Legislature passed the Metcalf-Volker bill, which provided that as of January 1, 1963, arrested narcotic addicts who show a potential for rehabilitation and whose crimes are not serious may *elect* to receive specialized treatment at a state mental hospital rather than be committed to a penal institution. This session also affirmed a larger commitment by the State to treatment and aftercare support for voluntary patients.

The impact of these new State programs was disappointing. The New York State Commission of

Investigation in 1965 began a review of the existing State programs. Among their findings, published in a report in March 1966, were the following:

1. The vast majority of addicts who were afforded an opportunity to elect treatment (for one to three years of supervised care, only a small portion of which would be in-hospital) preferred to take their prison sentence (since the average jail sentence imposed for a group of chronic offenders studied by the Commission was less than four months).
2. The Commission's survey of the case histories of 1500 of the 1742 arrested addicts admitted to the program from January 1964 through June 1965 revealed that 80 percent were rearrested subsequent to hospitalization, most more than once.
3. From January 1964 through June 1965, 1207 persons absconded and disappeared from the program.
4. Of the relatively small number of addicts who completed the program, 52 percent were rearrested shortly thereafter.[1]

The conclusion of the Commission was that "no program of rehabilitation which relies principally on the *voluntary* application of the addict for treatment can be sufficiently broad and comprehensive to deal effectively with the total problem of addiction."

Creation of the Narcotic Addiction Control Commission

During the time the Commission's investigation was proceeding, and presumably with the benefit of its preliminary findings, Governor Rockefeller, in cooperation with legislative leaders and other public officials, was preparing a revamped narcotic control program for presentation to the Legislature. The following three "Recommendations" of the Commission turn out to be key innovations in the State program that was outlined by the Governor in his Message to the Legislature of February 23, 1966:

1. "The Metcalf-Volker Act be amended to provide that persons convicted of crimes, on proof of addiction, be committed to a compulsory program of rehabilitation and treatment."
2. The Narcotic Rehabilitation Centers and after-care programs providing close supervision be operated by the State, along with existing private programs that should be financially assisted by the State.
3. "A State agency be created with the capacity and broad powers to develop, conduct and coordinate an anti-addiction program which should include those concepts of treatment, rehabilitation, education, training, after-care, research and evaluation."[2]

The legislation that was enacted in April 1966 as Article 9 of the Mental Hygiene Law includes a lengthy "Declaration of Purpose." This "Declaration" provides some insight into the goals and expectations of the Legislature — that is, into legislative intent. Further elaborations of the short-term and long-term objectives of the State program as they existed at that time are indicated in the legislative debates. Since the Legislature's work on narcotics at this session was devoted primarily to the civil and criminal commitment programs, and since the Executive had perceived the problem in even broader terms, a truly comprehensive picture of the State program must take into account the Executive as well as the legislative declarations.

Emphasis on Treatment

The basic premise of the program, if one were to take it directly from the "Declaration of Purpose," would appear to be as follows:

> The narcotic addict needs help before he is compelled to resort to crime to support his habit. The narcotic addict who commits a crime needs help to break his addiction. A comprehensive program of treatment, rehabilitation and aftercare for narcotic addicts can fill these needs.[3]

The debate in the Legislature suggests that at the time this basic premise was not, in fact, well established. One proponent of the bill made the following statement, which appears rather revealing:

> We are talking about a problem for which we know no cure, about which no data tells us there is a cure and yet we must do something.

It was on this same point, in fact, that one of the few critics of the legislation based his argument. His response to the speech just cited was:

> You admit that there is no cure, yet the statement on intent says "Experience has demonstrated that narcotic addicts can be rehabilitated and returned to useful lives only through extended periods of treatment in a controlled environment followed by supervision in an aftercare program."...I would suggest that this philosophy pervades the bill but I think this is where we disagree.

The intent of the legislature appeared to have been two-fold: first, the expectation that the vast majority of addicts who were convicted of misdemeanors, and who had previously been getting off with four-month-average sentences and no parole, would now be supervised for three years and, second, the *hope* that whatever compulsory treatment and rehabilitation services criminally and civilly certified addicts received would equip them to turn (or return) to socially acceptable life styles.

This "comprehensive program of compulsory treatment of narcotic addicts" ultimately was supposed to eliminate the threat that addict crime poses to the "peace and safety of the inhabitants of the state," and to "protect society against the social contagion of narcotic addiction."

The threat of addict crime to the peace and safety of the inhabitants of the state and the threat of the social contagion of narcotic addiction are problems that can be attacked through efforts to rehabilitate the addict. Rehabilitation alone, however, cannot be presumed and never was presumed to be *the* solution to these problems.

Continued Enforcement Pressure

The fact that the emphasis in the 1966 legislation was on treatment did not change the overall picture that included enforcement as a critical component. Enforcement resources were necessary both to apprehend the Narcotic Law violator in the first place and to assure that potential and actual absconder and repeat violators would be subjected to continuing pressure. The integral relationship between narcotic control and enforcement is represented in the title of Governor Rockefeiler's Special Message to the Legislature in February 1966, "War on Crime and Narcotic Addiction: A Campaign for Human Renewal."

The Governor, in first outlining the proposed new program to the Legislature on January 5, drew an important distinction between the "addict" and the "narcotics pusher":

> We must remove narcotics pushers from the streets, the parks, and the schoolyards of our cities and suburbs.
>
> I shall propose stiffer, mandatory prison sentences for these men without conscience who wreck the lives of innocent youngsters for profit. . . .
>
> In addition, we must deal decisively with the addicts themselves — to break them of the dope habit and rehabilitate them for useful lives.[4]

This distinction cannot, in reality, always be maintained, for it is generally agreed that more than half the pushers are themselves addicted, and sell to others to maintain their own habit. It is nevertheless important to remember that the street pusher is, like the tip of an iceberg, only the evident part of a large and much more menacing supportive structure. The supplying of heroin is now a most lucrative activity, and organized criminal elements are known to be the key operatives and primary beneficiaries. Obviously the abuse of narcotic drugs which we now confront could be virtually eliminated even without rehabilitation programs if the supply of heroin could be shut off.

The Governor's Special Message and the report of the Commission of Investigation both clearly pointed up the necessity that enforcement provide all practicable support for the total environment within which rehabilitative programs must operate. While the Governor in his Message of January 5, 1966 envisioned New York State creating "legislation to act decisively in removing pushers from the streets and placing addicts in new and expanded State facilities for effective treatment, rehabilitation and after-care," he also recognized that "the Federal government has the moral and financial as well as the legal responsibility to protect the American people from the havoc caused by the illegal importation of these drugs." The Governor drew the conclusion that "we have every right under the circumstances to expect the Federal government to shoulder a major portion of the cost," and in his Message to the Legislature a year later, he urged these Honorable Bodies "to memoralize Congress to recognize the magnitude of the addiction problem and the Federal government's primary responsibility in this field with a much greater financial contribution."

As the federal government began to respond, the State's enforcement activities branched out. There have been three noteworthy developments. A special Narcotics Unit was created within the Bureau of Investigation of the State Police in 1968, and in 1970 State Police personnel joined with narcotic officers from the New York City Police and agents of the Federal Bureau of Narcotics and Dangerous Drugs in staffing an innovative type of enforcement organization, the New York Joint Task Force on Narcotics. There was also established during 1970 an Organized Crime Task Force within the Department of Law.

Preventive Education

There is, in addition to rehabilitative treatment

and enforcement, a third significant dimension in New York State's drug control planning. It is preventive education.

The 1966 Act charged NACC with the power to:

1. Provide public education on the nature and results of narcotic addiction and on the potentialities of prevention and rehabilitation in order to promote public understanding, interest and support.
2. Provide education and training in prevention, diagnosis, treatment, rehabilitation and control of narcotic addiction for medical students, physicians, nurses, social workers and others with responsibilities for narcotic addicts either alone or in conjunction with other agencies, public or private.[5]

The rationale supporting this aspect of the program again was formulated, among other places, in the "Recommendations" of the Commission of Investigation.

The Commission proposed the creation of a "comprehensive public education program" in light of its claim to have

> found that the education of the public to the perils of narcotic abuse *can be effective* in preventing addiction. This is especially true in the case of young people who are particularly vulnerable and susceptible to contagion. Education of parents, teachers, and others who have contact with children in methods of recognizing narcotics and symptoms of narcotic abuse is also of prime importance.[6] [Emphasis added.]

Since 1966, not only NACC, but the State Department of Education and the Departments of Mental Hygiene and Health have been appropriated funds to support drug education activities.

The New York State effort to control the use of narcotics is concentrated in three major areas: law enforcement, to support compulsory treatment and to reduce crime; an extensive treatment program to rehabilitate present addicts; a widespread education program to prevent new addiction. The major sections of this report which follow review the State program in each of these areas.

III NEW YORK ENFORCEMENT EFFORTS

The Federal and State legislation enacted between 1914 and 1960[7] with the objective of keeping narcotic drugs out of the hands of potential users had a dual thrust. The primary objective was to put suppliers out of business either by the threat or the reality of imprisoning them. This approach was supplemented with the application of pressures to discourage users; again there were the direct pressures of the risk of arrest and punishment, and there was also the indirect pressure of higher prices for scarcer supplies whenever distributors might be squeezed.

The Impact of Enforcement on Suppliers

Since virtually all non-synthetic narcotic drugs originate as opium poppies grown and refined outside the United States, it is clearly the Federal government that has the primary responsibility for controlling the illicit supply. The limited success achieved thus far and the difficulties inherent in this task are related in the *Task Force Report: Narcotics and Drug Abuse* completed in 1967 by the President's Commission on Law Enforcement and the Administration of Justice.[8]

The prospects for substantially reducing the supply of heroin available on the streets of America have not been good in the recent past, and do not appear much more promising for the foreseeable future. The main reason for this situation is that the higher levels of the heroin distribution system are operated by the men and money of organized crime cartels; United States authorities know of thirteen major heroin smuggling rings in the world.[9] Very few of these members of the upper levels of the distribution system have ever been convicted, because these members of crime syndicates are protected from exposure by fear of retribution, which can be swift and final, and a code of silence.

The people at the lower levels of the distribution system — the "street peddlers" and "retailers" — are not members of crime syndicates and are very vulnerable to arrest; yet the risks that confront these suppliers are obviously not deterring enough people from engaging in this activity to produce a significant limitation on the supply. Detailed data on drug arrests and dispositions are readily available only for New York City, but these figures can be taken as representative of drug control efforts in the State since such a large portion of this activity is concentrated in New York City. All felony offenses under New York State narcotic laws involve the act of selling drugs or the possession of larger amounts. The New York City police made 15,431 narcotic felony arrests during 1969.

What is especially revealing, however, is the disposition of these arrests. The court records show there were 13,374 felony arraignments in New York City in 1969, and that 7,090 reached disposition. Of this 7,090, over thirty-six percent (i.e., over 2,500) were dismissed outright.[10]

The Supreme Court records on the disposition of the rest of these cases have not been compiled, but representative figures on the disposition of felony cases are available from the records kept by the Narcotic Bureau of the New York City Police Department. They have followed up on 2,214 felony arrests made since July 1969 that have been disposed of in Supreme Court. The Bureau's findings are as follows:

Dismissals		938
Direct Sentences		789
15 years or more	— 3	
more than 1-10 years	— 169	
1 year or less	— 617	
Probation		106
Discharged		86
Committed to NACC		159
Miscellaneous Sentences		97
Convicted, sentence unknown		39
Total		2,214

These figures reveal that forty-six percent (1,024 of 2,214) of the cases ended in dismissal or discharge, and that only eight percent (172 of 2,214) resulted in direct sentences of more than one year. It is roughly only this eight percent, then, who were ultimately convicted and sentenced for felony offenses, since it can be presumed that many of the 617 sentences for one-year-or-less were instances of "copping a plea" to a misdemeanor.

The conclusion that is suggested by this data on dispositions is that the relatively small scale narcotic suppliers are not in practice being very severely punished.

The Impact of Enforcement on Narcotic Users

The supply of narcotics was not the primary target of the New York State program launched in 1966. The program's objective was rather to reduce the demand for illicit narcotics by treating and rehabilitating the people already afflicted with the disease of addiction, and preventing other people from contracting this sickness.

Enforcement agencies still were a crucial element in this new approach of 1966. Many addicts were expected to come into treatment facilities through the criminal courts, so obviously the police had to be able to apprehend these people. It was also assumed that many of the addicts who would volunteer for treatment or otherwise come to NACC through the civil courts would do so at least partly because police anti-narcotic activities were making their lives more difficult. Any increase in efficiency on the part of enforcement agencies could also help deter potential drug users from ever beginning.

In light of the documentation above of the disposition of arrested felons, one would not expect that strong pressures are actually exerted on drug users. On the other hand, it might require more of a threat to deter a pusher than a user, especially if the pusher happends also to be an addict, which often occurs:

> In cases handled by the Bureau of Narcotics . . . more than 40 percent of the defendants prosecuted are addicts. However, these addicts almost invariably are also peddlers, who are charged with sale rather than mere possession. It is fair to assume that the percentage of addicts among the defendants prosecuted by State and local drug enforcement agencies is even higher. The enforcement emphasis on the addict is due to his constant exposure to surveillance and arrest and his potential value as an informant.[11]

The New York City police have also made increasing numbers of arrests on the lesser charge of possession of smaller amounts of narcotics which is a misdemeanor. There were 20,560 arraignments in the Criminal Court of the City of New York in 1969. (For the figures from 1960-1969 see Exhibit XIII.)

The disposition of these misdemeanor arraignments for narcotic violations in New York City in 1969 is as follows:

Total misdemeanor arrests	—	20,560
Dispositions to date	—	15,876
Outright dismissals	—	10,301
Convictions	—	5,210
Direct Sentences	—	3,598
Sentences for 90 days or less	—	2,415
Commitments to NACC[12]	—	194

These figures show that about two-thirds (10,301 of 15,876) of all cases are dismissed outright, and that only 23 percent (3,598 of 15,876) of all dispositions result in direct sentences. Furthermore, 66 percent (2,415 of 3,598) of these direct sentences are for 90-or-less days.

The evidence is clear that the prosecution of narcotics violators today carries no more punch than was found by the State Commission of Investigation in 1965. And at that time this Commission concluded that addict criminals much preferred to take their chances with a regular sentence, which they expected would be light, than with some kind of compulsory treatment.[13]

The Failure of the Criminal Justice System

New York State law fixes stiff penalties for offenses involving the sale or possession of narcotic drugs. All felony convictions for sale go so far as to carry mandatory minimum sentences. Yet this report has shown that only a small percentage of those who are arrested and charged on felony grounds are ever convicted and sentenced as felons, and a majority of defendants charged with misdemeanors have their charges dismissed outright.

There is a generally accepted explanation for these phenomena. Obviously there are some instances where police arrest addicts on insufficient evidence. For the most part, however, it is the now well-recognized overcrowding of the criminal docket that operates to undermine the deterrent effect of the criminal laws penalizing drug offenders, and to reduce greatly the number of arrested addicts who are convicted. Overcrowding places an overwhelming workload upon the parties

involved — judges, district attorneys, defense counsels, and other court personnel — and produces great pressures to dispose of cases without going through the entire trial procedure.

The primary technique for disposing of cases is "plea bargaining" between prosecutors and defense counsel, sometimes with the active participation of the judge. By this process a defendant usually is enabled to "cop a plea" to a lesser offense than that charged. Authorities estimate, for example, that about 90 percent of all criminal cases in New York City are disposed of in this fashion.[14] The data presented on the disposition of felony and misdemeanor narcotic cases in New York City conform to this general pattern.

Overcrowding weakens the deterrent effect of the criminal laws not only because many defendants know that usually they will be able to "cop a plea" to a lesser offense, but also in other ways. It leads to serious trial delays, during which witnesses may die or disappear and memories may become indistinct. Overcrowded prisons and detention facilities produce great pressures upon judges to relieve the situation by dismissing cases, releasing defendants on bail or on their own recognizance, and imposing lighter sentences. Several law enforcement officials commented that drug pushers or dealers released on bail or on their own recognizance often take up selling again while awaiting trial, believing that the police probably will not bother them at that point.

Several conclusions with regard to enforcement practice are generally accepted today, even in light of the limited success of enforcement activities just documented. First, the enforcement of narcotic control laws has made it much more difficult for people who might still want to use narcotics from actually doing so. Second, despite this pressure, illicit suppliers have been willing and able to absorb the increased costs of operating and to remain in business, and users have been willing and able to afford the resultant higher prices for the drugs that feed their habits. Third, it is desirable to have a substantial commitment of manpower to maintain and increase whatever pressure practicable on both the suppliers on all levels of the illegal distribution system and the users and potential users.

New York State Police Narcotics Unit

New York State, accordingly, has increased its enforcement resources committed to limiting the distribution of narcotic drugs during the past few years. There is a consensus among enforcement officials at all levels of government that the State has an important responsibility in this area. The proper role for New York State agencies is viewed as an intermediate one between — and sometimes linking — Federal and local operations. State efforts are thought to be particularly necessary in those communities, mainly upstate, where the Federal presence is least felt and the local police are least equipped to deal with narcotic and other dangerous drug violators.

The State Police in 1968 established a Narcotics Unit in the Bureau of Criminal Investigation. The principal activities of the Narcotics Unit include conducting criminal investigations and undercover work, and making arrests and seizing drugs. In these operations, the State Police often work closely with officers of the Federal Bureau of Narcotics and Dangerous Drugs and with local police.

The State Police also have a special responsibility to enforce those provisions of both Articles 33 and 33-A of the Public Health Law. Thus the Narcotics Unit is concerned not only with control of the manufacturing, distributing, and dispensing of narcotic drugs (Art. 33), but also depressant and stimulant drugs (Art. 33-A). Suspected violations of these articles usually are referred to the State Police for investigation and possible arrest by the Bureau of Narcotic Control in the Department of Health, which administers the regulatory provisions of Articles 33 and 33-A. In November 1970 the Narcotics Unit consisted of approximately 85-90 men. Almost half of these were located in New York City: 29 were working closely with the BNDD in the U.S. Department of Justice doing mainly surveillance work directed at organized crime, and 13 were assigned to the special task force on narcotics composed of Federal, State, and local policemen. The remainder of the unit was distributed throughout the State, with two or three narcotics men assigned to each of the regular trooper units.

In the New York City area the main enforcement effort is directed toward the heroin and "hard drug" traffic. In areas of the State outside of the larger cities the heroin problem assertedly is less critical; therefore the main effort is directed toward the "soft drug" traffic — marihuana, barbiturates, and amphetamines. In these areas the Narcotics Unit devotes the most man-hours to the marihuana traffic, which is often concentrated at colleges and schools.

Drug arrests and seizures by all State Police, regular troopers as well as narcotics officers, show 2,081 arrests and $41 million in drugs seized in

1968, and 3,594 arrests and $47 million worth of drugs seized in 1969. In the year prior to the creation of the Narcotic Unit, 1967, only 858 drug arrests were made.

New York Joint Task Force on Narcotics

One of the most interesting recent developments in law enforcement is the joint federal-state-local "task force" which is an attempt to formalize cooperation among the different levels of government. This concept has been applied especially to cope with criminal activities which cross jurisdictional boundaries, such as organized crime and the drug traffic. The Organized Crime Task Force just created in New York is an application of this concept at the State level.

The New York Joint Task Force on Narcotics, which began its operations in February 1970, is a pilot project applying the above concept to the drug traffic in the New York City area. The unit is composed of Federal, State, and New York City narcotics enforcement officers working together in the same operational groups. Except for the salaries of the participating State and city officers, the Task Force is funded entirely by the United States Government through the BNDD in the Department of Justice.

The Task Force was established to direct its primary effort against middle echelon dealers in the heroin distribution networks, i.e., those who sell from an ounce to as much as a kilo (2.2 lbs.) or more at a time. The middle echelon of dealers was believed to be a neglected target of the law enforcement efforts because the BNDD concentrated on the importers and large-scale distributors while the State and local efforts were focused on the small-scale street trade.

In late November 1970 the Task Force was composed of the following narcotics enforcement officers: 10 from BNDD, 11 from New York State Police Narcotics Unit, and 22 from Narcotics Bureau of New York City Police Department. It appears that these men were carefully selected and comprised a "crack" police unit. In addition to the State and local officers participating full time in the Task Force, both the State Police and the New York City Police maintained a liaison man between their forces and the Task Force. A considerable expansion of the unit was anticipated within the near future to 170 investigators.

The leaders of the Task Force have consciously adopted a so-called "systems" approach to drug arrests rather than the "numbers" approach which perhaps characterizes some narcotics enforcement units. Briefly, a systems approach is an attempt to get away from the numbers game of arresting as many possessors and sellers as possible without regard to their status in the drug traffic, and to concentrate instead on selective enforcement by arresting those who play a more significant role in the distribution network. But various pressures — public, political, administrative, or other — seem to cause some units to place undue emphasis on the sheer number of drug arrests. It remains to be seen whether the Task Force will be able to resist the kinds of pressures which produce such an emphasis.

One of the advantages of the Joint Task Force's operation is the flexibility it has in choosing the forum in which to prosecute the cases it makes. Criminal charges based on the unlawful possession and sale of narcotics and other dangerous drugs generally constitute both a State offense and a Federal offense, thus offering enforcement authorities a choice of where to prosecute the case. Normally, a case is prosecuted in the jurisdiction in which the case is made; that is to say, if the investigation and arrest are made by State or local officers, the case normally is prosecuted in State courts and likewise with a Federal case. The heads of the Task Force stated that they prosecute both ways, the choice depending upon a variety of factors.

Among the factors which deter[illegible]ice of a forum are the following:

(1) *Criminal caseload in the cou[illegible]* of the Task Force stated that [illegible]e taken to the Federal court [illegible]s criminal calendar is less clog[illegible] cases can therefore be pro[illegible]e promptly and justice adm[illegible]e swiftly.

(2) *Differences between Federa[illegible]* Among the differences betwe[illegible] State law cited by law enfor[illegible] as possibly affecting the cho[illegible] are the following:

(a) *State conspiracy statute[illegible]* the Federal conspiracy statut[illegible] law requires proof of an [illegible] by one of the conspirator[illegible] of the conspiracy in ord[illegible] a person of conspiracy. P[illegible] 105.20. Consequently, a [illegible] lacking good proof of su[illegible] is likely to be prosecuted [illegible] court. Several law enforc[illegible]s urged that the State [illegible]

be amended to resemble the Federal statute.

(b) *Differences in penalties.* A number of differences in penalties exist between the Federal and State laws, which may affect the choice of a forum. It should be borne in mind that a new Federal penalty structure becomes effective on May 1, 1971 under the recently-enacted comprehensive drug legislation. Public Law 91-513, 84 Stat. 1236. Unlike Federal law, State penalties depend upon the quantity of the drug possessed or sold. One present difference cited by enforcement officials as a possible reason for choosing a State prosecution is the new mandatory maximum life sentence imposed for heroin, morphine, cocaine, or opium. Penal Law, Sections 220.23, 220.44. The new Federal law, however, provides for imposition of a life sentence upon professional criminals engaged in the dangerous drug trade in a major way for profit. Sec. 408. The new law also provides for stiff sentences against persons defined as "dangerous special drug offenders." Sec. 409.

(c) *Differences in proof requirements.* Illustrative of proof differences is the current treatment of marihuana offenses. Since the Leary case, *U.S. v. Leary*, 395 U.S. 6, 89 S.Ct. 1532, 23 L. Ed.2nd 57 (1969), was decided in May 1969, Federal prosecutors have had to prove importation of marihuana under the Marihuana Tax Act of 1937 without being able to rely on a presumption of importation based on mere possession. The United States Supreme Court in the *Leary* case held that it was unconstitutional to presume importation from the fact of possession. Consequently, many marihuana cases have been prosecuted in State courts where proof of importation is not required. The new Federal law, however, dispenses with the requirement that importation be proved. Sections 401 et. seq.

Organized Crime Task Force

In discussing State law enforcement agencies concerned with enforcing the State drug laws, mention should be made of the Organized Crime Task Force established within the Department of Law by Ch. 1003 of the Laws of 1970. Executive Law, Sec. 70-a. That law provides for the joint appointment by the Governor and the Attorney General of a Statewide Prosecutor with the rank of Deputy Attorney General, who will be in charge of the statewide Organized Crime Task Force.

The Task Force is empowered to investigate and prosecute multi-county organized crime activities including, among others, trafficking in dangerous drugs. The Task Force has the duty and power to cooperate with and assist district attorneys and other local law enforcement officials in their efforts against organized crime. The Task Force will include several experienced prosecutors, who will be aided by accountants and by investigators provided by the Division of State Police. The Deputy Attorney General in charge will obtain assistance from various other named State agencies. The act also details various powers to enable him to carry out his statewide activities.

At the present time the Statewide Prosecutor or Deputy Attorney General has been appointed and is in the process of building his staff.

Evaluation of New York State's Enforcement Efforts

It is difficult to evaluate the effectiveness of the performance of the special Narcotics Unit in the State Police. Drug arrests by *all* state troopers more than doubled during the unit's first year of existence, but these statistics are an unreliable gauge of police effectiveness for several reasons:

(1) Increased arrests may indicate simply that additional men were assigned to drug law enforcement.

(2) The State Police statistics of drug arrests and seizures do not indicate how many arrests and seizures were made by regular state troopers and how many by the Narcotics Unit.

(3) These statistics do not indicate the type or quality of arrest or seizure because they are not broken down according to the type of drug or offense.

(4) Increased arrests and amounts of drugs seized do not necessarily show a reduction in the supply, since the supply may have increased even more rapidly. It is difficult, if not impossible, to measure the available supply, although experienced observers at the street level probably can detect trends from price, purity, availability, and the like.

Reliable standards to measure the effectiveness

of drug law enforcement are yet to be perfected. For example, the BNDD, an experienced enforcement unit, has itself only recently begun to develop some comparatively refined measures of police performance.

The Joint Task Force has been in existence too short a time to evaluate the effectiveness of its performance and the validity of the "task force" concept as applied to narcotics law enforcement. Given the alleged neglect of the middle echelon dealers in the heroin distribution networks as a target of a law enforcement efforts, the creation of a special unit to aim at that target seems appropriate.

IV CERTIFICATION OF ADDICTS

"A comprehensive program of compulsory treatment," is a key provision of the 1966 legislation establishing NACC. This compulsion is provided in every case by a court order certifying the addict to the custody of NACC. Because court certification is the means by which the Commission obtains jurisdiction of a narcotic addict for treatment and rehabilitation purposes, this is a critical step in evaluating the treatment and rehabilitation program. The number and types of addicts assigned to the Commission for treatment — the input into the system — is determined through the certification process. If certification does not function according to the statutory mandate, then legislative intent may be thwarted. Addicts whom the legislature intended to be certified to the Commission may not be certified; persons who are not narcotic addicts as defined in the law may be certified erroneously; constitutional or other legal rights of alleged addicts or other parties may be violated.

Statutory Provisions Concerning Types of Certification

Three different methods of certifying a narcotic addict to the care and custody of NACC are set forth in Article 9 of the Mental Hygiene Law:

(1) *Civil certification of non-arrested addict*

Under Sec. 206 an addict himself or anyone believing him to be an addict may petition a supreme court justice or a county court judge for certification to the care and custody of NACC. A person is not eligible for such certification if he is participating in a narcotic addict rehabilitation program in facilities or services approved by NACC, or if he has a criminal action pending against him. Certification may be voluntary or involuntary depending upon whether the petition is brought by the addict himself or by another. Even if the petition is brought by another, the addict may or may not contest it. The statute sets forth an elaborate procedure for adjudicating the question of addiction, largely in order to protect the alleged addict's constitutional right to due process of law. Upon satisfactory proof of addiction and compliance with the other statutory requirements, the court is required to certify the addict to NACC for a period of unspecified duration which cannot last in any event more than 36 months.

(2) *Civil certification of arrested addict*

An addict charged with a felony, misdemeanor, or the offense of prostitution has the choice under Sec. 210 of applying for civil certification to the care and custody of NACC rather than submitting to the criminal charge, if he satisfies the following eligibility requirements: no previous felony conviction; not previously certified to NACC; criminal charge against him not punishable by death sentence or life imprisonment; consent of district attorney obtained if the criminal charge is a felony. An eligible criminal defendant applies for civil certification by filing a petition with the court in which the criminal action is pending. If the defendant is eligible for civil certification and his addiction is established, the court has discretion to certify him to NACC for a period of unspecified duration which cannot last in any event more than 36 months and to dismiss the criminal charge. If the application for civil certification is denied, the court proceeds with the criminal action including possible criminal certification to NACC following conviction as provided in (3) below.

(3) *Criminal certification of convicted addict*

Sec. 208 distinguishes between addicts convicted of a misdemeanor or the offense of prostitution and addicts convicted of a felony. The criminal court is *required*, in

sentencing the defendant, to certify him to the care and custody of NACC if he has pleaded guilty to or has been found guilty of a *misdemeanor* or the offense of *prostitution* and is also found to be a narcotic addict. This certification is for an indefinite period of time with a maximum of *36 months*. In sentencing a person who is found to be a narcotic addict and who has pleaded guilty to or has been found guilty of a *felony*, on the other hand, the court has *discretion* either to impose a sentence under the penal law or to certify the defendant to the care and custody of NACC for an indefinite period of not more than *60 months*. Certification to NACC whether for a misdemeanor, prostitution, or a felony, is deemed to be a judgment of conviction.

To complete the statutory picture concerning the types of certification to NACC, mention should be made of youthful offenders who are narcotic addicts. Minors between the ages of 16 and 19 who are charged with criminal offenses may be entitled to a special "youthful offender" treatment under the penal law.[15] The certification provisions do not deprive a youthful addict of the right to apply for and receive youthful offender treatment, but they do require that a minor adjudicated as a youthful offender who is found to be a narcotic addict be certified by the court to the care and custody of NACC for an indefinite period of time but not more than 36 months.

Sec. 210-a provides that notwithstanding the provisions of Secs. 207-210 — which deal with the certification of arrested or convicted addicts — no certification order is effective unless NACC consents to it. The language of this section was tightened by Ch. 126 of the Laws of 1970 to make clear that an arrested addict seeking civil certification remains subject to the criminal charge until NACC consents to the certification. One judge has charged publicly that the 1970 amendment was for the purpose of enabling NACC to turn away hard-core addicts in order to improve its record, but NACC officials insist that the amendment was simply for the purpose stated above. NACC officials state that the power to refuse consent to a certification has never been exercised, either individually or on a group basis, although civil certifications were closed in the summer and fall months of 1968 because of overcrowded facilities.

To summarize, there are several ways in which certifications are significantly differentiated. On the one hand, certifications can be distinguished according to whether they are authorized in a civil court or in a criminal court. Civil courts grant certifications only under Sec. 206, and all other certifications originate in criminal courts. On the other hand, the statute itself refers to commitments to NACC under Sec. 210 as well as Sec. 206 [See (1) and (2) above] as "civil certification"; "criminal certification" in the language of the statute refers to Sec. 208 [See (3) above] and Sec. 209.

Certifications are also often distinguished in terms of "voluntary" and "involuntary." Applying the voluntary-involuntary classification to the three types of certification stated above, the only truly voluntary certification is that resulting from a petition by the addict himself under Sec. 206, and even such a self-petition might be filed for motives other than a desire to be cured. A decision by an arrested addict under Sec. 210 to choose "civil certification" rather than remain subject to criminal punishment can hardly be said to be a free choice.

Constitutional Questions

Several constitutional objections were made to those certification provisions compelling the commitment of narcotic addicts, especially to the provisions compelling the civil commitment of addicts who have not been arrested for any crime. The New York Court of Appeals in *Narcotic Addiction Control Commission v. James*[16] held that the compulsory civil commitment of addicts is constitutional. The court relied upon the following dictum in the leading case of *Robinson v. California*:[19]

> The broad power of a State to regulate the narcotic drugs traffic within its borders is not here in issue.
>
> ****
>
> Such regulation, it can be assumed, could take a variety of valid forms. A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or possession of narcotics within its borders. In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a State might establish a program of compulsory treatment for those addicted to narcotics. Such a program of treatment might require periods of involuntary confinement. And penal sanctions might be imposed for failure to comply with established compulsory treatment procedures. 370 U.S. at pp. 664-5.

Although the United States Supreme Court has not specifically decided whether compulsory civil commitment is constitutional, presumably the above dictum in the *Robinson* case indicates what its position would be. The holding in the *Robinson* case was that a California statute making it a crime *to be an addict* was a violation of the prohibition against cruel and unusual punishment in the Eighth Amendment of the U. S. Constitution. The court distinguished between simply being an addict and the acts of using or possessing narcotics.

Although compulsory civil commitment was held constitutional in the *James* case, the New York Court in that case held that compulsory temporary detention of an alleged addict for three days on an *ex parte* order, as was permitted under the previous wording of Sec. 206, is a violation of the due process clause of the Fourteenth Amendment of the U. S. Constitution. This section was amended by Ch. 772, Laws of 1968, to require a court hearing on notice before an alleged addict can be detained for medical examination.

In another leading case construing the 1966 Act creating NACC, *People v. Fuller*[18], the New York Court of Appeals held that, since compulsory commitment to NACC is for the purposes of treatment and rehabilitation rather than criminal punishment or incarceration, the procedural safeguards applicable to a criminal trial do not apply to an addiction hearing. Hence, the court held that the following procedures did not violate the constitutional rights of the convicted addicts certified to NACC in that case: admission in evidence at addiction trial of statements made in the absence of counsel to the arresting police officer and to NACC's examining physician during the court-ordered medical examination; requiring proof of addiction by only a preponderance of the evidence (civil test) rather than beyond a reasonable doubt (criminal test).

The court left the door open, however, for proof that the NACC program does not actually treat or cure addicts, but is simply a disguised form of imprisonment.

> If compulsory commitment turns out in fact to be a veneer for an extended jail term and is not a fully developed, comprehensive and effective scheme, it will have lost its claim to be a project devoted solely to curative ends. It will then take on the characteristics of normal jail sentence, with a side order of special help. The moment that the program begins to serve the traditional purposes of criminal punishment, such as deterrence, preventive detention, or retribution, then the extended denial of liberty is simply no different from a prison sentence . . . .
>
> The record is barren, however, of any evidence that the detention compelled under the statute is in effect punitive punishment, that there is no chance of cure and that this program is a sham and a cover up for the putting away of addicts for a few more years. If it were, society would have to find some other means of dealing with the problem. The substantive aspect of the program is entitled to a presumption of constitutionality, at least and until a record is established otherwise. For these reasons, we conclude that the appellants' privilege against self incrimination and right to counsel were not violated when evidence was received of admissions of addiction made to examining physicians during the course of court ordered examinations. 24 N.Y.2d at 302-303.

The court also decided in the *Fuller* case, however, that a convicted addict certified under Sec. 208 is entitled to a jury trial on the question of addiction because a non-arrested addict certified under Sec. 206 is granted a jury trial by the statute. To deny the convicted addict a jury trial, the court held, would deny him equal protection of the law in violation of the Fourteenth Amendment of the U. S. Constitution. The statute was amended in 1969 to grant a jury trial to convicted addicts. A closely related question which has not yet been decided by either the New York Court of Appeals or the United States Supreme Court is whether, under the state and federal constitutions, a jury trial can be eliminated altogether for both non-arrested and convicted addicts. Elimination of a jury trial for both groups would avoid the equal protection objection, but would create a substantive due process constitutional question regarding deprivation of liberty.

Proof of Narcotic Addiction

The term "narcotic addict" is defined in Article 9 of the Mental Hygiene Law to mean:

> a person who is at the time of examination dependent upon opium, heroin, morphine or any derivative or synthetic drug of that group or who by reason of the repeated use of any such drug is in imminent danger of becoming dependent upon opium, heroin, morphine, or any derivative or synthetic drug of that group; provided, however, that no person shall be

deemed a narcotic addict solely by virtue of his taking of any of such drugs pursuant to a lawful prescription issued by a physician in the course of professional treatment for legitimate medical purposes. Sec. 201 (2).

The Court of Appeals has not conclusively interpreted this definition as yet, but it has given some indication of its views in *Narcotic Addiction Control Commission v. James* and *People v. Fuller*. In the *James* decision the court stated:

> Persons "dependent upon" narcotic drugs, as the language and purpose of the statute make clear, are persons who, through the repeated use of narcotic drugs, have developed so great a physical and/or emotional dependence that they are no longer able to control craving for narcotics. 22 N.Y. 2d at 551.

In the *Fuller* decision the court stated that:

> There are three characteristic mental and physical responses which physicians look for in determining whether a person is an addict: (1) physical dependence (as evidenced by the occurrence of withdrawal sickness upon the termination of the use of narcotics); (2) tolerance (as evidenced by the requirement of ever increasing doses of narcotics to achieve the same euphoric effect or "high"); (3) emotional dependence or habituation. 24 N.Y. 2d at 307.

But the court declared that these three criteria do not have the force of law and do not constitute the statutory definition. In other words, the court seemed unwilling to state categorically that one, two, or all three of these criteria must be present to prove addiction.

The court also mentioned the kinds of evidence considered:

> In determining whether a patient is an addict, the court considers evidence as to the person's history of drug use, ability to cope with personal problems by socially acceptable methods, general mental situation and, of course, medical symptomology... *Ibid.* at 308.

This last passage from the *Fuller* opinion indicates that the court wants stronger evidence of addiction than the findings made during a routine medical examination. Two recent decisions by intermediate appellate courts have held that evidence obtained during a cursory medical examination is not sufficient proof of addiction. The Appellate Division, Second Department, held in *People v. Medina*[19] that the "mere discovery of hypodermic needle scars on one's arms, coupled with an admission of prior addiction," is not sufficient proof of addiction *at the time of the medical examination* when the alleged addict has been in custody for eight months prior to the examination.

In the second case, *Negron v. Narcotic Addiction Control Commission*,[20] the court held on October 20, 1970 that the discovery by a doctor of fourteen fresh needle marks or "track marks" along the basilic veins, without a urinalysis or other medical evidence, did not exclude the possibility that the alleged addict was using amphetamines or "speed," as he claimed, rather than heroin.

The *Medina* and *Negron* decisions and other lower court cases point up a major complaint made by judges and lawyers who have participated in proceedings to determine addiction, namely, that the evidence of addiction, both medical and non-medical, often is insufficient. Medical evidence may be insufficient because of delayed or incomplete medical examinations, or poor medical witnesses. Non-medical evidence may be insufficient because of failure or inability to prepare such evidence.

Unquestionably the adequacy of the proof of addiction is a critical element in the certification of narcotic addicts. No person should be involuntarily committed to the NACC program for a potential three or five-year period without sufficient proof of addiction. At the present time, however, this problem is diminished somewhat because the overwhelming majority of persons currently being admitted by NACC are certified without contesting the question of addiction. Most new admissions are being certified either voluntarily on their own petitions under Secs. 206 (non-arrested) or 210 (arrested,) or "involuntarily" on the petitions of other persons, mostly parents and close relatives, under Sec. 206. Most alleged addicts do not contest the question of their addiction in these "involuntary" proceedings. Hence, relatively few full-blown trials on the question of addiction are being held at the present time.

The definition of "narcotic addict" quoted above includes not only a person who *is dependent* upon opium, heroin, morphine, or any derivative or synthetic drug of that group at the time of examination, but also a person "who by reason of the repeated use of any such drug *is in imminent danger of becoming dependent.*" Two constitutional objections to this language have been made. One, it sets up an unconstitutionally vague standard in violation of the due process clause of the Fourteenth Amendment of the U. S. Constitution.

Two, the State has no power to commit a person who is not yet dependent upon narcotic drugs. Several lower New York courts have considered the quoted language, but the Court of Appeals as yet has not specifically interpreted this language or ruled upon its constitutionality.

Some guidance might be obtained, however, from the California Supreme Court's decision in *People v. Victor.*[21] The court upheld the constitutionality of similar language in response to the two objections mentioned above, and fully discussed the meaning of the language. The court declared that narcotic addiction is not so much an event as a process, and went on to list eight indentifiable stages in this process. The court also discussed in detail what it called the "three characteristic mental and physical responses of the addiction process; i.e., emotional dependence, tolerance, and physical dependence," which were mentioned also in the passage from the *Fuller* decision quoted above. And finally the court explained who is includible in the category of persons "in imminent danger of addiction":

> It is not enough that the individual be "addiction-prone," or associate with addicts, or even have begun to experiment with drugs; he must have subjected himself to "repeated use of narcotics.". . . Nor is it enough that the individual have thus "repeatedly used" narcotics, or even be "accustomed or habituated" to their use, unless such repeated use or habituation has reached the point that he is in imminent danger — in the common-sense meaning of that phrase discussed above — of becoming emotionally or physically *dependent* on their use. 398 P.2d at 406 407.

Although the New York Court of Appeals has not specifically interpreted the "imminent danger" language as yet, the Appellate Division, Second Department, in *People v. Medina*, cited above, expressed the view that "expert testimony as to the subject person's mental condition must be introduced" to show that the person "is in imminent danger of becoming dependent" upon narcotic drugs. Whether the Court of Appeals also will insist upon such psychological or psychiatric testimony remains to be seen.

THE CERTIFICATION PROCESS IN PRACTICE

The following description of the certification process is based on a study conducted in the summer and fall of 1970, which concentrated upon the situation in New York City. Based on interviews and observations outside New York City, it seems safe to generalize that in most places the certification process is functioning more smoothly than in New York City.

The main sources of information were actual observation of certification proceedings and numerous discussions with judges, lawyers, and the other principals involved. Several judges and lawyers stated that different judges may vary widely in their conduct of certification proceedings. One of the problems, indeed, has been the lack of a uniform procedure. Because of the impossibility, therefore, of talking to every judge and of attending all certification proceedings, some exceptions may be unaccounted for.

Another possible problem is the frequent modification of court practices. This is particularly relevant with respect to the certification process in New York City at the present time because of the controversy currently surrounding the handling of narcotic cases. As a matter of fact, both the State Supreme Court and the Criminal Court of the City of New York recently instituted, or are in the process of instituting, administrative changes intended to improve the handling of narcotic certifications.

The description of the certification process is organized according to the nature of the court — i.e., civil or criminal — in which the proceeding take place. This means in New York City that proceedings for the civil certification of a non-arrested narcotic addict are conducted in the State Supreme Court, and that proceedings for the so-called "civil certification" of an arrested addict and for the criminal certification of a convicted addict are conducted either in the Criminal Court of the City of New York (misdemeanor or offense of prostitution) or the State Supreme Court (felony). Certification proceedings elsewhere in the state are conducted in those courts having comparable civil and criminal jurisdiction.

CERTIFICATION IN THE CIVIL COURTS

Sec. 206 of the Mental Hygiene Law sets forth in great detail the procedure for civil certification of a non-arrested narcotic addict. These detailed safeguards are spelled out to protect the constitutional rights of the alleged addicts and to guarantee due process of law since compulsory commitment of an addict is a serious deprivation of personal liberty which requires stringent legal safeguards.

Briefly, the procedural steps for civil certification are as follows: petition — by addict himself or

by another; custody or non-custody of alleged addict; medical examination; court hearing or jury trial.

An alleged addict is entitled to be informed of his legal rights, including his right to counsel. With few exceptions the alleged addicts are represented by court-appointed counsel. A representative from the State Attorney General's office represents the State and acts on the relation of the petitioner, as required by the statute.

Petition — By Addict Himself Or By Another

A certification proceeding is commenced by a petition either by the addict himself or by anyone believing him to be an addict. NACC has prepared blank petition forms and distributed them to its local educational centers and to clerks of court. Many of these petitions are filled out with the assistance of NACC personnel at their educational centers.

Who are the petitioners? NACC's statistics enable some conclusions to be drawn. During the first year of its operation, April 1, 1967 — March 31, 1968, NACC admitted 657 self-petitioners and 820 addicts on petitions brought by others.[22] The comparable figures for the second year of operation were 526 and 538 respectively, virtually equal.[23] Provisional figures for the third year ending March 31, 1970 show 747 self-petitioners admitted and almost twice as many addicts, 1,525 admitted on the petitions of others.

Statistics showing the identity of petitioners other than the addicts themselves help to dispel the fears of some critics that the category of *other* petitioners is too broad in the statute, i.e., "anyone who believes that a person is a narcotic addict." Sec. 206 (2) (a). During the first two years of NACC's operation, out of an approximate total of 1,350 addicts certified on the petition of another person, approximately 98% of the petitioners were either members of the immediate family or other relatives.[24] Parents accounted for approximately 80 percent of petitioners, and other relatives for approximately 10 percent. Petitioners other than family or relatives accounted for only 18 (2.4%) and 10 (1.5%) petitions respectively for the first two years. Provisional figures for the third year shown very similar figures. In other words, the overwhelming number of addicts being certified on the petition of another person are being certified on the petitions of their parents or other relatives close to them, rather than by outsiders who may wish to "put them away."

Custody Of An Alleged Addict

The court has broad power to detain an alleged addict under the following provision:

> The court may, in an appropriate case, direct the detention of an alleged addict in any detention facility designated by the commission pending proceedings pursuant to this section. Sec. 206(8).

Similarly the court has power, if an alleged addict fails to appear or would be unlikely to appear for a scheduled court appearance or medical examination, to issue a warrant directed to any peace officer or police officer commanding him to take the alleged addict into custody and deliver him at the appointed time and place.

In New York City the principal detention center for alleged addicts pending certification proceedings is the Edgecombe Rehabilitation Center in Harlem, where an average of 75 detainees per month were maintained during the first six months of fiscal 1970. Additional detention facilities will be available when a new center in downtown Brooklyn is completed, hopefully by the end of 1970. At the present time detainees from Brooklyn must be transported from Edgecombe to Brooklyn for court appearances. NACC does not have jurisdiction over an addict prior to certification for purposes of rehabilitation or treatment, but it can administer methadone to relieve withdrawal symptoms.

In a study of civil certifications prepared for the Presiding Justice of the Appellate Division, First Department, one of the criticisms made of the proceedings at Edgecombe was the lack of a sufficient number of warrant officers attached to the court to serve warrants upon alleged addicts who failed to show up for medical examinations or court hearings. Brooklyn was reported to be better staffed with such personnel.

Medical Examination

The court is required to order an alleged addict to appear at a facility designated by NACC for a medical examination if, after the petition has been presented to the court and the alleged addict has appeared before the court, the court is satisfied that there are reasonable grounds to believe that such person is a narcotic addict. Sec. 206(2)(e,i). The statute further provides that

> The commission shall designate facilities and establish procedures for the conduct of medical examinations pursuant to this section and shall provide for the use of accepted medical procedures, tests and treatment

which may include but are not limited to narcotic antagonists and thin layer chromotography. Sec 206(3).

The medical examination is a crucial stage of the proceedings since the medical report in most cases is the single most important item of evidence on the question of addiction.

The Edgecombe Rehabilitation Center is the principal medical examination facility designated by NACC in New York City for processing civil certifications. In addition to examining alleged addicts from New York City and surrounding areas the NACC doctors at Edgecombe also examine some alleged addicts from nearby areas such as Nassau County who have been arrested and are subject to certification in the criminal courts.

One of the examining doctors at Edgecombe described the usual medical examination as consisting of: urinalysis, statements by alleged addict himself, check for evidence of withdrawal symptoms, check for recent needle or track marks on arm, and response of alleged addict to administration of methadone (in constrast to addicts, non-addicts were said to react unfavorably to methadone).

In a study conducted for the Presiding Justice of the Appellate Division, First Department, however, the court records revealed that the medical reports often were inadequate — that many did not include a urinalysis or were incomplete in other repects, and that many were based solely on statements by the alleged addicts themselves. A number of well-informed persons stated that the statements of narcotic addicts regarding their own addiction are unreliable.

A number of lawyers and judges familiar with the certification process complained about the adequacy of medical testimony and personnel. Comparatively low salaries for both doctors and nurses are a principal handicap which NACC has attempted to offset by hiring part-time medical personnel.

A continuing problem concerning NACC doctors has been the time lost in testifying as expert witnesses at addiction hearings. One of the reasons for the establishment of special courtroom facilities at Edgecombe was the time lost by NACC doctors in travelling from Edgecombe to the regular Bronx and Manhattan courtrooms to testify, and then sometimes, after waiting all or most of the day to testify, having the case adjourned because the alleged addict failed to show up. The lawyers from the Attorney General's Office have attempted with some success to minimize this problem by requiring the doctor's presence only when all the necessary parties were fairly certain to be present. The centralization of certification proceedings at Edgecombe and the new Brooklyn downtown center should alleviate much of this problem. The doctor at Edgecombe stated that low witness fees are an additional hindrance to recruiting well qualified part-time doctors to perform medical examinations.

Special Court Facilities For Certification Proceedings

In New York City, cases from Bronx and New York (Manhattan) Counties are heard by the State Supreme Court in special courtroom facilities set up at the Edgecombe Rehabilitation Center. Cases from Queens, Kings, and Richmond Counties, on the other hand, are heard at present in the regular Supreme Court courtrooms in each of those counties. The Brooklyn Detention Center, like Edgecombe, will include special courtroom facilities for hearing certification cases from Kings, Queens, and Richmond Counties, and, when it is completed, all civil certifications in New York City will be centralized at the Edgecombe and Brooklyn centers. Cases from Nassau, Albany, Erie, and, presumably, other counties in the state are heard in regular Supreme Court or County Court facilities.

Although habeas corpus proceedings have been held for some time at state correctional and mental institutions, it is unusual to hold the commitment proceedings themselves at institutions such as Edgecombe as is now the case. Several reasons were given for this innovation: problem of transporting alleged addicts detained at Edgecombe for medical examinations to regular courtrooms in Manhattan and Bronx; frequent abscondence of alleged addicts during such transit, leaving judges, lawyers, medical witnesses, and others with lost time; and unruly scenes in regular courthouses resulting from large gatherings of alleged addicts, their relatives, and others. To relieve this situation, NACC, with the cooperation of the Appellate Division, First Department (Manhattan and Bronx), set up special courtroom facilities at Edgecombe. These facilities are cramped, but practical.

Court Proceedings

Certification proceedings are held four days a week at Edgecombe, two days to hear Bronx cases and two days to hear Manhattan cases. The caseload has a daily calendar running from 30 to 40 cases or more, which leaves little time for each case. Relatively few of the cases, however, are

actual trials of the question of addiction. The cases run the gamut of the several stages of the certification procedure already discussed — e.g., order to take medical examination, issuance of warrant to take alleged addict into custody, and order certifying addict to care and custody of NACC. Most of the alleged addicts do not contest the question of addiction even when the petition is brought by another person.

One of the very real problems observed at Edgecombe was the heavy caseload thrust upon the respective lawyers, both the Attorney General's representative and the two court-appointed counselors who represent all but a few of the alleged addicts. Closely connected was the lack of opportunity by the lawyers in most cases to prepare beforehand by examining the papers or interviewing the parties. This produces a rather hectic scene at the court proceedings as the lawyers quickly peruse the papers in each file and briefly interview their new clients. The pressure of time results in the summary disposition of many items on the calendar, and this sometimes appears to leave the alleged addicts and their families feeling rather bewildered as to what actually happened.

Certification proceedings observed in a Brooklyn courthouse annex before Judge Miles F. McDonald, Administrative Judge of the State Supreme Court, appeared to be essentially similar to those at Edgecombe.

A number of alleged addicts at both the Edgecombe and Brooklyn hearings had criminal charges pending against them. Since a person who has a criminal action pending against him is not eligible for civil certification under Sec. 206, the court adjourned the case until the court-appointed lawyer could obtain a dismissal of the criminal charge from the district attorney's office. This has become a fairly common arrangement, at least in the Bronx, Manhattan, and Brooklyn, particularly in the case of lesser criminal offenses.

Summary Evaluation Of Certification In Civil Courts

The certification process in the civil courts is working in general as the Legislature intended. Some difficulties exist, at least in New York City, with the main problems brought about by the volume of cases which must be handled in limited facilities by small numbers of personnel. Some easing may be expected when the new Brooklyn court facilities are opened, and through some administrative changes by the courts. Increasing volume, however, may require additional facilities and personnel. A study made for the Presiding Justice of the Appellate Division, First Department (Manhattan and Bronx) made the following criticisms and recommendations concerning the certification proceedings at Edgecombe. The court is now in the process of attempting administratively to institute some of these recommendations.

(1) *Medical examination.* All medical reports should include a urinalysis and a complete medical examination. The urinalysis should include a thin layer chromotography test, as indicated in Sec. 206(3), and such other tests as will reveal, if possible, the nature and amount of the drug used.

(2) *Full-time coordinator.* A clerk, law assistant, or other court official should devote full time to coordinating the multifarious activities connected with the certification proceedings. Given the heavy caseload and the complex procedure, central coordination is needed to make the system operate smoothly.

(3) *Prior availability of papers to court and lawyers.* The coordinating official should see to it that the court and all lawyers have the court papers at least one day in advance of the court hearings. As mentioned above, both the Attorney General's representative and the court-appointed counsel come into most cases "cold", having only the briefest time to acquaint themselves with their clients and the facts.

(4) *Adequate staff of warrant officers.*

In addition, the court is studying the feasibility of a panel of doctors to serve, as an adjunct to the court, as medical referees on the issue of addiction.

CERTIFICATION IN THE CRIMINAL COURTS

There is general agreement that in the criminal courts of New York City certification of narcotic addicts to NACC is not working as intended by the Legislature in Article 9 of the Mental Hygiene Law. The Legislature intended that *all* criminal defendants convicted of a misdemeanor or the offense of prostitution and found to be narcotic addicts *must be certified* to NACC by the criminal courts. Sec. 208(4) (a). This is not being done.

The Legislature also authorized criminal court judges, in their *discretion, to certify* criminal defendants who are convicted of a felony and who are found to be narcotic addicts. Sec. 208 (4) (b). Few felons are being certified to NACC.

The Legislature intended further to encourage certain arrested narcotic addicts to choose civil certification to NACC rather than a possible criminal sentence. Sec. 210. Relatively few arrested addicts are choosing civil certification to NACC.

Why is certification not working in the criminal courts of New York City? There are several reasons for this, but the main ones are: a general logjam in the entire criminal justice system, and an apparently negative attitude towards NACC's program by the addicts themselves, the Legal Aid Society which represents more than 90 percent of the defendants, and lawyers from the district attorneys' offices. The general breakdown in the criminal justice system is caused in large part by the huge volume of cases on the calendar, which in turn is caused in large part by the tremendous number of narcotic offenses and narcotic-related offenses. New York City judges and others estimate that narcotic offenses and narcotic-related offenses constitute 60 percent of the criminal caseload in New York City.

Other factors which contribute to the inadequacies of certification in the criminal courts are the insufficiency of the proof of addiction in many cases and the cumbersomeness of the certification process. These points will be developed more fully below, but briefly, the proof of addiction is insufficient in many cases because of delayed or poor medical examinations, inadequate testimony, medical and otherwise, and inadequate preparation of cases.

This study of certification in the criminal courts has centered in New York City, but discussion with officials in Nassau, Albany, Schenectady, and Erie Counties indicates that the certification process in the criminal courts outside New York City, while experiencing some of the same difficulties, is working better.

Attention should be called to the lack of good statistical data on narcotic-related cases in the criminal court system, particularly with respect to the actual dispositions of such cases. The available time and staff did not permit the kind of extended empirical search of court records which could document such dispositions. Consequently, this description of the handling of narcotic-related cases in the criminal courts is based mainly on numerous interviews with judges, lawyers, court officials, and city employees, and observation of court proceedings. Some helpful statistical information is contained in a report on drug addiction and the administration of justice prepared recently by the New York City Comptroller's Office. At least one potentially significant empirical study of purported narcotic-related cases in the New York City criminal courts is presently being prepared by NACC's Division of Research and should be completed in the near future. In that study, approximately 1,100 cases selected at random are being followed through the criminal court system. At present record keeping is difficult since the courts do not employ a modern data processing system.

Failure of Certification Process in Criminal Courts

The failure of the certification process in the criminal courts to certify the number of addicts intended by the Legislature can be shown in several ways.

Initially NACC estimated that 75 percent of the certifications would be criminal (Secs. 208, 209) rather than civil (Secs. 206, 210).[25] Presumably this estimate was based in large part on the statutory requirement that all addicts convicted of a misdemeanor or prostitution be certified to NACC. Even if one includes civil certifications under Sec. 210, the number of arrested or convicted addicts certified by the criminal courts has never reached 75 percent of the total number of certifications, and the percentage has declined over the life of the program. During the first three years of NACC's existence, arrested or convicted addicts comprised 58.7 percent, 54.4 percent, and 39.8 percent respectively of the total number of addicts certified.[26] The actual numbers of arrested or convicted addicts certified were 2,092, 1,271, and 1,501 respectively. Comparable figures for the first six months of NACC's fourth year, April through September, 1970, are 40.4 percent and 1,308 arrested or convicted addicts certified.

The most flagrant violation of legislative intent is the failure to certify *all* addicts convicted of a misdemeanor, as *required* by Sec. 208(4) (a). Some indication of this failure appears in the following figures compiled by the Criminal Court of the City of New York, which show for several recent years (a) the number of persons convicted in that court on narcotic misdemeanor charges, and (b) the number of such convicted misdemeanants certified to NACC.[27]

Year	Misdemeanor Convictions for Narcotic Offenses	Narcotic Misdemeanants Certified to NACC
1967	3,590	228
1968	3,619	185
1969	5,210	194
1970	9,139	412

Because of the terminology employed by the Criminal Court in compiling these statistics, the conviction totals in the first column include non-narcotic drug offenses as well as narcotic offenses, but this qualification is minimized by drug arrest statistics prepared by the New York City Police Department which show that arrests on narcotic offenses comprised about 60 percent of all drug arrests in 1967 and that this percentage steadily rose to about 80 percent by 1970.[28] Even allowing, therefore, for non-narcotic offenses and for non-addicted narcotic users in the first-column totals, it seems clear that the number of narcotic misdemeanants certified to NACC as shown in the second column fell far short of the statutory mandate.

Another indication of the lack of certification to NACC in the criminal courts is the number of arrested and convicted persons certified to NACC as a percentage of those who are examined for addiction by NACC physicians and found to be addicted. A report prepared by the Office of the Comptroller of the City of New York, ("Drug Addiction and the Administration of Justice"), shows a small percent of positive medical certifications certified to NACC from New York County. These percentages in New York County were 21 percent for 1968, six percent for 1969, and five percent for the first three months of 1970.

Dispositions of Cases

The following summary of actual dispositions of criminal cases involving narcotic addicts includes the prevalent dispositions, statutory and extra-statutory, which were apparent in the fall of 1970. As mentioned earlier, some dispositions may not be accounted for because the practices of individual judges in this area vary considerably, and it was impossible to interview every judge. This summary is divided into pre-trial dispositions and post-trial dispositions, that is, dispositions before and after the trial on the criminal charge. This classification leaves out those who plead guilty without a trial, but those defendants are included in post-trial dispositions here.

Pre-trial dispositions encompass the following:

(1) *Civil certification under Sec. 210.*
(2) *Civil certification under Sec. 206.*
(3) *Referral to private agency* for rehabilitation and treatment.
(4) *Dismissal of criminal charge* for lack of evidence or other reason.

Disposition (1) needs no further explanation than it has already received, and disposition (4) is self-explanatory. Dispositions (2) and (3), however, are not within the legislative intent, and, therefore are explained below.

Pre-Trial Dispositions — Civil Certification

Some arrested narcotic addicts in New York City and elsewhere are being civilly certified to NACC, not under Sec. 210 as contemplated in the statutory scheme, but under Sec. 206, either by a petition brought by the addict himself or by another person, usually a parent or another member of the immediate family. Civil certification under Sec. 206 is not available to an addict who has a criminal action pending against him, but this difficulty is surmounted by having the district attorney dismiss the criminal charge. The State Supreme Court in Brooklyn, for example, has even established administrative procedures for facilitating this arrangement. This procedure, of course, depends upon the cooperation of the district attorney, but generally the district attorneys seem willing to cooperate by dismissing the criminal charge if the offense is not a serious one and there are not other limiting circumstances.

One objection to this practice might be that it contravenes legislative intent by circumventing the civil certification procedures set forth in Sec. 210. The end result, however, is the same, i.e., civil certification to NACC, whether it is done through Sec. 206 or Sec. 210. But the eligibility requirements imposed by Sec. 210 could be bypassed if the criminal charge were dismissed without regard to such requirements.

The exact number of arrested addicts being civilly certified under Sec. 206 by this procedure is difficult to ascertain without empirically searching the court records. NACC's census figures do not show how many of its Sec. 206 certifications had pending criminal charges against them which were discharged.

Pre-Trial Dispositions — Referral to Private Agency

One of the common pre-trial dispositions of cases involving addicts in the Criminal Court of the City of New York (misdemeanors), particularly in Manhattan, has been to adjourn the case and refer the addict to a private agency for rehabilitation and treatment. Approximately every three months the addict, accompanied by a representative of the private agency, had to appear before the court for a progress report. If the addict was doing well in the program, the court would continue the adjournment of the criminal charge for another three months or so. If the addict, in the view of the court, successfully completed the private agency's

program over the course of a year or so, then the court would discharge the addict from the criminal charge. If the addict were not doing well, or if he had skipped the program entirely, as some of them did, often within a few days, then he would be returned to stand for the criminal charge.

This referral arrangement depends, of course, upon an addict being willing to rehabilitate himself and upon the cooperation of the judges, lawyers from the district attorney's office and the Legal Aid Society (which represents most addicts), and the private agencies. Why referral to a private agency rather than certification to NACC? The basic answer lies in the apparently negative attitude towards NACC held by some addict-defendants and the Legal Aid Society. Most addicts do not wish to be certified to NACC for one or more of the following reasons: potential length of commitment period (three years); belief that NACC custody is simply a substitute form of imprisonment; the lengthy waiting period in city jails before NACC facilities become available; NACC institution may be upstate, a long way from home and friends; and some Legal Aid Society lawyers advise their clients against the NACC program.

Several serious objections have been made to the private agency referral arrangement:

(1) Supervision of private treatment programs is not a proper function of Criminal Court judges.
(2) Pre-trial referral of addicts to private agencies violates legislative intent by circumventing certification to NACC and thereby undercutting the authority of NACC.
(3) The Legal Aid Society exceeds its proper authority as a legal advisor if its representatives counsel disregard for the obvious legislative intent of a duly enacted statute.

The court system itself has taken several steps recently to abandon the referral arrangement as it has previously existed. The Presiding Justice of the Appellate Division, First Department, has more than once instructed Criminal Court judges not to engage in the practice described. Near the end of August, 1970 the Criminal Court of the City of New York distributed a memorandum to all of its judges detailing a new plan for referral of addicts to private agencies with the concurrence of NACC. This plan contemplates a plea of guilty by the defendant and certification to NACC for the statutory period of three years, but immediate referral to a private agency accredited by NACC with the prior agreement of NACC. If the addict leaves or fails to cooperate with the private agency, then NACC has authority to assume jurisdiction over him.

The plan provides for an adjournment period while the defendant's attorney, the private agency, and NACC try to reach agreement. The memorandum also lists all of the private agencies accredited by NACC and sets forth criteria to guide the judges in passing on each application. It remains to be seen whether this memorandum will be implemented by the judges and the other parties. The addicts and representatives of the Legal Aid Society might still object to the NACC certification and NACC's potential three-year jurisdiction.

Post-trial Dispositions

(1) *Acquittal of criminal charge.* The statute does not expressly provide for a defendant who has been medically determined to be an addict but is then freed of the criminal charge by dismissal or acquittal. NACC has followed the policy, therefore, of allowing the defendant to go free without trying to have him civilly certified. Apparently nothing would prevent any person believing the defendant to be an addict, however, from filing a petition under Sec. 206 to have him civilly certified.
(2) *Sentence of convicted addict under penal law.*
(3) *Certification of convicted addict to NACC.*

None of these dispositions on its face seems to need explanation, but what is discussed below is why so many convicted addicts, contrary to the legislative intent, are sentenced under the penal law rather than certified to NACC, especially misdemeanants and prostitutes who are *required* by law to be certified.

Post-Trial Dispositions — Failure to Certify Convicted Addicts

The most extensive violation of the clear legislative intent is the failure of the criminal courts to certify convicted misdemeanants and prostitutes who are also narcotic addicts to NACC, as required. This failure is shown by the data previously referred to. The main reasons for this failure are the overwhelming caseload in the criminal courts, the negative attitude towards the NACC program often held by the parties involved, and the insufficient medical evidence of addiction caused by delayed or inadequate medical examinations and poor medical witnesses.

The combination of a huge criminal caseload and the negative attitude towards NACC produces a common sequence of events, particularly in

Manhattan and Bronx. When the defendant has pleaded guilty to or has been found guilty of a misdemeanor or the offense of prostitution and the medical report and other information indicate addiction, then the defendant is given the opportunity to admit, deny, or stand mute on the question of narcotic addiction and to request a jury trial if he wishes to contest the issue. Because most addicts do not want to go to NACC, they generally deny or stand mute on the question of addiction and request a jury trial, which means that the matter must be set over from the Criminal Court of the City of New York to the State Supreme Court, since the Criminal Court does not have the authority to conduct the required type of jury trial.

With its tremendous backlog of felony charges and other more serious cases, the district attorney's office often is unwilling and unable to expend the time and effort needed to prepare for and conduct a jury trial on the issue of addiction. Consequently the district attorney's office, despite a positive medical report and other evidence of addiction, concedes non-addiction, and the defendant is sentenced to a correctional institution rather than certified to NACC. An almost classical set of practical circumstances seemingly conspires to thwart the legislative intent!

Another reason given by representatives of district attorneys' offices for not wanting to go to trial on the issue of addiction is that many medical reports are inadequate and incomplete. A major contributing factor is the frequent delay between the time of arrest and the time of the examination. A urinalysis should be conducted within 48 hours from the time drugs are taken to detect their presence. In many cases, however, the arrested addicts are not examined that soon, especially if they are taken into custody at night or on the weekend. All male addicts who are arrested and confined in one of New York City's detention facilities are transported to the Riker's Island detention center to be examined at the NACC medical facility there. All female addicts who are arrested and detained are detained at the Women's House of Detention in Greenwich Village and examined there. Medical examinations for male and female addicts who are arrested but released on bail or on their own recognizance are scheduled at the Edgecomb Rehabilitation Center or Women's House of Detention respectively.

Both the Bronx and Manhattan District Attorney's offices readily agreed that, for the reasons stated above, they usually concede non-addiction when confronted with the necessity of a jury trial on the question of addiction. A representative of the Brooklyn District Attorney's office stated that his office did not follow that practice, but at least one judge stated the contrary. In any event, even if the Brooklyn office does concede non-addiction it seems less prevalent than in Manhattan and the Bronx because the proportion of criminal certifications is higher in Brooklyn. It is highly doubtful that the district attorney's office has the authority to concede non-addiction when there is reasonable cause to believe that the defendant is a narcotic addict. The statute appears to require either a court or jury trial on the issue of addiction when the defendant denies or stands mute on that issue.

Waiting Period for Admission to NACC Facilities

One of the major criticisms made against NACC and one of the main causes of disaffection for NACC on the part of addict-defendants is the period of time which must be spent in city jails even after certification waiting for admission to NACC facilities. New York City has been urging NACC at least since June, 1970 to remove more rapidly the prisoners in city jails who have already been certified to NACC and are simply awaiting admission to a NACC facility. The following figures compiled by the New York City Department of Corrections for the Mayor's Criminal Justice Coordinating Council show the number of addicts in city jails already certified to NACC and awaiting admission to NACC facilities for each week since June 10, 1970. As these figures reveal, the number of addicts awaiting admission to NACC remained mostly in the range of 225-250 until the middle of October when the situation rapidly worsened to hit a high point of 444 addicts awaiting admission at the end of November. New York City officials made a strong representation to NACC to remove these addicts from the city jails, and an arrangement was reached in which NACC agreed to reduce the number with a view to phasing them out entirely.

The longest individual waiting periods were reduced between July 3 and September 25. The number of addicts held for more than two months declined from 43 on July 3 to 34 on September 25. On July 3 the longest period of detention was seven months; on September 25 it was just over three months.

Table 3

Addicts in New York City Department of Correction facilities certified to NACC and waiting for admission.[29]

Date	Total no. of addicts waiting	No. admitted by NACC	Date	Total no. of addicts waiting	No. admitted by NACC
June 10	245	—	Sept. 4	230	54
17	255	—	11	230	22
25	267	—	18	237	39
July 3	240	31	25	244	48
10	223	42	Oct. 2	269	20
17	225	37	9	169	99
24	229	38	16	242	22
Aug. 7	214	48	23	275	50
14	188	52	30	296	49
21	216	16	Nov. 6	316	(Figures
28	229	32	13	375	not
			20	406	available)
			27	444	

SOURCE: Figures compiled by New York City Department of Corrections for the Mayor's Criminal Justice Coordinating Council.

For a complete picture of the number of addicts who have been certified to NACC and are awaiting admission to NACC facilities, one would have to add the number of addicts civilly certified under Sec. 206 who are awaiting admission, and the number of addicts certified by criminal courts and waiting in jails outside of New York City. For instance, on November 19, 22 addicts were in jail in Buffalo awaiting admission to NACC facilities. Few matters have done more to sour addicts on NACC than the wait in jail to get into its facilities.

SUMMARY AND FINDINGS

A narcotic addict is not subject to the control of NACC unless he is certified to NACC by a court. Certification, therefore, is the court procedure by which an addict is assigned to the care and custody of NACC. To determine whether the Legislature's 1966 program for the treatment and rehabilitation of addicts is being properly carried out, therefore, one must begin by looking at this first step in the program to see whether the persons intended by the Legislature, and only those, are being certified to NACC as fairly and efficiently as possible.

The Legislature set forth several ways in which an addict can be certified. A non-arrested addict can be *civilly certified* either (1) voluntarily on his own petition or (2) involuntarily on the petition of any person believing him to be an addict. (3) An addict arrested for a lesser criminal offense can be civilly certified on his own petition rather than stand for the criminal charge. An addict convicted of a criminal offense (4) *must be criminally certified* if convicted of a misdemeanor or prostitution, or (5) *may be* criminally certified if convicted of a felony.

The distinctive feature of the certification provisions in the 1966 legislation is the compulsory commitment of addicts for treatment. The compulsory civil commitment of non-arrested addicts in particular drew the objections of civil libertarians, but the New York Court of Appeals has upheld its constitutionality in *N.A.C.C. v. James.*

Are the certification procedures working according to the legislative intent? A mixed picture is presented. Civil certification is working reasonably well, but criminal certification is not working in New York City.

Civil certification procedures 1 and 2 above are working reasonably well, although a heavy caseload in Manhattan, Brooklyn, and the Bronx presents several serious problems. Among the problems related to the heavy volume of cases are the lack of prior availability of court papers to the court and lawyers, the brief period of time which the judges and lawyers can devote to each case, and the lack of overall coordination of the complex proceedings. Some easing may be expected through administrative changes by the courts and the opening of new court facilities in Brooklyn, but the increasing volume of cases may require additional facilities and personnel. A problem of inadequate medical evidence of addiction is similar to that experienced in criminal certification proceedings.

Relatively few arrested addicts have "volunteered" for NACC under the third civil certification procedure described above.

The most serious violation of legislative intent occurs in the criminal certification process. The certification of arrested and convicted addicts by the New York City criminal courts is not working as intended. The violation of legislative intent is particularly evident in the failure of the courts to certify addicts convicted of a misdemeanor or the offense of prostitution, as required by the fourth statutory procedure mentioned above.

The principal explanation for this lack of criminal certification is the general breakdown in the criminal courts of New York City caused primarily by the tremendous volume of cases and the consequent shortage of judges, lawyers, and other court personnel to handle the workload. This load factor, plus a generally negative attitude towards the NACC program by the addicts, their attorneys, and lawyers from the district attorneys' offices, combine to produce few certifications to NACC because the addicts contest the question of addiction and request a jury trial, as is their right, whereupon the district attorneys often concede non-addiction either because they do not have the personnel and resources to litigate the question of addiction or because the evidence of addiction is insufficient.

V TREATMENT AND REHABILITATION

The declared intent of the legislation as finally enacted, indicates the initial emphasis of the State's narcotic control program was placed on treatment and rehabilitation.

> The purpose. . .is to provide a comprehensive program of human renewal of narcotic addicts in rehabilitation centers and aftercare programs.[30]

The principal treatment for narcotic addiction has been a combination of detoxification, psychotherapy, and counselling. While drugs were slowly withdrawn from the addict, professional staff (primarily psychologists and psychiatrists) tried to come to grips with the complex behavioral factors believed to have caused the addiction. This traditional method of treatment, subject to a variety of modifications, is still prevalent in most drug treatment centers in the nation. Although statistics indicate the long-term success rate (patient not becoming readdicted to using narcotics) has been very low, no more effective treatment has been demonstrated.

From the beginning, NACC's approach to rehabilitation and treatment was based on the concept that no single treatment program would be adequate and that it would be necessary to provide several programs to meet the needs of addicts. Accordingly, a number of major approaches were chosen for the New York State program:

1. The principal NACC treatment approach is interdisciplinary and offers a mix of individual and group counselling and therapy, education and vocational training, and recreation.

NACC offers its commission operated program of rehabilitation and treatment in a dozen residential facilities followed by a supervised period of aftercare which, hopefully, prepares the addict for community living on a drug free basis.

2. NACC executed agreements with other appropriate state agencies to utilize their expertise in the development of special programs of treatment for certain groups of addicts.

The Department of Mental Hygiene employed a "psychiatric" approach. The "correctional" approach of the Department of Correction offers the same essential treatment mix in the setting of a correctional institution for addicts convicted of serious crimes. A contract with the Department of Social Services offers a program for "youthful" addicts.

Separate contracts with the City of New York through its Addiction Services Agency provide primarily for support of the "therapeutic community" concept in the Phoenix Houses which utilize the ex-addict in the treatment program.

3. In another approach, NACC funded (on a demonstration grant basis) a number of private voluntary agencies located mainly in the New York City metropolitan area.

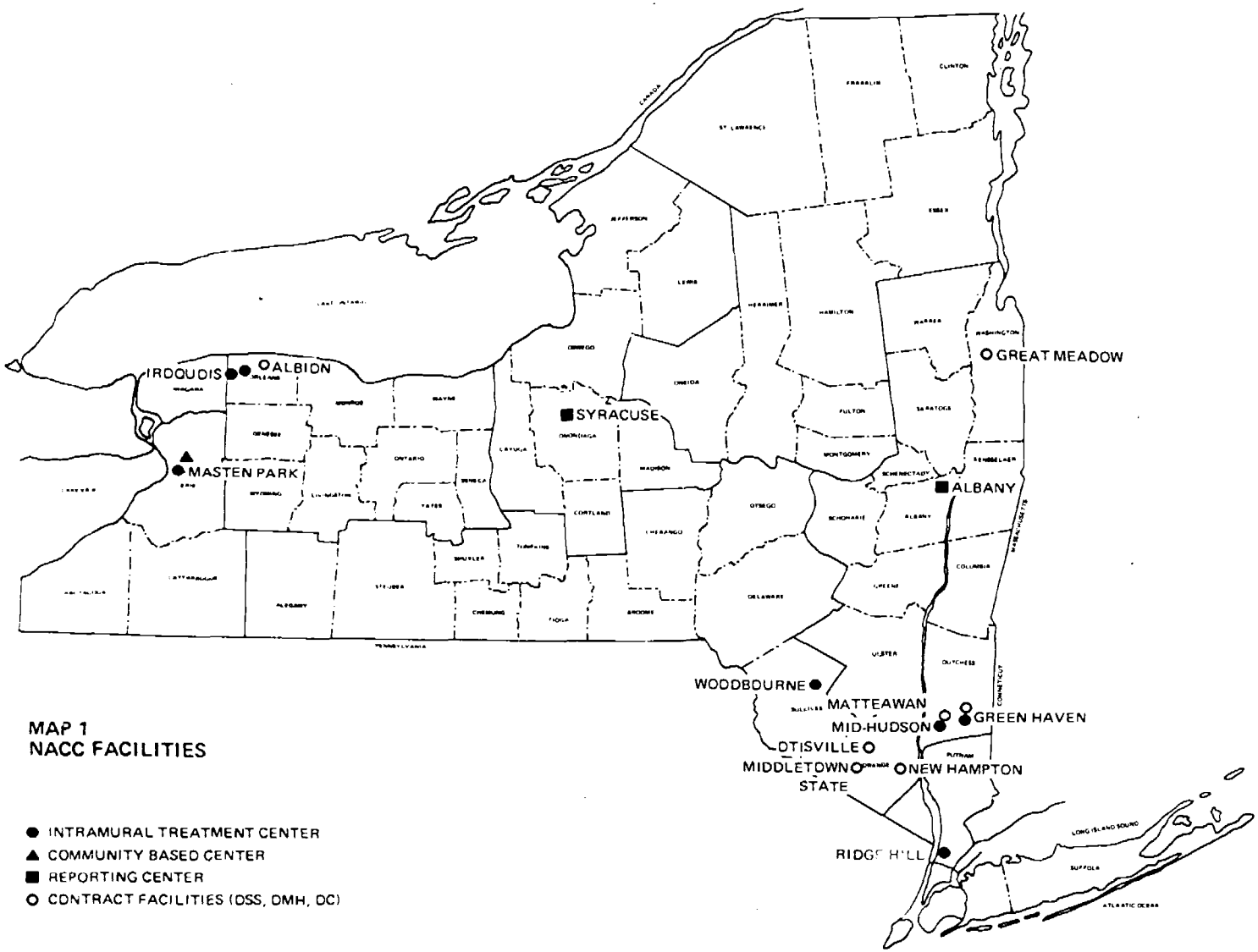
4. A "chemotherapeutic" approach is supplied primarily by methadone maintenance, which is used in both NACC operated and private programs.

This was the principal as ignment of NACC and it has devoted its primary effort to setting up a broad based program of treatment and rehabilitation.

NACC has developed and operates its own treatment centers (13 to date), which employ an interdisciplinary approach; it has provided funds for almost any reputable private treatment program (19 to date), and has contracted with the State Departments of Correction, Mental Hygiene, and Social Services, as well as 14 public agencies including New York City's programs. (See Maps 1 and 2.) Since October 1967, it has funded the only major new treatment concept – methadone maintenance.

In the first three years of its existence, NACC spent $98 million of its $103 million total operating expenditure for treatment and rehabilitation and $124 million in capital expenditures for facilities.

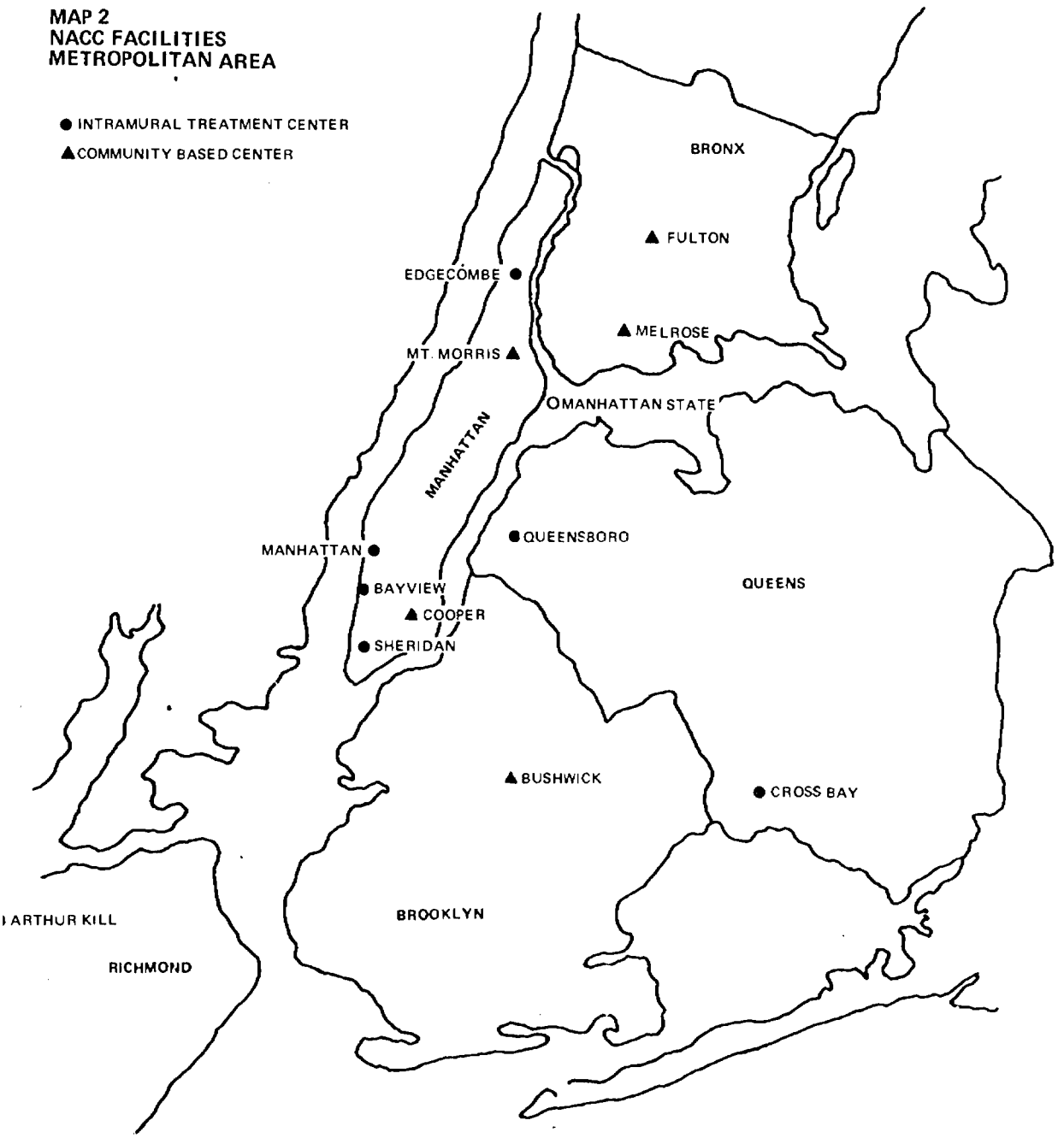
As of January 31, 1971, NACC has 10,764 certified addicts in treatment, aftercare, and con-



MAP 1
NACC FACILITIES

- ● INTRAMURAL TREATMENT CENTER
- ▲ COMMUNITY BASED CENTER
- ■ REPORTING CENTER
- ○ CONTRACT FACILITIES (DSS, DMH, DC)

MAP 2
NACC FACILITIES
METROPOLITAN AREA



tract programs. An additional 10,419 non-certified volunteers are receiving some form of treatment in NACC supported private agencies.

There is every indication that NACC understands its principal assignment and has tried to execute it.

Screening

Once a person has been certified to NACC, his first step usually consists of a screening interview. This interview is an attempt at a broad character evaluation to determine the most appropriate treatment modality. The interview also presents information on the operations of NACC to newly certified addicts. There appears to be much negative information about NACC programs in the courts, in the prisons, and on the streets.

Conducted by a member of NACC's screening unit, the interview usually lasts an hour, and takes place at rehabilitation centers for civil certificants and at jails for criminal certificants. The primary source of information is the certificant himself, with additional court, medical, historical records, and other documents when available. Often this background information, necessary for a meaningful character evaluation is unavailable, and a systematic means for assembling such documents is absent. Members of the screening unit resort to personal contacts to assemble as much information as possible about a new certificant. Since addicts have been described as highly manipulative individuals, such background information would clearly be useful to screening personnel in their evaluations.

The screening unit evaluation attempts to select a suitable treatment modality for a new certificant. Among the criteria used are: certificant needs, program availability and degree of security required. Personal traits are taken into consideration, and an initial decision is made of the most appropriate treatment modality (and one alternative). These modalities include: NACC rehabilitation centers, "Instant" aftercare, private accredited programs, methadone, and other programs in State agencies under contract with NACC.

The screening unit is composed of eight counselors (SG-18), two supervisors (SG-21) and the unit head (SG-23). An average of five people are screened per day per interviewer; this workload plus staff meetings and conferences, left little opportunity for the screening unit staff to visit NACC facilities and other agencies to develop firsthand knowledge of the treatment modalities. They rely on information from other staff members or representatives of private agencies. Certificants referred to private agencies have been assigned on the basis of formal requests made by the private agency.

Evaluation of Screening

While the screening interview should be considered an important first step in the treatment of addicts, many screening counselors have had relatively little experience. Virtually all members of the unit are on the beginning level as counselors (SG-18). They may have received on-the-job training with NACC or have passed the civil service examination for counselor, but they have little academic or formal training in the social or behavioral sciences. Thus, important decisions basic to successful treatment and rehabilitation—the heart of NACC's program—are being made by inexperienced counselors. Screening interviews

Subjects Under Treatment

	In Residence (or on leave)	In Aftercare	Total Certificants Under Care	Under Treatment by Accredited Agencies	Total
1968*	2,976	188	3,164	3,158	6,322
1969*	3,405	1,003	4,408	6,257	10,665
1970*	4,828	2,247	7,075	6,704	13,779
1971**	6,141	4,623	10,764	10,419	21,183

*March 31
**January 31

SOURCE: NACC Annual & Monthly Reports

might be more meaningful if the tests were administered, interviews conducted, and evaluation undertaken by a group of more experienced counselors with relevant backgrounds.

RESIDENT MOVEMENT AND CENSUS CONTROL SECTION

The Resident Movement and Census Control Section (RMCC) of NACC is a depository for records of persons certified to NACC. RMCC records the location of certificants and continually updates this information. RMCC also operates as an information center handling some 150 to 200 telephone calls and inquiries a day from parents, courts, attorneys and others.

When a certificant is assigned to a treatment facility, his file is sent to that facility and treatment records and evaluations are added. If a certificant is transferred, his file is sent to the new facility. When a certificant absconds, is lost to contact, is discharged from NACC or dies, the records are returned to the RMCC depository. Patient information is also forwarded to a central office in Albany, where many reports are processed and added to a computer file of NACC certificants.

The screening unit informs RMCC of preferred treatment assignments for new certificants. While RMCC tries to follow this recommendation, it has been suggested that the availability of bed space becomes the primary criterion by which assignments are made. RMCC is informed daily by treatment facilities of available beds. RMCC believes that the reports from facility directors are reasonably accurate. However, beds may remain empty because a facility director might do so for cause, or, for logistical reasons.

RMCC is also responsible for issuing warrants for certificants who have escaped from residential facilities or have absconded. The unit issues recalls and cancels warrants when certificants have been returned to custody.

Evaluation of RMCC

RMCC has as its major operational problem the unavailability of bed space. For example, on November 2, 1970, according to RMCC sources, there were at least 366 persons in jail awaiting assignment to facilities, some of whom had been waiting since August. It was further estimated that approximately 1,000 beds would be required to eliminate overcrowding in jails, NACC facilities, and the Edgecombe Reception Center. A number of these beds also would be used by absconders who are being returned to treatment facilities.

Another aspect of the record-keeping function which poses a potential problem area is personnel. RMCC is presently staffed largely by provisional appointees, many of whom live in the area. When RMCC moved from Manhattan to Long Island City, many experienced staff transferred to other NACC units or other State agencies. RMCC claimed that Civil Service has not been successful in recruiting people for these permanent positions, and the unit has come to rely primarily on a local employment office for personnel. The lack of experienced personnel has serious implications for record-keeping accuracy.

NACC INTRAMURAL FACILITIES

The NACC approach to compulsory treatment is spelled out in Article 9, Section 200 of the Mental Hygiene Law. This section states, in part, that:

> Experience has demonstrated that narcotic addicts can be rehabilitated and returned to useful lives only through extended periods of treatment in a controlled environment followed by supervision in an aftercare program. The purpose of this article is to provide a comprehensive program of human renewal of narcotic addicts in rehabilitation centers and aftercare programs. . . .

The NACC intramural program provides residential treatment for certificants in its facilities and in facilities operated by State agencies under contract with NACC. The principal objective of intramural treatment is to prepare certificants to return to their communities to live on a supervised drug-free basis.

NACC's treatment program is interdisciplinary in approach, and emphasizes individual and group therapy, counselling, education, vocational rehabilitation, recreation, and security.

Individual and Group Therapy and Counselling

Individual and group therapy and counselling is included in programming to improve the certificant's attitude toward himself and society and to enable him to cope with the underlying problems which led to the use of drugs. Primary emphasis is on group therapy sessions with counselors and other professional support. In some cases, group sessions are conducted by counselors; in other cases, Narcotic Correction Officers (NCOs) may participate in group sessions. Individual therapy is provided, but, for the most part, it only supple-

ments the basic group session. Some facilities emphasize group and individual counselling; other facilities, such as Iroquois, place less emphasis on formalized counselling but stress participation in work programs. Bayview Rehabilitation Center also provides family counselling where addicts participate with members of their families.

It must be recognized that the quality of these counselling sessions is an important element in the treatment process. Since counselling is a highly subjective input, counselors with differing methods may be equally effective with certain types of individuals. In the most positive cases, counselors may cause major changes in an addict's behavior and life style; in the most negative cases, counselors have little or no impact upon an addict's behavior and adjustment. In the great majority of cases, the quality of counselling services falls somewhere between these two extremes.

Education

The educational component of NACC's treatment program focuses on remedial courses in reading, writing, and arithmetic, and secondary education courses leading to a high school diploma. In cases where addicts have graduated from high school, college level courses may be offered by part-time instructors from local educational institutions.

Vocational Rehabilitation

NACC's vocational rehabilitation training program offers workshops and instruction in various industrial and business vocations and techniques including pre-vocational work habits. Special emphasis is placed on the development of pre-vocational work habits including punctuality, organization, cooperation with peers and supervisors, and care of tools. The most numerous vocational shops are woodworking, metal working, arts and crafts, electrical, office machinery and typing. Other vocational shops are devoted to auto mechanics, barbering, and tailoring. Facilities for female addicts offer courses in cosmetology, dressmaking, homemaking and office machinery.

While residents may sometimes be awarded certificates of achievement in vocational courses, more often they develop only a familiarity with the concepts of the trade and its tools. Hopefully, they also discover whether or not they wish to pursue it further. Additional training in local vocational training programs may lead to employment opportunities after they return to the community. Facility directors pointed out that the continuing emphasis on vocational training has been directed toward the cultivation of positive work experiences.

Recreation

NACC provides recreational programming at all rehabilitation centers. Recreational activity develops cooperative attitudes and team efforts besides providing entertainment, relaxation, and increasing physical fitness. The types of recreational activities at intramural facilities depend upon site limitations. For example, rehabilitation centers such as Sheridan or Bayview have minimal areas devoted to recreational activity while centers like Arthur Kill or Iroquois in open settings devote large areas to both indoor and outdoor recreation. All facilities have some areas for recreation. Active recreation consists of baseball, basketball and other "team" sports, weight lifting and similar activities, while passive recreation consists of movies, TV, card playing, libraries, music and lounge areas. While the exact 'mix' of these activities varies considerably, it is determined by the limitations of physical space and availability of equipment.

Security

Since intramural facilities provide treatment for people who have been criminally or civilly certified by the courts, security is an important element at NACC facilities. NACC rehabilitation centers run the gamut in security from the relatively open setting at Iroquois Rehabilitation Center, a former Job Corps camp, which does not have any physical constraining devices, to the highly secure environment and highly structured programs at Woodbourne Rehabilitation Center. Woodbourne, a former correctional institution for boys, is still staffed by correction officers who wear uniforms and carry night sticks. Many of the Woodbourne residents have been transferred from other NACC facilities because it was determined that they had behavior problems. It was felt they would benefit from the highly structured and secure setting at Woodbourne to which civil and criminal certificants are assigned.

All of the NACC rehabilitation centers range in security between these two. With the exception of Woodbourne, security is provided by NCOs, few of whom have correctional backgrounds, who wear civilian clothes to minimize the security aspect of their jobs. At some NACC intramural facilities, NCOs play more important roles in the treatment process by participating in group therapy sessions and providing counselling service. Some NCOs with

proper educational background have elected to become counselors after serving as NCOs.

NACC COMMUNITY BASED CENTERS

In accordance with Article 9 Section 200 of the Mental Hygiene Law, NACC's comprehensive program of compulsory treatment for narcotic addicts calls for ". . .extended periods of treatment in a controlled environment followed by supervision in an aftercare program." The major objective of the Community Based (Aftercare) Treatment program is to prepare addicts for independent community living, free of psychological and physical dependence on drugs.[31]

Community based centers (CBC) are geared to providing services for 800 certificants: 50 in residential programs, 150 in day-care programs, and 600 on field service. Certificants in residential and day-care programs receive services similar to those in intramural facilities, including education, vocational training and rehabilitation, counselling, and recreational activities. The largest number of certificants, those on field service, live in the community.

In addition to the five CBCs in New York City and the one in Buffalo, there are two Aftercare Reporting Centers in the upstate area (Albany, Syracuse). These centers do not have the full array of services found in community based centers, and provide only field service for addicts on aftercare status who reside in the upstate area.

In view of the rapid expansion of NACC's methadone treatment program, four of the CBCs (Fulton, Bushwick, Cooper in New York and Masten Park in Buffalo) have initiated outpatient departments for methadone maintenance programs. In those cases, the CBC model serving 800 persons has been modified for an additional 200 to 300 persons in methadone programs.

Transfer to Aftercare

After a certificant has been in treatment at a rehabilitation center for a period of time, and the staff has decided that satisfactory progress has been made, a recommendation for aftercare is made. The aftercare center nearest the certificant's home is notified of the proposed transfer and contact with the certificant is made by a Narcotics Aftercare Offier (NAO). He checks the certificant's background and treatment history, evaluates the certificant's family status through a visit to his home, assesses his employment opportunities, and makes a preliminary determination of the preferred aftercare services (residential, day care or field service). This preliminary decision is discussed with the certificant, and a request for transfer to aftercare is submitted to NACC. Upon NACC approval, the certificant is released from the treatment center and is told to report to his community based center. Aftercare supervision of the addict is essentially the same whether an addict has been in a NACC intramural program or in a program run by a contract agency.

Community Based Center Residential Program

A certificant is assigned to a CBC residential program if it is felt that his home life is not conducive to continued rehabilitation, or if the CBC staff feels he requires closer supervision than can be expected on either the daycare or field service program. In a residential program, the certificant is encouraged to participate in the activities available at the CBC. The primary emphasis of CBC programming is to help the certificant re-enter the community by seeking employment and attending school or training programs.

Variations of the CBC residential program are made available to certificants as required. One program, designated "instant aftercare", is a concept of treatment for addicts with marginal drug problems, some positive signs of social responsibility (academic achievement, good employment record, good family relationships,) and minor or no criminal history. Certificants are admitted to instant aftercare programs as a result of the determination that they do not require the more intensive residential treatment. However, "instant aftercare" certificants live in the facility and receive more intensive programming than residents in regular residential CBC programs. If "instant aftercare" does not help, certificants can be transferred to regular intramural treatment facilities. The "instant aftercare" program at CBCs is designed to run for three or four months.

The residential program at CBCs also helps those certificants on aftercare status who may have resumed using narcotics. When this occurs, some may be returned to rehabilitation centers while others, who do not require the greater security or supervision, may be admitted for detoxification at one of the CBCs. Detoxification may take from three to five days, but certificants also receive additional supportive services, including group and individual counselling, during the two-week period which they remain in the CBCs.

Community Based Center Day-Care Program

Certificants in CBC Day-Care programs live in

the community and participate in CBC activities during the day. Addicts in this program usually possess few skills, are not able to compete in the job market, and require a wide variety of supportive services. However, they may live at home since their family ties are good and serve as a positive factor in rehabilitation and readjustment. The day-care program is geared to an eight-hour day, although it appears difficult to keep them busy.

People in this program participate in shop programs to strengthen work habits and other pre-vocational attitudes, participate in group and individual counselling sessions as needed, attend classes and avail themselves of employment and placement counselling.

Community Based Center Field Service Program

The field service program, offered at the six CBCs and two upstate reporting centers, requires the least programming and supervision of all NACC operated programs. Under NACC's conceptual model of treatment and rehabilitation, the field service program is the last step in the rehabilitation and treatment process and the final point prior to the termination of certification.

Certificants on field service report initially to a NAO weekly. If they function well, they may be required to report only bi-weekly or monthly. Certificants are spot checked for narcotics use by urinalysis and may have to submit to a visual examination for needle marks. NAOs also function in a supportive role by providing guidance and advice for certificants, by referring them to appropriate staff members for specialized help. A certificant's visit is supposed to be more than just "checking-in" with the NAO. The addicts should receive counselling, job placement and other supportive services. However, some field service programs have become little more than a "checking-in process" because of the large number of cases NAOs are now supervising. NAOs may not visit the addict's family once a month as required, and this further dilutes the quality of supervision.

According to NACC statistics for October, 1970, only about 31 percent of the certificants in aftercare programs were employed full-time, with 24 percent working part-time or counted as students or housewives. Another 45 percent were classified as either not employed or not reported (See Exhibit XV).

If a person certified to NACC begins to abuse narcotics while on aftercare, he may be returned to residential treatment. NACC issues warrants for the arrest of people who abscond from facilities or who become lost-to-contact while on aftercare. Time spent on abscondence from the program is added to the certification period if the absconder is found and returned.

EVALUATION OF NACC TREATMENT PROGRAMS

In recognition of the fact "that not all narcotic addicts can or should be treated in exactly the same manner," there are several distinct treatment modalities used in intramural treatment programs.[32] These are conducted by NACC in its own facilities and in those under contract with the Departments of Correction, Mental Hygiene and Social Services. The principal objective of intramural treatment is to prepare certificants to return to their communities to live on a supervised drug-free basis.

It is difficult to consider the NACC treatment and rehabilitation program as composed of several separate and distinct treatment modalities. It would be more accurate to think of it as a broad continuum ranging from the highly structured and very secure setting of the NACC-Department of Correction interdisciplinary approach in operation at several correctional institutions, to the relatively open and work-oriented program at the Iroquois Rehabilitation Center at Medina. All other treatment programs conducted at intramural facilities are located along this continuum and vary in the 'mix' of counselling, vocational and educational training, recreational activities and in security.

The programming 'mix' varies from center to center with respect to the proportion of the above activities. At some intramural facilities residents are programmed for the whole day and have a minimum of free time; at others residents appeared to have little to do during the day. Some directors explained that residents "were not yet fully programmed" or that some of the planned activities "still weren't operational."

Many treatment facilities have been opened with components of the treatment program missing. It was recognized that NACC had been operating for little more than three years when this study was undertaken and that some treatment and aftercare facilities had only recently opened. Many shops and classrooms are still in planning, while others are inoperative because of a wide variety of technical problems (i.e., inadequate wiring, incompatible equipment and electrical outlets) while others stand idle for want of qualified instructors.

The NACC vocational instruction shops are based on plans which have been modified in light of space limitations and other considerations at each of the facilities. As of mid-September 1970, there were 150 to 160 planned shops in all NACC facilities of which approximately one-third were fully operational, one-third were marginally operational, and one-third were in the planning stage. It should be noted that some of the operational shops were incorporated in facilities that had been set up by other state agencies (i.e., Woodbourne vocational training areas originally designed and operated by the Department of Correction).

Several community based centers have been open for less than a year. Nearly all the structures converted to CBCs have undergone extensive renovation. Where renovation work is still going on, certificants and instructors try to make the best of the situation. In other cases, facilities have been open for many months before receiving shop equipment. For example, Fulton CBC has been open for six months and, when visited, it's shops were still not operational.

The vocational training component which is especially important for those certificants that require day-care services, is either absent or limited in many CBCs. In the few cases where shops are operational, there appears to be a gap in NACC's ability to provide continuing vocational training and services that smooth the transition from intramural facilities to CBCs.

A question can be raised concerning the goal of NACC's vocational training program. It is stated that vocational training places emphasis on pre-vocational skill development, but it appears that some shops have been equipped with new, elaborate and expensive equipment which could be used for much more than the development of positive attitudes and work habits. It is doubtful whether more than positive work attitudes can be developed in a limited day-care program. Additional vocational skills might be developed by the establishment of closer ties with existing vocational training services and programs when available in the community. There are indications that some of the vocational courses offered by NACC are providing training in skills for which there may be little market in the near future. Barbering, tailoring, and key punching are among the vocational courses offered where future employment opportunities may not be especially promising. In light of these findings, one can conclude that many certificants who have completed, or who are currently in treatment, have not had adequate opportunity to develop pre-vocational work attitudes, habits, or fundamental shop skills. The development of these are of critical importance in the long-term rehabilitation of certificants.

For many subjects, the transfer from intramural to aftercare programs is quite difficult. Addicts who have done reasonably well during the intramural phase report they were unable to handle the less structured aftercare situation, and thus reverted to drugs. This claim by addicts is consistent with the conclusion of medical researchers that the addict's return to community life often will be an even more trying experience than first getting off drugs, especially because the returning addict may well have lost both his friends in "straight" society and his ability to form new social relationships (other than in structured treatment circumstances).

NACC claims to make special efforts to help the addict through this transition stage. A NAO always meets with a certificant who is scheduled for release to aftercare while he is still in intramural residence. While the purpose of such meetings is to assure the addict of continued support, these promises are sometimes not fulfilled. The addict often expects continued close supervision, but the NAOs have 40 to 60 cases per officer instead of the 30 called for in the program design. The addict expects continuity between phases of treatment, but frequently finds that aftercare fails to build upon intramural treatment.

An addict's progress in rehabilitation may be set back not only by actual aftercare performance deficiencies, but also by the delays between the request and transfer to aftercare. These delays, which range up to two or three months, have the effect both of increasing the addict's insecurity and apprehension, and of keeping residential bed space tied up that would better serve new certificants.

Average Certification Period

Under the certification procedure, addicts are under NACC supervision for a period up to three years for civil certificants and criminal certificants sentenced for misdemeanors, and up to five years for criminal certificants charged with felonies.

In most cases, certificants spend part of their certification in an intramural treatment center followed by a period of supervision on aftercare. However, a certificant may be discharged from certification if NACC finds that he has remained free from drugs for an appropriate period of time.

It has been determined that the typical addict now spends between six and nine months in his initial exposure to treatment at an intramural

facility. A year ago, the typical addict was in an intramural facility for nine to fifteen months. In at least one center, the stay has been shortened to about three months.

Many NACC staff persons attribute the shorter initial treatment time, in part, to a change in treatment philosophy. NACC now prefers to have addicts undergo a short period of treatment and return to "the street" to observe how well they do. If certificants start using drugs, NACC can provide additional supportive services. Another suggested reason for the cut in treatment time is that NACC's program has improved and less time is now needed to achieve positive results.

While NACC's changes in the concept of treatment time may be acceptable to some observers, there is no evidence to indicate the treatment program has progressed since there is a lack of meaningful statistical data on program results. Since the treatment time dropped rather abruptly early in 1970, one must question how this improvement in programming could have occurred in such a relatively short period of time.

Increasing pressure for bed space at treatment centers was probably the principal reason for the decrease in treatment time. NACC facility directors now must provide information to headquarters when a certificant is in residence more than nine months. It appears that facility directors and staff must now justify more than nine months of intramural treatment for residents. It is suggested that, administratively, this requirement may minimize the number of residents who stay in intramural treatment for periods exceeding eight or nine months. Yet most facility directors stated that they were not sending people to aftercare unless they were ready.

While NACC recognizes that the initial screening process provides a broad evaluation used to select an appropriate treatment modality for new certificants, it was stated that additional screening occurs if residents are reassigned to other treatment centers. Little reassignment now takes place because of the shorter treatment period, except for addicts who require more secure environments or for those who apply and are accepted by Iroquois Rehabilitation Center.

Urinalysis

The spot checking of addicts' urine is the principal means for the detection of illicit drug use. There is considerable variation in the spot checking of urine. Several highly secure facilities do no urine testing. Others, however, collect urine several times a week and analyze a sample of those collected.

Urinalysis is provided by a California laboratory under contract to NACC although some samples are tested locally. Most facilities have been satisfied with the laboratory's work. However, criticism has been directed at the length of time required to receive reports from the laboratory. While this lag may not be important when residents are in intramural facilities, staff in aftercare centers and private agencies commented that it did not help in their supervision of addicts. This problem may clear up in the near future when the NACC laboratory in Brooklyn opens.

Abscondences from NACC Programs

All of the NACC operated facilities and contractual agreements have as their goal the treatment and rehabilitation of addicts so that they can be returned to the community where they can lead drug-free lives. The question that must be raised and answered is "how successful are these programs in achieving that goal?"

It seems clear that many of the persons certified to the NACC program have not adjusted to NACC's programming, nor have they displayed what might be even termed positive outlook or motivation to deal with their addiction. As of September 30, 1970, there were a total of 13,420 certifications to NACC. Of this total, 7,582 abscondences occurred between April 1, 1967 and September 30, 1970. However, this does not mean that 7,582 different individuals escaped from programming, since a single certificant may have absconded more than once. Nevertheless, 2,641 certificants were counted as absconders as of September 30th; this figure indicates that no less than 20 percent of all people who have been certified to NACC for treatment have escaped. It would seem reasonable to conclude that the large majority of these absconders have probably reverted to the use of opiates. Even for those certificants who have completed the NACC treatment program and have been certified as drug-free, there is still little information on how long a person remains off drugs. Some people probably do not revert to heroin use, others may only use heroin or other drugs from time to time, and some may become re-addicted to heroin. At the present time, only if a certificant is rearrested is there any indication as to whether he has again become "caught up in the drug culture."

In order to obtain improved information on the success of NACC's treatment programs, more

complete statisticai information on programming and information from follow-up studies should be gathered. Systematic follow-up studies, perhaps based on a reliable random sampling of persons who have been through NACC programming, are sorely needed. Furthermore, information is needed on program deficiencies so that NACC can provide more meaningful treatment for certificants and for groups of people that escape from NACC facilities and revert to drug use.

Besides these primary considerations for improved information and follow-up statistics, there is the concern for the *esprit de corps* of the NACC treatment staff. Because of the nature of NACC's program, professionals in treatment and rehabilitation have little indication how people who have been through their facilities' programs are doing. These staff people are patient-oriented and committed to the successful rehabilitation of their clients, and they want to know how well they are achieving that goal.

PROBLEMS OF PERSONNEL

Facility Directors

Facility directors enjoyed good relations with the senior NACC officials responsible for their programs. NACC officials have indicated an awareness of the need for closer supervision and are moving to improve contact.

NACC has issued broad guidelines for the operation of intramural facilities, but many directors have considerable flexibility "filling in" these guidelines and in the day-to-day operation of the centers. All facility directors and high echelon officials connected with intramural treatment felt that variations in treatment approach resulting from directors' innovations were a positive element of the program.

Narcotic Rehabilitation Counselors

The Narcotic Rehabilitation Counselors (NRCs) play prominent roles in the rehabilitation program. NRCs serve as the primary link between NACC and the residents in treatment. NRCs participate in group and individual counselling, provide information to residents, arrange for educational and vocational programming, keep records of the residents' progress, note changes in behavior patterns, meet with other members of staff to discuss the status of residents, and the residents' existing and potential problem areas.

Rehabilitation facilities in the metropolitan areas have recruiting problems. While they may benefit from a metropolitan location, they suffer from a salary structure which is not competitive because of higher living costs and competition from other programs. This higher cost of living is recognized by the New York State Department of Civil Service which has authorized a pay differential of $200 for virtually all state employees in the New York City metropolitan area. However, according to facility directors, this salary adjustment still does not provide an adequate differential.

It was the opinion of facility directors and head counselors that counselling staffs were overworked and were unable to spend adequate amounts of time on each resident. Some facilities are operating without a full complement of counselors. Since counselling services are deemed to be an important component in the treatment and rehabilitation of addicts, limited quantities of such services are undermining the rehabilitative aspects of the program.

Medical Personnel

There was general agreement among facility directors that professional psychiatric and psychological services were limited because of a shortage of qualified personnel. Psychiatrists were difficult to recruit since State salaries were not competitive with salaries in the private sector. However, some facility directors have had success in providing psychiatric and psychological services by filling positions with several part-time professionals.

Some centers have had difficulty in recruiting nurses and doctors. Several facilities have filled positions with part-time medical personnel. Most facility directors felt that the situation needed improvement. They attributed the problems in recruiting to three principal reasons: (1) general shortage in the professional fields; (2) non-competitive State salaries and (3) remoteness of facilities.

Institutional Teachers and Vocational Instructors

Institutional teachers' primary responsibility in the NACC program is to provide educational services for residents. Since many addicts have not attained more than grade school educations there is a focus on developing basic reading, writing and arithmetic skills. For residents with these basic skills, emphasis is placed on the achievement of high school equivalency.

It is reasonable to expect individual differences in teaching quality from teacher to teacher. It has been suggested that the low grade at which instructors are hired does little to promote teach-

ing excellence. Until early in November 1970, beginning institutional teachers with provisional certification were classified at salary grade 12 which has since been raised to salary grade 13. To indicate the relative inequity of this salary grade for a teacher with a minimum requirement of a baccalaureate degree, it should be noted that beginning Narcotic Correction Officers are also at salary grade 13. (NCOs under current civil service standards are not required to have more than a high school education.) Eventually, with permanent certification and two years of experience, institutional teachers may attain salary grade 17. Even with this recent salary adjustment, institutional teachers remain at a salary disadvantage when compared to teachers in the educational systems of municipalities in metropolitan areas. Consequently, there has been a high rate of turnover of institutional teachers which varies from facility to facility.

Many of these same problems also pertain to institutional vocational instructors.

NACC CONTRACTS WITH OTHER STATE AGENCIES

Article 9, Section 204 (2) charges NACC with "...the responsibility for interdepartmental cooperation and program development in drug addiction, promote, develop, establish, coordinate and conduct unified programs for education, prevention, diagnosis, treatment, aftercare, community, referral, rehabilitation and control in the field of narcotic addiction, in cooperation with such other Federal, State, local and private agencies as are necessary and...implement and administer such programs."

NACC's philosophy of treatment is based on the recognition that not all addicts should be treated in the same manner, and, therefore, provision has been made for joint, interdisciplinary treatment programs with the Department of Correction, the Department of Social Services, the Department of Mental Hygiene, and, under new legislation passed earlier this year, with the Division of Youth.

The interdisciplinary treatment programs for certified addicts operated under contractual agreements with these Departments, are designed specifically for the types of addicts assigned to those departments.

Department of Social Services

NACC has found that the number of youthful addicts (i.e., 17 years of age or less) has accounted for approximately five percent of total certifications. In view of the fact that youthful offenders usually require expanded education and counselling programs, NACC's contract with the Department of Social Services (DSS) focuses on the Department's program designed specifically for youthful addicts.

DSS' stated goal is to improve the social functioning of children when they return to the community. To achieve this result, programs have been developed which focus on education, training, and guidance activities which operate throughout the period of institutionalization. Part of the rehabilitative effort is centered on activities in the living units, where residents are encouraged to learn and practice socially acceptable modes of behavior within a family setting. Organized recreational activities focus on the development of "team" cooperation. Social services are provided both on a group and individual counselling basis. Psychiatric and psychological counselling is available for residents to aid in their adjustment to community living.

An education program with emphasis on more personalized attention through smaller classes is operated at DSS institutions. Academic subjects are taught to the majority of residents, and there is special emphasis upon the development of basic reading and writing skills. Vocational courses are also available.

The NACC-DSS agreement during fiscal year 1970-71 calls for the provision of treatment for an estimated one hundred civilly certified addicts under 17 years of age at a recommended cost to NACC through a budget apportionment of $951,200. Between May and November 17, 1970 the census of NACC certificants being treated in DSS facilities has ranged between seven and fifty-six persons.

Department of Correction

The purpose of the joint NACC-Department of Correction program is to afford society protection by maintaining continuing supervision of offenders committed to correctional institutions and by providing the offenders with appropriate care. The program is aimed at modifying the anti-social behavior and attitudes of offenders by humane correction treatment, and appropriate discipline and supervision.

The rehabilitative program operated by the Department of Correction includes educational and vocational training, individual and group counselling, recreation, and correctional industry work activities.

The NACC-Department of Correction interdisciplinary treatment program contract calls for the provision of bed space for some 800 criminally certified addicts during fiscal year 1970-71 at a total recommended cost to NACC through a budget apportionment of $4,085,000. Between May and mid-November of 1970, the number of certificants assigned by NACC to Department of Correction institutions has been between 872 and 979 persons.

An average of 600 narcotic certificants have been and are being supervised and treated in Great Meadow and Green Haven Correctional Institutions. In addition, the Department of Correction supplies custodial and security services for NACC operated facilities at Woodbourne, Green Haven, Matteawan, and Albion.

Department of Mental Hygiene (DMH)

The principal aim of the NACC — Department of Mental Hygiene program is to provide treatment for persons addicted to narcotic drugs. This program consists of supportive psychiatric counselling, educational and vocational training, recreational activity and social case work counselling. Since this joint program is referred to as the "psychiatric approach" by NACC, it is implicit that the programming emphasis centers on more intensive psychiatric counselling than in NACC operated facilities or under contracts with other state agencies.

During fiscal year 1970-71, the NACC contract with the DMH calls for the provision of bed space for some 240 civilly certified addicts at a total cost to NACC through a budget apportionment of $1,773,500. The Department of Mental Hygiene maintains bed space for NACC certificants at two facilities, Manhattan State Hospital with some 200 beds for male civil certificants, and Middletown State Hospital with some 45 treatment beds for female civil certificants.

Since May 1970 the number of NACC certificants assigned to DMH for treatment has ranged between 137 and 226.

Evaluation of Contract Agency Programs

NACC does not provide separate and distinct treatment modalities for certificants. Instead, NACC treatment and rehabilitation programs range along a continuum and there are few, if any, meaningful distinctions in the programming offered by NACC at its intramural treatment centers and at those facilities operated by other State agencies. While there are criteria for assignment to the programs of DSS (i.e., 17 years of age or less) and to the Department of Correction programs (NACC criminal certification), the components of treatment have the same kinds of variations as at NACC intramural facilities.

The psychiatric treatment approach claimed for the NACC—Department of Mental Hygiene interdisciplinary program did not appear to be incorporated in the treatment program at Manhattan State Hospital, the largest of the two NACC—DMH programs. In fact, Manhattan State's program now focuses on a team concept of psychologists and social workers, and the psychiatrists are being "phased out" of programming. There is little difference in the programs offered by DMH and those offered at NACC treatment centers.

Programs conducted jointly by NACC and other agencies may, in fact, dilute the effectiveness of treatment for certificants. For example, criminal certificants assigned to correctional institutions are integrated with the regular prison population in every way except that they are required to participate in group counselling sessions conducted by correction officers trained by the ex-addict staff of Reality House. At one correctional institution, a supervising officer stated that the ex-addicts had relatively little input once they had helped set up the program and had provided the correction officer counselors with some basic counselling insight and training.

Criticism of the NACC—DSS program appears warranted on the basis that there is no special program being offered to youthful certificants. The youngest certified addicts (i.e., 17 years of age) are assigned to DSS facilities for treatment. No distinctions are made between certificants and the rest of the population, and addicts are intermixed with other youthful offenders and receive the same programming.

The director of a DSS facility stated that no operating problems had occurred as a result of the joint relationship between DSS and NACC. He elaborated on this by stating that NACC was content to let DSS do it because it had experience with young people.

Since there are no major differences from treatment program to treatment program at NACC and other state agency institutions housing NACC certificants, there appears to be little or no justification for the interdisciplinary treatment programs funded by NACC. At a minimum, this joint administration appears to be causing problems among senior staff who are not certain of their lines of responsibility or of their channels of

communication. Furthermore, in some programs, staff operating under NACC program guidelines are looking to other departments for promotions and other benefits. This tends to split their allegiances.

Of more importance is the assessment that contractual programs are probably providing less intensive, rather than more intensive, programming designed to treat and rehabilitate addicts. Certificants might receive more in the way of treatment and rehabilitation services at NACC treatment centers.

PRIVATE AGENCIES — TREATMENT AND REHABILITATION PROGRAMS

A principal approach of NACC in the area of treatment and rehabilitation has been the funding of private agencies located primarily in the New York City metropolitan area. Many of these private agencies pre-date the founding of NACC. When NACC was created, several of the private agencies were receiving funds from the City of New York as well as from other sources. However, other agencies which have proposed additional approaches for the treatment of drug addiction also have been funded by NACC. Dr. Donald B. Louria, president of the New York State Council of Drug Addiction, stated, "Currently virtually every voluntary program with the capacity to help in the anti-addiction fight is funded through the Narcotic Addiction Control Commission, and any other responsible organization not so funded undoubtedly can be by proper application to the Commission."[39]

NACC, charged in part with accrediting and funding some privately operated narcotic addiction control programs in the State, took over the partial funding of some and the total funding of the majority of private agencies on "three to five year demonstration grants." Demonstration grants were selected because NACC was aware there was no single appropriate treatment modality in narcotics addiction, and the programs of the private agencies represented a variety of treatment approaches. NACC decided to place few restrictions on the agencies during the demonstration period so they could manifest the effectiveness of their treatment approaches and not accuse NACC of adversely affecting programs.

As a result of this decision, there has been little, if any, evaluation of private programs. NACC sources have stated it would be inappropriate to conduct such an evaluation until the end of the demonstration period. However, the demonstration models of most programs have been broken, since private agencies have expanded in size. In many cases, original project designs and treatment approaches have undergone change and a vigorous evaluative study may be extremely difficult to do.

An examination of the funding provided by NACC indicates the increase which took place. For example, four private agencies (Exodus House, Greenwich House, Lower Eastside Service Center and Quaker Committee) in the 1967-68 fiscal year were authorized a total of $939,100. In fiscal year 1970-71 these same agencies were authorized $1,656,000. In addition, the Beth Israel Medical Center methadone program was authorized $889,000 in fiscal year 1967-68 for the five-month period between October 1967 and March 1968; in fiscal year 1970-71, the program was authorized $6,000,000 as shown in Table 4.

These agencies were chosen as examples primarily because they have been among those funded for the longest period of time, yet if one looks at any of the other programs funded by NACC, it is apparent that the majority of these agencies have expanded also. This increase in funding, except for Beth Israel, appears to have taken place without rigorous evaluation by NACC and without submission of supporting evaluative data other than standard demographic characteristics.

Private Agency Programs

The programs of private agencies can be divided into three categories: residential, outpatient, and methadone maintenance. In addition to different program concepts, there are differences in program emphasis in each category.

The residential facilities operated by private agencies are generally smaller (25-75 residents) than those operated by NACC. Most operate on the concept that the addict, in order for treatment to be successful, should be removed from society and the addict world for a specified period of time, usually from nine months to two years, so that anti-social behavior or personality traits can be modified.

The residential settings are voluntary. Residents may leave the facility whenever they desire, whether or not they have completed the prescribed treatment program. In fact, many clients do leave before they are deemed ready for "graduation." Virtually all of the programs directors admitted their "split rate" varied between 30 and 80 percent.

Table 4

Authorized Funding for Selected Private Agencies

Agency	1967-68	1970-71	Percent Increase
Exodus House	$294,800	$395,000	34
Greenwich House	241,300	422,500	75
Lower Eastside Service Center	391,600	447,500	14
Quaker Committee	191,400	391,000	104
Sub-Total	939,100	1,656,000	76
Beth Israel Medical Center	889,000*	6,000,000	575
Total	$1,828,100	$7,656,000	319

*Period 10/1/67 - 3/31/68

SOURCE: NACC Budget Office, Contract Agency Funding (Unpublished)

Most people who leave a program do so in the early stage of involvement. Because of a lack of follow-up data, there is virtually no way to determine how many "splitees" either return to the original program or enter another for treatment. It is generally agreed, however, that a substantial number of people do, in fact, re-enter. The treatment approaches of the residential programs range from the intensive therapeutic communities (especially those based on the peer group confrontation methods of the Synanon model) to the more highly diversified interdisciplinary approaches incorporating both educational and vocational training, therapy and counselling.

In the therapeutic communities (i.e., Daytop Village, Odyssey House) a resident spends most of his time in group sessions. These may total eighteen hours a day. There is little time left for formal academic or vocational training. It is felt these skills may not be important until the ex-addict has come to grips with his fundamental personality problem.

At the other end of the spectrum, are programs that have vocational shops which emphasize the development of job skills in order to prepare a person to take a productive place in society. One program requires that residents learn two different skills for greater employment flexibility. Other programs emphasize educational goals such as high school equivalency. Another program does not permit graduation unless the resident has passed a high school equivalency examination.

The primary goal of these programs is to cultivate and reinforce acceptable social behavior and discourage anti-social attitudes. One or more of the following components, in various degrees, are utilized: group therapy, individual therapy, educational and vocational programs. There is minimal individual therapy in most private agencies' programs. The therapeutic community approach may be difficult for residents who do not relate well in groups or who cannot learn to do so. Most programs use incentive systems in which positive behavior changes, considered important to the maturation process of residents, are rewarded with privileges or increased responsibilities. These privileges include visits with family and friends, phone calls, escorted or unescorted passes, and better living accommodations.

Some programs require that a person begin at the bottom of a well defined job ladder working in the kitchen or cleaning house. The resident must

demonstrate honesty and an acceptable pattern of behavior before he moves up to a better job. A person breaking one of the important program rules may be punished by loss of status and may be required to repeat the whole treatment process. Some smaller programs, especially those housing 25 to 30 addicts, try to impart a feeling of family life and responsibility as compared to the more traditional institutional settings of larger facilities.

Some residential facilities are coupled with day-care centers which serve as clearing houses and induction units for the program. A person may be required to attend the day-care facility daily while remaining drug free, to demonstrate motivation and willingness to participate in the program before being allowed into the facility. In this way the houses avoid overcrowding, program dilution, and excessive waiting lists. People in the day-care program frequently are expected to come to the facility eight hours daily and participate in the various programs. When a vacancy occurs, a person who has demonstrated the proper "motivation" is then admitted.

Outpatient Programs

In addition to residential and associated day-care facilities, there are some programs funded by NACC that function strictly on an outpatient basis. In outpatient programs, clients report on a daily basis and return home each night.

Lower Eastside Service Center and Greenwich House reported that 295 and 424 addicts, respectively, were being treated as of the end of September 1970. This compares to an average of about 100 persons in treatment at each of eight residential facilities of six private agencies. NACC reported that its cost for operation of Lower Eastside Service Center was $140 per patient month and Greenwich House was $56 per patient month for the period April 1, 1968 to March 31, 1970. This compares to an average cost of $326 per patient month for the six residential programs during the same period.

It is important to note that philosophies guiding the residential and the outpatient programs are different. Directors of outpatient programs contend that residential facilities create an environment that bears little resemblance to the "real world," and while it may be well and good to treat an addict in a protected environment he may be unprepared to meet the challenges of normal living when released. This may be one reason so many return to drug use. Some directors believe outpatient programs are the only ones which provide realistic experiences as the addict faces the daily test of avoiding drug use when he returns home.

Program content at outpatient facilities varies as much as in residential programs. Common components are: group and individual therapy, educational and vocational classes, job placement and the like. Some programs have workshops while others rely on traditional social service agencies to provide the services which they do not or cannot provide.

The essential differences between residential and outpatient programs, aside from philosophy, are intensity and size. The outpatient programs accommodate more people per staff person than residential programs, but therapy is less intensive because of non-residency. While there are almost no reliable data, the estimated "split rate" for outpatient programs appears similar to that of residential programs.

Evaluation of Private Agencies

One fundamental difference between the programs run by NACC and those of private agencies is the voluntary nature of the latter. NACC, because of the certification process, has stringent controls over certificants. Addicts who elect to go to private agencies, on the other hand, often do so out of desire to "kick" their drug habit, even if only temporarily.

Private agencies, because of their voluntary nature, became appropriate only for those people, often referred to as "motivated" addicts, who have decided to do something about the problem of addiction. Some observers point out that addicts enter private agencies as a condition of their parole, when there is a "panic" in the streets and their source of supply is threatened, when they are trying to avoid certification to NACC, when they feel that their heroin dosage is approaching a dangerous level, or when their habit becomes too costly. When these outward pressures or conditions are removed, the addict often returns to drug use. These same observers maintain that the pleasures derived from injecting heroin are too great to be given up easily.

Legal requirements and the nature of the State program are such that NACC takes virtually all of the people certified to it for treatment. Private agencies, on the other hand, have the option of screening out people they consider undesirable and taking only those they want into their programs. This screening process may be more passive than active. Most agencies say they never turn away anyone who tries to enter the program, but the very nature of the program may be such that only

those who feel comfortable with the treatment will stay. The others will leave. This kind of freedom is not possible in NACC facilities.

The population served by NACC and private agencies differ in other aspects as well. The State is committed to treating only opiate addicts. Private agencies, on the other hand, are not so restricted but are free to deal with other forms of drug addiction including drug abuse problems that may be easier to deal with. A major problem hindering any meaningful attempt to analyze the operations of private agencies is the lack of hard data other than basic demographic statistics. Many programs have been operating for a number of years, but the service philosophy has taken precedence over the acquisition and analysis of pertinent evaluative data. However, this data must be collected and analyzed to determine the effectiveness of various treatment modalities.

As Charles Winick pointed out in a research paper prepared for the New York Association of Voluntary Agencies on Narcotic Addiction and Substance Abuse (now AVANT), "Each research director has been collecting data that appeared to flow naturally from the special historical background, clientele, and treatment philosophy of the agency. Because of the idiosyncratic development of the data collection enterprise and the varying salience of research at each agency, there has been no uniform collection of research statistics. The data collected are non-comparable."[34]

The agencies suggested they are now in the process of obtaining some of the necessary information. Unfortunately, they have not yet agreed on what pertinent data should be and NACC has not, to date, made evaluative information collection a condition of funding (or if they have, it clearly has not been enforced).

One result of this paucity of data is that many agency directors have made unchallengeable statements in public and to the media about their "fantastic" success rates. One director stated that his program had a "67.5 percent success rate." When questioned further, however, he admitted that he did not know how many people had graduated from his program nor had he or his staff done any follow-up studies to determine how graduates were doing.

There is a great need for follow-up studies to determine not only how well graduates of programs are doing but also how people are doing who have left the programs before graduation. It has been suggested that there are many who have completed some part of a program, who have not graduated, who may be leading drug-free lives.

Comparable statistical data from the private agencies is needed so their programs can be evaluated, and determinations made as to which programs are the most successful as a condition of future funding. Spot checks of the collection of data and evaluative techniques in order to ensure the validity of the statistics have not been made. Furthermore, follow-up interviews are essential but lacking.

Comparison of Program Costs

Another difference between private agencies and facilities operated by NACC is operating costs. NACC facilities, because of security aspects, employ security personnel around the clock. In general, when the staff of NACC residential facilities is taken into account, the ratio between staff and residents approaches 1:1. This ratio is lower for community based aftercare facilities.

Private agencies, on the other hand, do not have security personnel. Many therapeutic communities employ few professional staff relying instead on para-professional ex-addicts.

According to NACC statistics, the average cost per person per month for all NACC operated residential facilities for fiscal year 1969-70 was $770.72. (See Exhibit VIII) When the per person costs of contracts with other agencies are added the monthly per person cost drops to $713.21.

The average monthly cost to NACC per person in a private agency is $146.08. Several points regarding this figure must be kept in mind. First, the average cost figure reflects the cost of outpatient programs as well as residential ones. Second, not all operating costs of private agencies are included since NACC counts only its direct costs. In other words, welfare costs, private contributions and funding from other local, state and federal government agencies are not included in NACC's tabulations. However, it should be noted that when these other costs are taken into consideration, it is still less expensive to run one of the private agencies than the NACC program because of differences in staffing patterns, security requirements and underlying program concepts.

It is apparent that many renovations in private facilities have been made with materials and supplies obtained from people in the community. It is rare to find a private residential facility that has not had considerable improvements made by its residents, a free source of labor the use of which has been justified as being part of the treatment program.

Detoxification Facilities

A major problem faced by private agencies is the lack of beds available for detoxification in the City of New York. Major Mary C. Davis, Director of Women's Correctional Services Bureau of the Salvation Army, pointed out in a paper for AVANT, that there are only 562 detoxification beds in the City of New York. Of that total, 314 are in the Morris J. Bernstein Institute with an average waiting period of from four to six weeks; 2-3 beds are available in Manhattan State Hospital with a three to four-week waiting period; 20 beds are in Metropolitan Hospital Center with a two-month wait; and Bronx State Hospital has, "beds only for those who are going to participate in the methadone program." In addition, there are 28 beds in St. Luke's Hospital that are restricted to adolescents from two programs. Interfaith Hospital has 40-50 beds, but they have been unavailable since February 1970 because of building renovations.

Presently, there are only 337 beds available on a regular basis, and all have long waiting periods. In reflecting on the seriousness of the situation, one program director pointed out it took the better part of a day to find a bed for an emergency case.

For many private programs the lack of detoxification beds means that they lose addicts who are either unwilling or unable to wait for a bed. It is claimed that the addict is, at best, an impulsive person with a low "frustration tolerance" who is unable to wait for long periods of time. As Major Davis points out, "The desire to change is often only a frail spark and is all too easily snuffed out by adverse circumstances."

Longer Treatment Periods

Another difference between private agency programs and those run by the State is the duration of treatment. Most NACC facilities formerly kept their residents some nine to fifteen months. Lately, this period of time has decreased. The average treatment in most NACC facilities is now six months. This reduction in treatment time may result from an increase in knowledge on the part of staff and an increased understanding of and experience with the treatment process. It appears, however, that the NACC program is under very real pressure generated by numbers. There are many more addicts trying to begin treatment than there are treatment beds.

The resulting backlog has caused two things to happen. First, some court judges are more willing to send prisoners to other programs or to let them plead to lesser charges so they will not have to go into the NACC program. Second, many facilities seem to be reacting to pressure for beds by turning people over to aftercare facilities in a shorter period of time.

Employment of Ex-Addicts

The private programs call for residents to be in treatment a minimum of one year, and in many cases the staff of these agencies believe two years of intensive treatment are essential to make the personality changes believed necessary.

Many private agencies depend on ex-addicts for a great deal of their staffing. Some programs are operated almost exclusively by ex-addicts. These agencies claim the ex-addict plays a role in the treatment process that cannot be duplicated by someone who has not been addicted and who has not "kicked the habit." It is also claimed: the ex-addict is more likely to know when an addict is lying and manipulating staff members; the ex-addict is an important role model, a living proof for the addict that a drug-free productive life is possible; and the ex-addict is better able to establish meaningful communications with the addict than personnel who have not been part of the drug scene. This viewpoint has resulted in a rapid increase in demand for ex-addicts to establish programs. The programs are usually therapeutic communities based on the California Synanon model or on one of its variations.

Directors of existing programs commented that several ex-addicts who have taken jobs with other programs are, in fact, "splitees" who never graduated. These directors point out that, in many cases, they do not consider these people qualified for work in their own program much less as directors of other agencies. But, they add there is "big money" in the field.

Many observers feel an ex-addict subculture is being perpetuated. It is not denied that ex-addicts can play an important role in treatment, but how effective a role is debated. Some programs have elected to use ex-addicts extensively as co-therapists along side professional psychologists and psychiatrists; others do not use professionals until the addict is on his feet and in need of traditional services such as education, vocational assistance, job placement, etc.; still others have used ex-addicts, and have concluded they do not work well, or do not fit their particular needs.

The role of the ex-addict in treatment and rehabilitation is questioned by some who are not certain what qualifications ex-addicts bring to the job aside from former addiction and treatment

experiences. It has been suggested that the ex-addict would be more useful and his role clearer if, in addition to his experience, he had formal training in counselling, vocational training, or in the social and behavioral sciences.

It is further argued that the ex-addict cannot be considered successful as long as he is in the narcotics treatment field, because he has not left the program. The supportive services provided to residents are still available to the ex-addict staff. Critics maintain that in order to be successful, the addict must seek a job outside the narcotics rehabilitation profession, if only for a few years.

Program Expansion

Other than basic accounting and some data collection, few controls have been exerted on the private agencies by NACC. Agencies have been allowed to expand and have received additional funding from NACC for their programs. Substantial changes in the size of a program may effect its operations and the concepts on which it operates.

In light of the original demonstration grant rationale, it is difficult to see how increased funding can be justified. Some program costs have more than doubled without being subjected to meaningful evaluation. There have been no indications that these programs represent successful treatment modalities in the field of drug rehabilitation. New programs have been funded solely on the basis that they provide a unique approach to the problem of drug addiction, yet NACC officials have been unable to explain the criteria used in determining the uniqueness of new programs. It appears that programs have been able to expand simply by playing on demonstrated concerns shown by the public rather than documented evidence of successful rehabilitation.

One rapidly growing program has made an issue over the lack of adolescent drug addiction treatment programs. The importance of this problem has been disputed by the director of another program who maintains that although there is a growing problem of teenage drug abuse, it is best handled by existing social agencies rather than by creation of new adolescent residential treatment facilities. Yet, there is no reliable data to substantiate either claim.

Supportive Services

NACC facilities are designed to provide, when fully operational, a range of services that are generally similar. This is not the case with private agencies, some of which offer a full complement of services while others rely on those provided by social service agencies in the community.

Many of the private therapeutic programs provide few services besides therapy. Hart Island is beginning to offer educational programs and has an educational research project to determine special educational needs of addicts. Daytop and Odyssey House employ certified public school teachers.

Some programs insist that addicts attain a high school equivalency diploma before graduating. Yet others stress development of vocational skills and assume people must possess specific skills before reentering society. Unfortunately, skills which are in demand in the job market are not always known.

Salaries

The private agencies indicate they have difficulty locating qualified people at salaries established by NACC, especially medical and nursing personnel.

Agencies not funded by the State have indicated that one reason they have not contracted with NACC is directly related to NACC hiring policies and salaries. In addition, they want to avoid the kind of administrative rigidity they felt would be imposed. They fear their role as program innovators would be lost if they accepted public funds. They are reluctant to try new treatment concepts for fear of failure and a resulting loss of funds. What is not mentioned is that private agencies, since the inception of NACC grants, have criticized NACC and have competed among themselves to get a larger share of the NACC financial pie. To date, the spirit of cooperation between involved parties has not been good. This is unfortunate considering the present state of the art and the concomitant lack of knowledge. As Miss Judy Calof of the Community Service Society pointed out in an article in the *Antidote*, a newsletter of AVANT, "Honest efforts have been made but effective treatment remains elusive. . .Knowledge of what programs are appropriate for different addicts eludes us. There is no system to help the addicted into the most suitable program."

The Association of Voluntary Agencies on Narcotics Treatment — AVANT

AVANT is an association of 11 private agencies funded by NACC who joined together to provide a common front in the treatment of drug addiction in New York City. AVANT is the successor of a similar organization that began in 1958.

The member agencies were initially unhappy

with the State's program which they viewed as little more than incarceration. The agencies thought they could develop better solutions if they pooled their knowledge and experience and improved their own programs. AVANT establishes standards of admission for member agencies, provides a forum for the exchange of meaningful information, and has begun to explore the possibilities of standardized data collection and evaluation. In addition, AVANT prints and distributes the *Antidote*, a newsletter detailing the operations of its member agencies and also publishes articles related to narcotics addiction.

In March 1969 the Association hired an executive director, who has been successful in promoting an improved spirit of cooperation among the members and a more positive attitude towards NACC.

NEW YORK CITY ADDICTION SERVICES AGENCY

The Addiction Services Agency (ASA) was established in 1966. Originally it was called the Office of the Coordinator of Addiction Programs (OCAP) and was located in the Office of the Mayor. OCAP established information centers but did not become directly involved in treatment and rehabilitation. In 1966, there were no public programs in operation and a handful of small private agencies were trying to provide help for an increasing number of addicts.

Dr Ephren Ramirez, was recruited to establish treatment programs based on drug abstinence. The basic concept of the Ramirez program was that an addict should be willing to accept responsibility for his own rehabilitation, and this responsibility should increase as the addict progressed through the program. Dr. Ramirez developed the Phoenix House program based on a threefold treatment and rehabilitation concept — induction, treatment, and reentry. At the present time, the Phoenix House approach to treatment is still the mainstay of ASA supported treatment programs.

ASA contracts with the Phoenix House Foundation to provide treatment services in some 15 facilities. In addition, ASA also funds treatment facilities not associated with the Phoenix House Foundation but based on similar concepts. ASA funds programs in local neighborhoods — Day Care Centers, Community Centers, and Youth Centers which are primarily educational and informational units but which do provide some counseling help for addicts on an outpatient basis.

In October 1970, the City Comptroller issued a management analysis of the Phoenix House — ASA program. The report stated, in part, that Phoenix House was "so closely identified with the city agency as to be inseparable." The report also said that as a result of the lack of distinction between the two agencies, the city paid bills that should have been charged to the Phoenix House, ordered supplies for them, and used city employees to work for the Phoenix Foundation.

Among the other findings of the N.Y.C. Comptroller were that the Foundation's books and records were chaotic and inadequate; that the Foundation, an unincorporated association (Friends of Phoenix); and the Foundation's instrumentalities in its various real estate ventures (Harness Realty) — may have violated a wide variety of Federal, State and local laws concerning fund raising and taxation.

There are indications that the Phoenix House — ASA relationship will be changed with the management of the Phoenix House program going entirely to the Foundation. In view of recent organizational changes in the city's administrative structure, ASA is to become more closely associated with the Office of the Mayor and will again become principally a staff rather than an operating agency.

Phoenix House Program

Phoenix House is a "therapeutic community" program, staffed by ex-addicts for the treatment and rehabilitation of heroin addicts and other drug abusers. The program is voluntary and designed for people who have problems with any drug (not just opiates) and even includes people whose problems are non-drug related. The staff claims the only criterion for admission is a sincere desire and commitment on the part of the individual to deal with the emotional and social problems that have led to the use of drugs.

The Phoenix House program began in May 1967 and by August 1970 there were over 1,000 residents in 15 separate facilities. As of mid-September 1970 about 43 percent of the residents were under 21 years of age.

There are approximately 200 Phoenix House staff members. Over 75 percent of the staff are ex-addicts and former drug abusers, and the remaining 40 to 50 persons are doctors, nurses, social workers, teachers, and other professionals.

Residents generally remain in the program for two to three years, while they learn to face and

deal effectively with the realities of their lives. "Encounter" group sessions several times a week help residents cope with their feelings and their behavior. The staff claims that seminars and a full program of informal and formal education provides additional skills for residents. Household work assignments provide a "sense of community" and help residents take responsibility for the chores of daily living.

Most people join the program after learning of it at one of the six Phoenix Centers. The induction period provides a watered down program where new residents become oriented to the concepts and methods of Phoenix House. The treatment phase of the program lasts the longest and consists of all components of Phoenix House programs. Finally, residents move into the re-entry phase of the program during which they may work as staff at one of the Phoenix House centers or seek employment or educational opportunities outside the program.

NACC — Phoenix House (Hart Island)

The five Phoenix Houses on Hart Island are funded by a contract with NACC through ASA. The City of New York leases Hart Island to the State for use as a rehabilitation center.

As of the end of October 1970 there were some 375 residents in the program. According to Phoenix staff, all but 50 residents were NACC certificants. NACC certificants are selected for the program by a Phoenix House screening group.

Evaluation of Phoenix House Program

An unpublished study of the ASA — Phoenix House program indicates that there were 2,110 cumulative admissions between May 2, 1967 and February 11, 1970. Of this total, there were 1,113 withdrawals from program (52.7 percent) and 918 people remaining in program (43.5 percent). The study found there were 79 residents who had completed the program (3.7 percent). Many of those who left the treatment program before graduation may have stayed drug free. However, of the 79 residents who completed the program, two people had returned to drug use, one of whom had returned voluntarily. Of the 77 people who graduated from treatment and who reputedly were drug free, 42 were salaried and working within Phoenix programs, 17 were working for other voluntary addiction programs, and the remaining 18 are working in other fields, unrelated to the treatment and rehabilitation of addicts.

METHADONE MAINTENANCE PROGRAMS

Methadone is a synthetic opiate that was developed by the Germans during World War II. It is called a synthetic opiate because, although synthesized in the laboratory, its chemical properties resemble those of morphine. The Germans used the drug as a pain killer because of the difficulty in obtaining morphine during the war. Methadone has been used at the U. S. Public Health Service facility in Lexington, Kentucky and at other facilities to detoxify narcotic addicts.

In the early 1960's, another use for methadone was discovered by Drs. Vincent Dole and Marie Nyswander (at Rockefeller University) who found that if methadone was administered orally to heroin addicts, it had the capability of blocking the heroin high. In other words, addicts who took methadone and later took one of the opiate drugs, heroin or morphine, reported that they received no "kick" from it.

Research indicates that methadone when administered orally produces none of the unpleasant attributes of heroin. It is longer lasting and therefore requires only one dose daily; it does not cause debilitation, euphoria, and its side effects — sweating and constipation — are relatively minor problems. Additionally, methadone does not create a demand for an escalation of dosage as do other opiate drugs. Once a patient has been placed on a maintenance dose (generally 80-110 mgs. daily), it remains stable and can be reduced if required.

Until methadone programs were established, the principal treatment for narcotic addiction had been a combination of detoxification and psychotherapy. This traditional method of treatment subject to a variety of modifications is still being used in many of the drug treatment programs in the country, though statistics to date indicate that the long term success rate (patients not returning to the use of narcotics) has been low.

Methadone maintenance programs have been set up within federal guidelines related to the use of methadone established by the Food and Drug Administration of the Department of Health, Education and Welfare and the Bureau of Narcotics and Dangerous Drugs of the Department of Justice. The criteria and guidelines for conducting research in this area were announced in June 1970, and are expected to be further modified and amended early in 1971.

The oldest and largest methadone program is in

operation at the Beth Israel Medical Center. The program is predicated on the model based on the research of Dole and Nyswander. Their research was originally funded by a grant from the New York City Department of Hospitals, but since October 1, 1967 it has been funded by NACC.

The current budget of Beth Israel provides for the care and treatment of about 2,100 people at a cost of some $4.2 million, out of a total budget of $6,000,000. The remaining funds are allocated for program development, supplies and contingencies.

The Beth Israel program has three phases. In the first phase the patient enters the program, is given a complete physical exam, and begins his doses of methadone. The doses are increased until an appropriate maintenance level has been established which, in general, is around 80 to 110 milligrams a day. This process takes about six weeks after which the patient takes his established dose of methadone daily.

Most of the patients initially were handled on an in-patient basis. In the last year, however, most of the people have been handled on an ambulatory basis. Nearly 80 percent of the new patients do not have to be admitted as in-patients. If necessary, they can be admitted to selected hospitals for any medical problems that exist or occur.

Once stabilization has been achieved, the patient enters the second phase or out-patient part of the program. During this period he comes to the clinic daily for his oral dose of methadone. He is required to leave a urine sample which is tested for drug use. If he remains "clean," the number of visits per week is reduced until the patient comes only once a week to pick up his methadone and leave a urine sample.

The third phase of the program begins when the patient has led a "productive", heroin-free life for one year. At this point he is supposed to be a functioning member of society. Clinic visits and contact with the staff become less frequent. However, he must report to the clinic weekly to leave a urine specimen and to be observed taking one dose of methadone.

The Beth Israel program currently consists of five in-take facilities and 22 ambulatory and outpatient clinics. Admissions to the program are voluntary but are subject to the approval of the facility director. The following criteria have been established for admission:

1. A person must volunteer for the program.
2. He must be 18 years of age or older; parental consent is necessary for those under 21.
3. The patients must have a heroin addiction of at least two years and generally not have a history of mixed drug abuse.
4. The patients must be free of severe psychiatric disorders.
5. If a patient's spouse is also an addict, both of them must participate in the program.

It is claimed that once the patient has been relieved of the need to support a heroin habit, he becomes more amenable to rehabilitation. He receives personal counselling and referrals to the appropriate community agencies for additional assistance in vocational training, job placement, or schooling.

Data Bank for Methadone Program

A data system for evaluating the operations of the methadone program at Beth Israel and its affiliated facilities has been established at Rockefeller University. The system was designed to monitor a large number of patients and provide analyses of clinical, laboratory, research and administrative information. This information is kept in computer data files for immediate access. Currently the system stores information on some 4,000 individuals, and its designers claim it can handle information on 25,000 patients without major changes. As additional clinics at other hospitals are set up under contract with Beth Israel, they will be required to collect data which will be added to the files of the Rockefeller University Data Bank.

Methadone Program — NACC

In Fiscal Year 1969-70, NACC began operating methadone programs for some 300 certificants in two facilities — Cooper Community Based Center and Masten Park Rehabilitation Center. In 1970-71, largely basing its justification on the clinical findings of Dole and Nyswander and Beth Israel experience, NACC received increased appropriations to expand its methadone programs to treat an additional 400 certified addicts. This brings to about 700 the number of certificants provided with methadone in NACC facilities.

As of November 10, 1970 there were 31 certificants being stabilized on methadone at intramural facilities. An additional 669 persons were in community based methadone programs. Another 193 certificants were being stabilized on methadone at the Cross Bay Rehabilitation Center.

The NACC methadone program is a two-phase operation: a residential six-week period for stabilization and ancillary medical care; and a supervised

period of aftercare during which the addict reports for methadone and additional services as required.

If the certificant does well on methadone, his required visits per week to the community based facility decrease until he reports only weekly. If, on the other hand, a person does poorly, he may be required to report to the facility daily. Further, if a person's behavior is poor enough, he may be withdrawn from methadone and sent to an intramural facility for residential rehabilitation.

During aftercare, certificants in the methadone program are expected to avail themselves of the supportive services offered by the CBC's. The "reporting in" requirement is based on the certificant's apparent adjustment to community living and is tempered by work, schooling, family responsibilities and other considerations.

The Cross Bay Methadone Treatment Center which opened in March 1970, is considered by NACC to be primarily a research facility. It was established to obtain data, gain experience and examine the potential uses of methadone for different sub-groups of narcotic addicts. Cross Bay also houses the NACC central pharmacy which prepares methadone doses for all NACC patients. Methadone is received in bulk, prepared in individual dosages, as required, and distributed to the various NACC methadone programs several times a week.

The program at Cross Bay operates on a six-week cycle for a maximum of 225 male and female patients per cycle. During the residential period each patient is given a complete medical examination and is gradually stabilized on methadone, while under observation of the medical staff. In addition to its primary function as a research facility. Cross Bay also provides supportive services for patients: group counselling, aptitude development programming (pre-vocational training), recreation, and work assignments in and around the facility.

Three research protocols have been established at Cross Bay and only people who meet the criteria are eligible. Patients in the first control group must satisfy the following criteria: (1) between 21 and 40 years of age; (2) no prior involvement in programs at other NACC facilities; (3) no chronic physical illness; (4) no history of assaultive behavior; (5) no mixed drug use; (6) addicted to narcotics a minimum of four years.

The criteria for the second research group are: (1) a minimum of 21 years of age; (2) addicted for at least two years; (3) less importance placed on assaultive history; (4) fewer restrictions on behavioral characteristics; (5) prior involvement in NACC treatment; (6) possible mixed drug use.

The third research design is the newest and is in the process of being set up. The criteria for this program are: (1) over 21 years of age; (2) criminal certification; (3) recent certification; (4) no special attention to patient's history.

Once the six-week cycle at Cross Bay is completed, the patients are assigned to a CBC methadone outpatient facility. The period of aftercare treatment and supervision is similar to that of other certificants being treated in the NACC methadone program.

Private Agency Methadone Programs

In addition to the programs already mentioned, two private agencies, Lower Eastside Service Center and Greenwich House Counseling Center, operate outpatient methadone programs.

The Lower Eastside Service Center has some 50 people in its methadone program. Recently it had a contract with the New York City Health Services Administration approved for 125 people and it will become one of twenty methadone clinics now being set up by the city and funded by NACC.

Greenwich House Counseling Center operates a methadone program for some 110 people in conjunction with St. Vincent's Hospital. The staff established the following criteria for admission: (1) a person must request methadone; (2) he must have first tried abstinence programs; (3) a psychiatrist must determine his mental fitness; (4) a medical doctor must determine his physical fitness for this program.

At present the staff said there are some 800 people on a waiting list for the program which provides methadone on a five day-a-week basis to "avoid abuses." The participants are given a weekend supply of the drug when the clinic is closed.

Evaluation of Methadone Maintenance

The Methadone program is probably the most controversial approach to the problem of narcotics addiction currently being tried in this country. The controversial nature of methadone treatment stems primarily from the fact that methadone is itself an addictive drug.

Proponents of methadone treatment point out that under proper medical supervision, a single daily dose of methadone blocks the narcotic effects of heroin without necessitating the escalation of the dosage. It is claimed that a person on methadone will generally be unable to "overshoot" the methadone blockade with heroin. There are

several other positive aspects of methadone treatment. It is a long-acting narcotic whose effects last from 24 to 36 hours. Proponents say that methadone is relatively safe when taken orally. Research indicates a high degree of tolerance to methadone itself with patients who had received double doses showing no signs of adverse reaction. This is important since a substantial tolerance to the treatment drug is needed for success with the blockade treatment. Methadone research to date seems to indicate no *major* medical problems attributed to its use, although research in this area is still continuing. The principal medical complications are increased sweating and constipation. Finally, methadone does not create a demand for increased amounts, as do other narcotic drugs.

On the other hand, the proponents of methadone consistently fail to make clear the consequences of making patients dependent on large doses of methadone, and the withdrawal syndrome that will occur if the drug is not received.

It is readily apparent that, "Methadone is a dangerous drug and the doses used for maintenance are highly toxic to the non-tolerant individual."[35] A few deaths resulting from accidental swallowing of methadone doses already have been noted by the Medical Examiner's Office in New York City.

"Methadone is a narcotic and produces in nontolerant patients a type of euphoria, regardless of whether it is injected or administered orally in orange juice, that is qualitatively similar to heroin. Further, it produces a type of tolerance and physical dependence that is indistinguishable from that of heroin or morphine. It has high abuse potentiality."[36]

"Patients' acceptance of the methadone maintenance or continuing in the program should not in itself be taken as a measure of its success The dependence-producing property of methadone dictates this result, for it must be remembered that physical dependence forces them to remain in the program just as physical dependence on heroin causes them to seek illicit narcotics."[37]

The methadone program in operation under the aegis of the Beth Israel Medical Center is the only one that has produced substantial statistical information. Frances R. Gearing, M. D., of the Columbia University School of Public Health and Administrative Medicine has headed an independent evaluation team since the program's inception.

According to reports released periodically by the evaluation unit twenty percent of the people admitted to the program have been administratively discharged often for drug or alcohol abuse. The staff of Beth Israel commented that of the 80 percent who remain in the program, 85 percent are leading "productive and socially acceptable lives." This state is measured by an addict's involvement with employment and educational activities and his arrest free record.

One of the methods used by the evaluation unit to dramatize the "success" of people on methadone, as compared to addicts who are not, is to compare groups of people in the program with, what the reports refer to as a "contrast group." The contrast group is composed of a selected number of addicts, who have been detoxified at Beth Israel. These addicts are then matched by age and ethnicity to people in the methadone program When the arrest records of the two groups are compared, the group on methadone shows fewer arrests.

The evaluation report, however, fails to note the differences between the two groups. There are many differences in motivational levels. People in the methadone program are volunteers who often had to wait a year or more to get in. The addicts who have been detoxified were hospitalized for short periods of time to withdraw from heroin because, in general, the amount used each day was approaching the danger level or because the cost of the habit was becoming impossible to maintain.

In addition, people in the methadone program are screened before they are allowed to participate. Even the most minimal screening would eliminate a substantial number of addicts with mixed drug usage and behavioral problems; addicts who would normally be included in the detoxification group.

Another dissimilarity is that people on methadone continually report to a center to receive their supply of the drug and their behavior is observed and checked. The people in the detoxification group, however, are not followed actively. Instead, they become known only when they become rearrested.

As one observer noted, "One cannot be certain to what degree the results obtained thus far with methadone can be extrapolated to the addict population at large. It is quite clear from Dr. Gearing's data that at this time the patients who have been accepted for methadone treatment are not representative of the addict population. This would be expected to some degree, since the selection criteria themselves lead to a nonrepresentative sample of the addict population. This bias in itself does not detract from the merits of the treatment; however, it is obvious that one cannot

generalize the results to the addict population. Further, one cannot compare samples from different populations and attribute differences in outcome to treatment effect (e.g., methadone maintenance)."[38]

The evaluation reports state that people on methadone have fewer arrests than addicts in the contrast group. Yet, the reports fail to point out that the people on methadone had fewer arrests before they entered the program than the detoxification group. The people on methadone do have fewer arrests, but it is hard to determine how much of the decrease is directly attributable to methadone maintenance.

It must be recognized that methadone maintenance in and of itself deals only with the symptoms of the problem of addiction rather than with underlying causes of the problem.

Staff at Beth Israel said they utilize counselors to help the addict get back on his feet and the appropriate community resources are called on, when necessary, for those services that are unavailable at the hospital. In addition to counseling services, the hospital provides necessary back-up medical and dental services. Hence, educational and vocational programs are not carried on by Beth Israel but are obtained from social service agencies in the community. It is difficult to determine the degree of utilization of these services. All too often it appears that a patient enters the clinic, leaves a sample of urine and receives his dose of methadone. In fact, it has been noted that patients in the Beth Israel program are required to see counselors only once a month.

One reason for questioning the existence and the nature of supportive services in a methadone program is the percentage of people who are administratively discharged. Reports of the evaluation team indicate that some 20 percent of the people in the Beth Israel program are discharged either voluntarily or because of behavioral problems. According to the latest Gearing report, "Reasons for leaving thy program continue to be the same as in previous reports. Voluntary withdrawals, and discharge for medical and behavioral reasons have accounted for the majority of dropouts in the early months. Abuse of alcohol and chronic abuse of amphetamines or barbiturates were the major causes of discharge in the second or third year. Alcohol was the major reason for discharge among the white and Puerto Rican patients."[39]

The future for people who leave the program is grim. In a study of 350 people withdrawn from methadone, Dr. Dole pointed out that heroin hunger returned in almost all the individuals immediately after the withdrawal of methadone. He concludes that "individuals who have stopped heroin use with methadone treatment but continue to steal, drink excessively or abuse non-narcotic drugs, or are otherwise antisocial, are failures of the rehabilitation program but not of the medication."[40]

Interestingly, although the Beth Israel program maintains that it has selection criteria for participation in the program and that each patient is carefully interviewed by one of their experienced intake workers, nevertheless the directors of the various neighborhood facilities where methadone is dispensed have a veto over the selection of people to be served by their facility. Why this veto is allowed after the patient has been screened is not clear.

One of the major problems inherent in a methadone dispensing system is security. Since methadone is an addictive and therefore dangerous drug, most programs insist on security measures to try and prevent the illicit leakage and use of methadone. Additionally, it is desirable by means of urinalysis to determine whether a person in the program is abusing drugs.

Some programs observe the urine giving process in order to be sure the sample was given by the donor. The staff at Beth Israel does not observe the urine giving process. They claim the staff has been "in this business for a long time," and thus can determine visually if someone in the program is using drugs.

Concern has been expressed by some observers that it is too easy for addicts to get into a methadone program where they can continue to use drugs and obtain methadone which they can take, sell, or give away on the street.

Evaluation of Data Bank

One of the uses of the data bank at Rockefeller University is to hopefully guard against patients joining more than one methadone program. The staff at Beth Israel said that a patient's file would consist of standardized data obtained from personal interviews as well as any pertinent information from other social service agencies. The staff said that the patient, for instance, would be required to give his mother's maiden name, social security number, and other information to help avoid the problem of duplication. However, one administrator noted that although the patients would be asked to leave a urine sample after every

visit, they would not be required to have their finger prints taken once, because, as he put it, "It destroys the relationship between the staff and the patient."

Methadone Maintenance Program - NACC

The study team observed only two of the three methadone outpatient programs in operation at the CBCs. The certificant presents an identification card to the dispensing nurse, leaves a sample of urine which is later spot checked for drug use, and receives his methadone. The oral ingestion is supposed to be observed by the attending nurse who is required to engage him in conversation to verify that the methadone has been swallowed and not mouthed.

Many people pass through these methadone clinics daily, and the same process is repeated continuously. There was an inadequate amount of security in effect to prevent the leakage of methadone to the street. Nurses frequently did not observe the ingestion of the liquid and urine specimens were usually not given in the presence of a NACC employee who could attest to the validity of the sample.

The NACC methadone program design, also calls for the reduction of the number of visits required if the patient demonstrates acceptable behavior. As more and more patients are permitted weekly rather than daily visits, increased vigilance will be required to make certain that patients provide valid urine specimens and that they are not enrolled in more than one program. If safeguards are not provided, serious methadone abuses may occur.

Private Agency Methadone Programs

Two private agency methadone programs are operated by the Lower Eastside Service Center and Greenwich House Counseling Center. The staff of the LESC program was critical of certain aspects of the methadone program. They said that it was their experience that many of their people, once they became stabilized on methadone, were no longer interested in treatment and rehabilitation. The staff said there was still some strong opposition in the Black community to the use of methadone. In addition, they felt that methadone programs were widely dispersed, and this could be used to the addicts' advantage. They were especially concerned about the apparent ease by which addicts can become enrolled in more than one methadone maintenance program.

The staff of the Greenwich House Counseling Center said that most people in methadone programs did stop using heroin, but many of them turned to other substances-- pills, liquor. In addition, they pointed out that they experienced a very different success rate from the Beth Israel experience. The staff estimated that their current success rate ran between 50-60 percent. They attributed this to the fact that their participants were not as exclusively screened as at other programs. They also have had some cases of people who have been withdrawn from methadone without data to show how this group is doing.

Expanding the Methadone Program

The State has decided to greatly expand the use of methadone in the treatment of opiate addiction. Governor Rockefeller on many occasions has stated his intent to have 20,000 people in methadone programs by the end of the current fiscal year.

New methadone programs are being established and rapidly expanded, usually with few supportive services and frequently without the types of evaluation and follow up necessary in large scale research programs. Further, it is clear that ancillary supportive services are not heavily utilized in several programs.

As of September 8, 1970, according to a press release from the Governor's office, 19 contracts have been awarded to provide for treatment for up to 11,875 persons under the $15 million methadone program. "This combined with the program for treating up to 2,488 persons, carried out by the Narcotics Commission itself at their centers, accounts for a total services level of 14,363 persons."

The question must be asked, however, whether the highly selective criteria originally used for the selection of patients in the Beth Israel program can be maintained with the addition of several thousand new addicts to methadone programs. If not, can it be assumed that the success rate obtained and widely publicized by Beth Israel can be maintained? There are strong indications based on results from other programs operated by private agencies that success rates may be substantially lower when addicts are chosen on the basis of less selective criteria. One observer stated that the success rate will go down as more and more addicts enter the program.

In the final analysis it is virtually impossible to predict how successful methadone may be in treating opiate addiction. To date the evidence suggests that a great deal more objective research and evaluation are necessary before any judgement can be made about the applicability of

methadone maintenance programs to more of the general addict population than just a carefully screened group.

PROGRAM COSTS

Perhaps as an indication of the importance attached to the narcotics control problem, there has been generous funding provided. The NACC appropriation in the first year, 1967-68, was almost six times as much for its operating budget as had been appropriated for the predecessor program under the Metcalf-Volker Act in its last year of operation-$35 million for NACC compared with $6 million for Metcalf-Volker.

In its first year NACC utilized only $21 million of its $35 million appropriation, and in succeeding years has operated well within its budgeted appropriations.

NACC Budget and Expenditure Comparisons

	1967-68	1968-69	1969-70	1970-71
Budget Request	$45,880,000	$55,543,000	$56,830,000	$85,000,000
Appropriation	35,000,000	38,443,000	52,773,000	85,146,000
Total Expenditures	20,739,000	33,216,000	49,535,000	22,662,000*
Unused Appropriations	14,261,000	5,227,000	3,238,000	—

*As of September 30, 1970.

SOURCE: NACC Budget and Audit and Control Report, September 30, 1970

The overall operating expenditures have increased at an average rate of approximately 60 percent per year.

	Operating Expenditures	% of Incr	Subjects Under Treatment (March 31) Number	% Incr	Patient Months of Care (March 31) Number	% Incr
1967-68	$20,739,000		6,322		9,617	
1968-69	33,216,000	60	10,685	69	25,300	163%
1969-70	49,535,000	49	13,779	29	41,963	65%
1970-71	85,146,000[2]	72	17,251[1]	25	60,107	43%

[1]As of October 31

[2]Appropriations

SOURCE: NACC Financial Reports and Monthly Census

This increase in operating expenditures has nearly paralleled the increased in subjects under treatment.

Operating Expenditures for Intramural Facilities

The largest portion of the NACC budget, 60 percent in the 1969-70 year, is spent for the treatment program in the NACC residential facilities and those contracted with other State departments. This item constituted more than half of the total NACC budget in the first three years and has been the item of largest increase. This expenditure has been increasing at a substantially faster rate than the number of patients treated.

	No. of Subjects in residence (As of Mar. 31)	% of Increase	Operating Expenditures (Residential Treatment Centers) (000)	% of Increase	Resident Months of Care	% of Increase
1967-68	2,976		$10,374		9,617	
1968-69	3,405	14	18,141	75	25,300	163
1969-70	4,828	45	29,928	65	41,963	65

SOURCE: NACC Financial Reports and Monthly Census

The greatest contrast is between the first and third years when expenditures increased by 188 percent while subjects under treatment rose by only 62 percent.

In addition to the sharp rise in overall treatment costs, there are wide variations between unit costs in the various NACC facilities.

This would indicate a difference of more than 100 percent between the lowest and highest per patient cost in NACC facilities. As a general rule, average costs for similar institutional care vary directly with the size of the population, with the larger institutions showing lower per capita costs. NACC facilities follow this pattern. (See Exhibit VIII.)

This factor of size may account in part for the wide difference between the costs in NACC facilities and those of the contract departments. NACC

Average Cost per Patient
NACC Residential Facilities

	Monthly	Per Diem
High (Queensboro)	$1,164	$38.16
Low (Woodbourne)	558	18.28
Average (All NACC)	771	25.27

current operating costs per resident are 75 percent higher than those in facilities operated by the Department of Correction and 30 percent higher than the operating costs in facilities operated by the Department of Mental Hygiene.

Average Cost Per Patient

	Monthly	Per Diem
NACC	$771	$25.27
Dept. of Mental Hygiene	588	19.28
Dept. of Correction	440	14.41

The average per diem costs in regular Mental Hospital facilities is $15.80 a day, reflecting in part larger institutions, but the differences are great enough to warrant careful review.

Capital Expenditures

Because of the urgency of its assignment, NACC acquired a number of existing public and private institutional facilities: a convent, a hospital, a YMCA, a Job Corp Training Center, and some excess facilities from the Department of Correction. Most of these were old and required extensive renovation.

The acquisition and adaptation cost per bed ranged from a few hundred dollars at Mid-Hudson and Iroquois to an expenditure in excess of $35,000 per bed at the newly constructed Ridge Hill facility. The average cost to date is slightly more than $20,000 per bed. (See Appendix A.)

NACC has indicated a halt in the construction of treatment centers at the present time as more emphasis is shifted to the aftercare program, and methadone maintenance with construction emphasis shifting to Community Based Centers. NACC has expended $124 million of its current $159 million authorization for capital facilities.

Costs of Aftercare

A substantial reduction in treatment cost comes when the subject is transferred to aftercare, since this is primarily an outpatient program. Expenditures to date indicate a cost to NACC about one-sixth that of intramural treatment.

As an increasingly large percentage of NACC's patient load is shifted to aftercare, average costs for treatment should drop correspondingly.

Costs of Private Programs

NACC has expanded the funding and the number of volunteer patients under treatment in the private programs almost as fast as the number of certificants in the regular NACC program which increased from 3,164 in 1967-68 to 9,039 in October 1970.

There is a wide variation in the direct cost to NACC for the services of these private agencies,

Cost f Aftercare

Year	Number of Subjects in Aftercare	Client Months of care	Operating Costs of Community Based Centers
1967-68 (March 31)	188		$ 160,084
1968-69 (March 31)	1,003	15,802	1,038,056
1969-70 (March 31)	2,247	18,498	3,192,797
1970-71 (Oct. 1970)	3,691	42,641	6,502,090 (Budget)

SOURCE: NACC Financial Report and Monthly Census

Volunteer Private Agency Programs

	No. of Patients	NACC Funding
1968 (Mar. 31)	3,158	$ 3,252,000
1969 (Mar. 31)	6,257	8,979,000
1970 (Mar. 31)	6,704	9,158,000
1970 (Oct. 31)	8,212	10,554,000*

* NACC Budget Allocation

from as low as $55.73 per month at Greenwich House for a program that is exclusively outpatient, to as high as $471.78 per month at Exodus House for a program that includes both residential and outpatient services. (See Exhibit VII.) The average monthly cost per patient to NACC in those private programs is $146. However, the direct cost to NACC which is used in this report may, in some cases, be only part of the actual costs. Additional operating costs that are financed from other sources are not reflected in NACC cost figures. For instance, some of the private agencies insist that their people get on welfare and turn their checks over to a central fund to pay operating expenses. Additionally, the private agencies often have income from private contributions, and several receive funds from other government agencies.

Costs of Methadone

The cost of the Beth Israel methadone program to the State was $153.16 per patient per month for the 1969-70 year. This is slightly higher than the $146.08 average cost per patient, to NACC directly, per month for the voluntary agencies, and is not the "pennies a day" cost quoted by some enthusiastic supporters of methadone maintenance. The maintenance cost is substantially less than the average $771 per patient month cost in NACC residential facilities. It must be pointed out, however, that the methadone cost figure is based on a program that is largely outpatient in nature whereas the NACC cost is for a residential program with a large security component.

VI PREVENTIVE EDUCATION

The report of the State Investigation Commission which led to the creation of NACC encouraged the inclusion of an educational component in light of findings "that the education of the public to the perils of narcotic abuse can be effective in *preventing* addiction." This conclusion appears to be largely an expression of faith, for there do not exist even today well-documented studies on the effectiveness of any large scale drug education projects (partly because few such projects have been undertaken).

THE NACC EDUCATION ASSIGNMENT

NACC was given broad responsibility in the law which created it. It was directed to:

> provide education and training and prevention, diagnosis, treatment, rehabilitation and control of narcotic addiction for medical students, physicians, nurses, social workers, and others with responsibility for narcotic addicts either alone or in conjunction with responsible agencies, public or private.
>
> Provide a public education on the nature and result of narcotic addiction and on the potentialities of prevention and rehabilitation in order to promote public understanding, interest and support.
>
> Disseminate information relating to public and private services and facilities in the State available for the assistance of narcotic addicts and potential narcotic addicts. [41]

In order to implement its mission and legislative mandate, NACC has organized a Division of Prevention headed by an Assistant Commissioner. This division has the following bureaus: Professional Relations, Community Prevention Centers, Community Assistance, and College Relations. This formulation is a result of a reorganization study conducted by the Division of the Budget, dated December 1968. Two of these bureaus, Community Assistance and College Relations, have been staffed.

The principal NACC education efforts have been made through its Narcotic Education Centers and the Narcotic Guidance Councils.

Narcotic Education Centers

In terms of staff and activity the Bureau of Community Prevention Centers is responsible for the Education Centers, of which there are presently six seen statewide—nine in the New York metropolitan area and seven upstate. The centers disseminate information about drugs and drug abuse and promote activities to carry out drug education. Staff members have visited over 3,500 schools and organizations since 1968, lecturing in total to over a quarter of a million people. NACC has produced and distributed more than ten million pamphlets and newsletters since 1967. The education centers are estimated to have reached more than 8,000 people in their local communities, many of whom have been assisted in preparing applications for civil certification.

The New York City Centers devote most of their time to assisting addicts and their families in the preparation and presentation of commitment petitions. This petitioning load has increased in many education centers concurrent with NACC's expansion of its program and reaction to requests from various local groups. The staff complement in the larger downstate centers is usually about seven professionals, operating virtually a social referral agency. The centers outside New York City are engaged more in the dissemination of information over a much wider base of operations. They are not as involved in the direct petitioning process as their downstate counterparts because of less prevalence of hard drug addiction. Usually two professionals comprise the staff of such centers.

The Narcotic Guidance Councils

NACC's other approach to "prevention" is the Narcotic Guidance Council, which was authorized by legislation in 1968 to "develop a program of

community participation regarding the control of the use of narcotics and dangerous drugs at the local level." NGCs were to:

> make immediately available to the community basic knowledge acquired in the field of drug use . . . and create a climate in which persons seeking assistance . . . can meet . . . with responsible individuals or agencies . . .[42]

NACC has promoted the growth of these councils, and has available for newly formulated NGCs a workshop training course to help orient members. The Bureau of Professional Education is heavily utilized in this area.

As of October 30, 1970, approximately 250 councils were established with 140 proposed. The original legislation (1968) contained no provision for funding. However, an initial $250,000 was provided in the 1969-70 supplemental budget for Narcotic Guidance Councils. These funds were to be utilized on youth related drug programs. This amount was increased by NACC's approved request for $700,000 in the 1970-71 budget, and an additional $200,000 provided for New York City NGCs and helping services.

NGC Expenditures

NACC reimburses 100 percent of the administrative expenses of an NGC in its first year up to $1,000. NACC also shares in 50 percent of the program costs of an NGC up to a maximum of $10,000. As of October 30, 1970, 29 councils had requested funding for the 1970-71 fiscal year. Of these, approximately half have requested $1,000 or less. Sixteen councils have executed contracts with NACC but only two have expended money, a total of less than $2,500 to date.

Expenditures for all of NACC's education efforts have been less than three percent of the Commission's total budget to date. Annual expenditures have ranged from $1,058,141 in 1968-69 to $572,180 in 1969-70 with $2,134,800 budgeted for 1970-71.

Evaluation of NACC Education Programs

Preventive education as conceptualized and practiced by NACC is essentially a drug awareness program. Films, pamphlets, lectures bearing the seal of "authority" are presented with the assumption that providing information on dangers will influence behavior in a socially acceptable direction.

NACC's Education Centers and Guidance Councils have provided a sense of community presence, and it is reaching some of the addict population through the petitioning assistance given in the education centers. Impact of the extensive public relations program—lectures, publications, etc.—is always difficult to judge. However, there is evidence of much continuing skepticism among judges, lawyers and addicts themselves about NACC's ability to help the addict.

Underlying the spirit of the NGC legislation is the idea that the Narcotic Guidance Councils would be able to communicate with the youth in the community who face the perils of drug abuse. NGCs often have a difficult time relating to individuals with drug problems because they lack youth membership and treatment back-up facilities. Both these shortcomings were items covered by amending legislation in 1970. Persons under 21 were specifically authorized as Council members and a $65 million appropriation was authorized for a 50-50 state-local sharing of financing for youth treatment centers. Local reaction to both these provisions has been slow in developing and availability of this $65 million has been extended to include educational purposes.

STATE EDUCATION DEPARTMENT PROGRAMS

Major responsibility for developing preventive education programs in the State is shared by the State Education Department. Chapter 787 of the Laws of 1967 authorizes the Commissioner of Education to establish a continuing program for critical health problems in which

> educational requirements regarding cigarette smoking, drugs and narcotics, and excessive use of alcohol become the basis for broad, mandatory health curricula in all elementary and secondary schools.

The education of school age children is emphasized in the act, but the legislation indicates that all "citizens" of the State are to be educated (Ch. 674 of the Laws of 1970). It is noted that the Education Law, Section 804a (1952) has required that instruction be provided to students with regard to the nature and effects of drugs and alcohol.

The 1970 Legislature in the Supplemental Budget Bill (Chapter 157) appropriated a $... million lump sum from the State Purposes Fund toward drug education. The legislative language reads:

> for services and expenses for the dissemination of information relative to the treatment and prevention of drug addiction and use aimed at youth and their parents. Activities to achieve such dissemination shall include but not be limited to mass media campaigns,

college volunteer programs, in-service teacher training, local assistance for narcotic education programs, school community pilot projects and the provision of additional departmental staff.

A Division of the Budget certificate of approval dated June 30, 1970, allocated $1.175 million to the State Department of Education for this purpose.

The basis of this new program was originally intended to be a curriculum on Sociological Health, Drugs and Narcotic Education ("Strand II") that was completed in 1967 and available for grades 4-12. Strand II was conceived along conventional lines—information, presumably "authoritative," was to be given students in lectures by teachers who needed limited special training in this area. Strand II has been applied minimally, with a current budget of $30,000 to cover the preparation of curriculum materials. The little experience with Strand II has revealed it is seriously inadequate. Effort is therefore now being directed toward what is believed to be an effective method for dealing with the subject of drug abuse, peer group involvement. This technique relies on student participation in planning and conducting activities. Strand II is thus currently being revised so it will be more process oriented.

The Education Department launched in 1970 an extensive set of programs to prepare teachers, administrators and students for involvement in future drug education classes in which the utilization of innovative materials and student participation would be stressed. The following programs have been set up: in depth drug training for health teachers, training of trainers, school-community teams, and the college volunteer program.

In-Depth Drug Training for Health Educators

Experienced professional health educators from six colleges and universities in the State were selected to offer intensive teacher training programs to prepare instructors to teach new drug health materials as part of a Master's Degree program in health education. Teachers eligible for this program included not only hygiene instructors, but also those from other disciplines. By retraining teachers holding other certificates, the program was to set an important precedent, demonstrating that schools can meet new priorities by retraining existing staff rather than hiring additional personnel.

This past summer, 189 teachers were involved in the program and plans are underway to begin the training of additional teachers during the 1970-71 school year. The ultimate objective is to place in each school a person with the expertise of the educator and the content background of a health professional. The State, after September, introduced the requirement that money continue to those teachers who began only if that teacher is involved in two or more health courses a week at his school. Because of this action, the original objective of the program has seen a major reversal. In excluding the teacher not meeting the new requirements, the effort is now one characterized by providing the health instructor a graduate degree and not cross training the history or math teacher.

The Training of Trainers

The training of trainers program has been funded with $100,000 of State money and an additional $200,000 of federal money. This drug education program is being conducted principaliy at Adelphi University, which is offering a series of workshop sessions in drug education for school health education personnel. The purpose is to train teachers to conduct local in-service training programs for teachers in their own and neighboring school districts. The program is divided into two phases. Phase one consists of the training of approximately 150 teachers to teach in-service courses on drug abuse to elementary and secondary school teachers in the State. Two groups of 50 each were to attend a two-week training session at Adelphi University in the summer of 1970, but only 81 completed the program. An additional 50 teachers are now being trained.

Phase two involves these trained teachers returning to their local districts to teach in-service courses to their peers. For each in-service course taught, the teacher receives a $600 stipend from the State. The teachers already trained are not having the impact that was originally projected. Districts sending a teacher to Adelphi contracted to make time available for the trained teacher to conduct in-service courses for other teachers in the district. According to educators on the Adelphi team who have made follow-up visits to assist and evaluate local efforts, some local school districts have not promoted in-service courses.

School-Community Team Project

The allocation for the school-community team project is $270,000. This program sponsors workshops conducted for school-community teams made up of school administrators, guidance coun-

selors, teachers, students, and community leaders. The objectives in these workshops are: (1) to provide factual data concerning drug use and abuse; (2) to provide an opportunity to discuss and become involved with effective new techniques in combatting drug misuse; (3) to enable each participating team to develop its own school-community action plan; and, finally, (4) to begin a collection of data providing a base for research and evaluation to determine the effectiveness of the new approaches and techniques.

The first of these workshops was held in July, at the end of the school year. Since most teachers and students had left for vacations, there was a good deal of difficulty in recruitment. This school-community workshop program was handled by a consultant group (Education Dynamics) which lacked the comprehensive drug-related expertise associated with this type program. There was little or no follow up or evaluation.

College Volunteer Program

The college volunteer program is designed to train and equip college student volunteers throughout the State to work with their peer groups and provide a trained volunteer contingent which would be available to elementary and secondary schools in carrying out drug education programs. They would be able, further, to assist in counseling prospective drug users, providing a dialogue among students regarding their concerns about the drug situation. Assistance would also be furnished to help secondary school students organize and develop their own groups to counter, or deter, drug use. As of early October 1970 proposals were submitted from ten schools to conduct college volunteer programs. Of these ten proposals, none has been funded nor have contracts been signed. No contracted program activity is under way at the present time.

Another element of this program is a proposal with Xicom Development Corporation which would develop a series of audiovisual tapes to be made available to the college councils. Of the ten colleges that currently have submitted proposals, it should be noted that only one of these schools is in the New York City area, in Staten Island.

Many questions may be raised regarding the funding procedure that will be implemented for these ten colleges. Basically it consists of the students proposing a program which they in turn submit to the unit of the college that will handle the legal contract. The college submits the program to the State Education Department for review and approval. When approval is granted and the contracts are signed, the funding channels back through the college to the students conducting the program. In terms of target numbers of students involved, it was originally hoped that approximately 250 college students would participate on 15 campuses throughout the State. At the present time it appears that there will be only ten colleges conducting programs with approximately 20 students in each program. Therefore the effect of this program in quantitative terms has somewhat diminished.

Local Pilot Projects

The local pilot projects, funded at $120,000, attempt to identify innovative and exemplary programs or program proposals of drug education. The objective is to stimulate the development of new aspects in drug education that may be utilized by all school districts. It would appear that this area is one of discussion principally, as funds were never made available in the department for its implementation.

Evaluation of the State Education Department Programs

The size and scope of the programs of the State Education Department were relatively small scale and experimental through 1969-70. The Department has proceeded slowly, apparently recognizing that it had to develop and substantiate a drug prevention curriculum, and prepare teachers to use such a curriculum before any large-scale program could be launched.

In its attempt to stress peer group involvement and teacher training efforts, the Department of Education makes crucial assumptions. The prevalent assumption here is that individuals differ in the reasons for drug use and that varying approaches are indicated for particular individuals. Involving the peer group and providing them with the responsibility of combatting drug use is the goal of the peer group educational effort. Teacher training, on the other hand, is vital because the element of overriding importance in drug education is the teacher. His role is not only that of a conduit of knowledge; he must, indeed, personify an active force in molding student actions.

During fiscal 1970-71, however, monies became available through the evolution of education as a component of the Youthful Drug Abuse Treatment Program.

With a prospective 25-fold increase in funding, it becomes even more essential that any educational

program be carefully planned and tested before it is implemented statewide.

YOUTHFUL DRUG ABUSE TREATMENT PROGRAMS

Chapters 607 and 608 of the Laws of 1970 authorize NACC to provide State aid for the conduct of a drug abuse treatment program providing ambulatory or in-patient services, or both, designed primarily for persons 16 years of age or less, as prescribed in Section 213-A of the Mental Hygiene Law. The Legislature, in its declaration of purpose, stated:

> it is hereby declared to be the policy of the State to act in partnership with local governments to provide improved programs for the care and treatment of youthful addicts and other regular drug abusers which should be conducted in facilities located close to those served and which should speed rehabilitation and restoration by involving families and community resources to the greatest extent possible . . . the conduct of drug abuse treatment programs and the construction, acquisition, reconstruction and rehabilitation of such facilities are hereby declared to be public purposes for which public monies may be expended.

The initial guidelines for State aid to local agencies for the operation of drug abuse treatment programs for treatment of youthful addicts were distributed by the Narcotic Addiction Control Commission on May 29, 1970. These guidelines, in an attempt to implement the above legislative references, defined program eligibility requirements and the procedures involved in the application for State aid. Once again, a drug abuse treatment program in this context was defined as an "ambulatory or in-patient program for the treatment, including but not limited to counseling of addicts or regular drug abusers, or both, designed primarily for persons 16 years of age or less."

The initial Commission guidelines allocated funds on a geographic basis in accordance with such factors as need and likelihood of utilization. Fifteen million dollars of the total appropriation was to be reserved for matching the cost of loan amortization, including rental payments, for facilities utilized in the treatment program. Of the remainder, it was planned that approximately $40 million would be earmarked for matching the operating costs to be incurred in the New York City and adjoining counties of Nassau, Suffolk, Westchester, and Rockland. The balance of the appropriation was to be allocated for matching the costs to be incurred by the local agencies in the remainder of the State. Any balances allocated for a particular geographical area which were uncommitted by October 31, 1970 were to be considered available for use by other areas.

The initial guidelines further discussed the definition of operating costs to include personnel, maintenance, debt service and capital costs, and other expenses which qualified for reimbursement. In this line gifts, grants, and contributions (including possible federal grants) were to be considered eligible for State aid under the matching formula. State aid in the form of financial support was to be available, according to the appropriation and the legislation authorizing the program, to the extent of 50 percent of the operating costs of the local agency.

Further elaboration of the above guidelines found NACC suggesting a treatment program at the county government level with a county agency responsible for the treatment program. It was suggested that the treatment and rehabilitation program might be administered either by the community mental health board, the Department of Mental Health, a specially constituted narcotic and drug abuse commission, or a county NGC.

The original guidelines for this program have been changed significantly. NACC, in August 1970, issued revised State aid guidelines for local agencies operating youthful drug abuse treatment programs. The revised guidelines include the following modifications of the initial guidelines.

1. Specialized preventive education services conducted in conjunction with a treatment and rehabilitative program are eligible.
2. Eligible programs are not restricted to those "designed primarily for persons 16 or less"; school-age groups in general are appropriate.
3. Matching funds considered eligible include local expenses made from a direct federal grant to a private agency which has a contract to conduct the drug abuse program with the local agency, and federal funds, such as OEO and model cities funds, received by a county or the City of New York, which are passed through to a private agency conducting a drug abuse program pursuant to a contract with the local agency.
4. All private cash grants or gifts received by a local governmental agency and given by it to support an approved program will be eligible for State aid.
5. The reimbursable costs for which State aid

may be obtained may include the value of in-kind contributions of personal property, such as furniture, equipment, and supplies, and a volunteer's services.

6. A local agency whose budget was adopted prior to the enactment of the law may request an advance of State aid to cover the cost of its approved program for a period not greater than six months.[43]

There is no doubt that these changes constitute an extension or reinterpretation of the original intent of the Youthful Drug Abuse Treatment legislation. The Commissioner of Education released the following statement on September 25, 1970:

> . . . it is extremely important to note developments in another part of Governor Rockefeller's and the Legislature's drug abuse program. The Legislature last session enacted a $65 million, 50-50 matching program for treatment of youthful drug addicts. Under the original guidelines for this program, . . . *education* programs were not eligible for State funding. The guidelines have been changed now to the effect that education programs—*prevention and referral where related to treatment*—are now eligible for funding on a 50-50 matching basis.[44]

Although this statement of the Commissioner emphasized education "related to treatment," the treatment component subsequently was detached. The Education Department, in conjunction with NACC, held a meeting for administrators from all school districts in the State on October 22, 1970. It was explained to this gathering that a school's expenditures for health and drug education could be utilized as a part of a community's contribution in the application for funds; in other words, the education program itself did not need to have an integral treatment component; it would be sufficient that treatment resources existed or were planned for the community.

The message of this conference is clear. The strong treatment component of the Youthful Drug Abuse Treatment program has been displaced by a standard educational component. There exists considerable pressure to commit these funds under the revised guidelines. School districts have had hurriedly to prepare applications under the incentive of impending deadlines. There has been a flurry of activity accompanied by little meaningful planning (e.g., ASA models distributed to all city school districts). This undertaking may result in the expenditure of a substantial amount of money on projects which have not even been tested experimentally.

This new approach will perhaps also have the effect of penalizing schools and school districts that have reacted to the educational mandate of Chapter 787 of the Laws of 1967, which called for the instruction of drug-related subjects as part of the total health curriculum. Few school districts have implemented this mandate in a thorough manner. Districts that have spent considerable time and money in attempting to develop a program do not qualify for support under the revised guidelines, which do not fund an on-going program of drug education. To receive funding, a program must be expanded or represent a new or innovative effort on the part of the school district. Those school districts, therefore, that have failed to commence activities in this area might be rewarded by the receipt of financial support to begin drug education efforts that were mandated approximately three years ago. In some cases, these funds might even be financing curriculum development.

NEW YORK CITY PREVENTIVE EDUCATION PROGRAMS

New York State, through NACC and other agencies, contributes several millions of dollars (the New York City budget indicates almost $10 million) a year to support programs of the Addiction Services Agency, which is the organization responsible for handling the City's drug control activities. ASA has only recently undertaken sizeable efforts in preventive education. Its major projects, like those of the State, encompass teacher training, and ten people were assigned to this activity by November 1970. The total school program budget of ASA is presently less than $100,000.

At the first level of ASA action are orientation programs. Groups of teachers receive approximately ten lectures covering basic informational aspects of drug use control, usually including components on ASA and NACC operations. ASA estimates that approximately 4,000 teachers have thus far participated.

People are selected from this orientation group for more complete preparation in a regular, or summer institute, intensive training course, and only the people who complete this advanced course are considered by ASA to be trained teachers in the field of drug education. There are seventy-two of these graduates.

The regular intensive courses are normally conducted in the teachers' school, and the summer institute is run through several units of City

University of New York. In the regular intensive course, the objective is to involve teachers in the drug situation and drug scene of their schools. Problem-solving, rap encounter sessions, and other types of attitudinal training are utilized. The summer institute is designed as a graduate level course with academic credit granted upon completion. This course represents an experimental effort to probe behavioral modification, inculcate teaching and educational skills, and help the teacher solve particular situations. ASA also provides a follow-up training course for those who complete the intensive courses. This entails a four-hour session held every other week at ASA headquarters.

ASA's school program also consists of student rap sessions within the schools. This generally involves a member of the ASA educational staff visiting a particular school and spending a day or two at the school working with the principal, guidance counselors and other teachers of the school. The ASA representative announces throughout the school that a rap session will be held that day following normal school hours. ASA's experience with this type of activity has been that more students sign up and want to participate in such sessions than trained group discussion leaders are available to accommodate.

ASA's other activities include sponsoring the teaching at Lehman College of a regular credit undergraduate course in both semesters of the 1970-71 academic year, and the training of truant officers in the Bureau of Attendance.

The most significant development for the ASA school program staff has been its involvement with the Youthful Drug Abuse Program. ASA has been designated contractor for this program in New York City and therefore has the responsibility for reviewing, monitoring, and accounting of funds from NACC to the various school districts. Their hope is to get every school district involved in drug education by providing them with "innovative models" for their program applications. Any results of their efforts will not be evident until sometime after the first projects are launched in early 1971.

The New York City Board of Education also has conducted a serious review of what contribution it might make in the area of drug education. Its Division of Health and Physical Education has proposed that the position of "Narcotics Coordinator" be created in each junior and senior high school as a focal point for all the school's drug control activities. No action on the implementation of this proposal has yet been taken.

The description of the New York City programs reveals that no carefully controlled preventive education pilot projects have been launched that are likely to produce findings soon that could be fed back into the larger effort of the State Education Department to develop a comprehensive curriculum, with adequate material and personnel resources.

OTHER STATE PROGRAMS

The Legislature in 1970 involved two additional state agencies in a campaign for "the dissemination of information relative to the treatment and prevention of drug addiction and use aimed at youth and their parents." The Department of Mental Hygiene has been assigned $400,000 for this purpose in fiscal 1971 and the Department of Health, $200,000.

The Department of Mental Hygiene is attempting to involve in a more meaningful way the local Community Mental Health Boards. At the start, a survey was conducted to locate throughout the State the highest areas of drug use as shown principally through drug death statistics, and engage with indigenous mental health related operations associated with the Community Mental Health Board. As a result of this preliminary screening, seven agencies, concentrated in the New York City area, were selected. These sponsoring agencies are conducting a wide range of preventive information, education, and counselling services through local individuals and groups. The sponsoring agencies and local partners are to incorporate their work as part of a comprehensive action to improve the general quality of life in the local area. The peer group approach characterizes this work. It is felt that only through individual contact will any impact be made.

Of the $400,000 involved, $390,000 represents contracted work which will be spent in the locality by the local sponsoring agency. The remaining $10,000 has been set aside for Hygiene's own administrative evaluative expenses. The first approved contract with an agency was consummated only on October 16, 1970. While Hygiene's insistence upon, and supervision of, evaluation on the part of contractor is noteworthy for its inclusion, the first set of final reports on the success of activities is not due until December 1971.

The Department of Health views its role in terms of drug education as supportive to the roles of the major departments. Approximately one half of the funds are being expended on educational mate-

rials—e.g., films, brochures, pamphlets. The remainder is being utilized on professional education which attempts to instruct doctors on such things as emergency treatment involving the addict. The feeling is that physicians are reluctant to treat addicts in their offices and, as a result, have generally fallen behind in the area of narcotic addiction treatment. The effort is to keep doctors informed and up to date on medical treatment of the addict. The drug abuse program of the Department of Health therefore involves three major activities all directed toward the doctor: the development and distribution of films, the formulation and presentation of slides, and the utilization of publications. Health is printing new leaflets and drug charts, along with a specific bibliography and other literature, for wide distribution and is developing a desk reference for physicians. Health is coordinating its publication projects with those of NACC to eliminate duplication.

VII. SUMMARY AND FINDINGS

Enforcement

The combined efforts of enforcement agencies at all levels have not yet significantly reduced the supply of narcotic drugs available in New York State, and the prospects for a significant reduction in the foreseeable future are not encouraging. These agencies have succeeded, however, in bringing large numbers of addicts into court.

The New York City police alone made over 100,000 narcotics arrests between April 1967 and October 1970, and in more than 70,000 of these the drug involved was heroin. The New York City police also identified more than 21,000 "admitted users" of narcotics among the arrests recorded in 1969. The records of the Federal Bureau of Narcotics and Dangerous Drugs, which are based entirely on police reports, show 30,119 active narcotic addicts in New York City in 1969, along with 3,222 in the rest of the State, for a total of 33,341.

Many of these alleged narcotic addicts have been arrested and examined for addiction by NACC doctors. Between April 1967 and October 31, 1970, NACC conducted almost 66,000 examinations. The results are as follows:

Residence	Total Examinations	Positive Examinations
New York City	55,415	28,826
Long Island	5,280	1,431
Upstate New York	3,506	2,174
Other	1,730	735
Total	65,931	33,166

SOURCE: NACC Monthly Census Report October 1970

The arrest and medical examination statistics, taken together, clearly indicate that a substantial proportion of the estimated addict population has been apprehended by enforcement officials during the period since NACC's inception.

Thousands of alleged addicts are being arrested, but only a small percentage of these people are certified to NACC or receiving severe jail sentences. Addicts are not being taken out of circulation, and the State's efforts to strengthen deterrence are thereby undermined. These shortcomings are due to failings in the system of criminal justice beyond the ability of the police to apprehend criminals.

Compulsory Certification

The objective of returning addicts to useful lives in numbers that exceed the appearance of new addicts is, according to the legislation creating NACC, to be accomplished largely by forcing a substantial percentage of addicts into treatment through compulsory certification by a court of law.

The certification of addicts in the *civil* courts is working reasonably well. This finding holds even in Manhattan, Brooklyn and the Bronx, where a heavy caseload presents certain problems. Relatively few arrested addicts, however, have "volunteered" for NACC under the provision which permits addicts with minor criminal charges to choose a NACC treatment program.

The certification of addicts in *criminal* courts, on the other hand, is not working as intended in the area of greatest activity, New York City. This development is a part of the general administrative problem of the criminal courts of New York City caused primarily by the tremendous volume of cases and the consequent shortage of judges, lawyers, and other court personnel to handle the workload. This load factor, plus a generally negative attitude toward the NACC program by the addicts, their attorneys, and lawyers from the district attorneys' offices combine to produce few certifications to NACC, contrary to the expectation of the Legislature in 1966 that all addicts convicted of a misdemeanor or prostitution would be certified. This expectation has been thwarted because of the problem of proving addiction.

Addicts are advised to contest the question of addiction and request a jury trial, as is their right. At this point the district attorneys often concede non-addiction, either because they do not have the personnel and resources to litigate the question of addiction or because the evidence of addiction is insufficient. The evidence of addiction is insufficient sometimes because of delayed or inadequate medical examinations or weak medical witnesses. Rather than being certified to NACC, therefore, most addicts are referred to private agencies or given a penal sentence.

It follows that there are several changes which, if introduced, could bring the process of certifying addicts more in line with the original intent of the law. First, NACC might persuade more people that it does have an effective treatment program. Second, proof of addiction might be made less stringent. Third, the suggestion has been made by a number of public officials that special courts are needed for the processing of narcotics cases.

It would not make sense, of course, to improve the State's ability to get addicts committed to NACC unless there is a demonstrated ability to provide effective treatment.

Treatment and Rehabilitation

In carrying out its assignment, NACC has acquired and staffed enough facilities so that it can now deliver "extended periods of treatment in a controlled environment"—that is, intramural services—to more than 6,500 subjects at a time: 4,500 in 13 residential facilities of its own and 2,000 under contracts.

This is a program with almost three times the capacity of the Federal facilities at Lexington and Fort Worth.

NACC has developed six Community Based Centers and two Reporting Centers from which to provide "supervision in an aftercare program" for more than 5,000 people.

NACC supports outpatient services for 3,400 more addicts through contracts with four additional public agencies including Nassau County and New York City's ASA.

Finally, NACC currently funds 19 private treatment programs, which divide into the following three categories: a limited residential program, outpatient and methadone. These private agencies are serving 10,400 non-certified subjects.

As of January 31, 1971 a total of 16,270 addicts had been certified to NACC since it began operations in April 1967. The point of greatest interest is the subjects who "complete" the treatment and aftercare phases and are discharged, and the subsequent behavior of these people. Since most subjects are kept under control for three years, the first large number of discharges was not until April 1970. From April 1 through December 31, 1970 a total of 925 people have been discharged. Of these, 717 were discharged because of the three-year time limit, an additional 28 were discharged as rehabilitated before the three-year limit, and 180 were discharged for other reasons.

Information is not yet available on the behavior of these subjects since their release, although NACC is currently planning a follow-up program on a sample basis to determine to what extent the objective of "returning people to useful lives" has been achieved.

The most crucial issue in an assessment of the New York State narcotic control program is the capability to deliver effective treatment. The 1966 legislation creating NACC confidently stated that "narcotic addicts *can* be rehabilitated and returned to useful lives," although "only through extended periods of treatment in a controlled environment followed by supervision in an aftercare program." However, even the supporters of this legislation acknowledged in debate that this reference to effective treatment relying on strong aftercare was much more theory than fact. They recognized that there was no demonstrated medical procedure that had a high probability of working on the great majority of addicts who were to be brought into the planned treatment facilities. The first important operating achievement that might have been expected from the New York program was either demonstration of a treatment of potentially wide applicability or documentation of procedures that had limited or no effectiveness.

This study found few significant differences among programs and services included in NACC's interdisciplinary approach or the special approaches of other public agencies, and no meaningful records to provide a basis for evaluating one form of treatment against another.

There is also no reliable information available on the results of the treatment administered by the private agencies. In most cases, the private agencies have not had either the resources or the inclination to gather even the most basic evaluative data. Instead, they have relied on their service orientation to justify their operations, and NACC has not insisted upon fulfillment of its contract by requiring a record-keeping system that would assure comparable evaluative data on results.

This deficiency ought to be corrected where it

exists in any NACC or NACC-supported operation. If this remedial action is not taken, it will never be possible to make reasoned calculations about which treatment and rehabilitation approaches, if any, are good investments. The ranking administrative and research officials in NACC now recognize the crucial importance of developing plans on the basis of input from follow-up studies, but they are just beginning.

The Beth Israel Methadone Maintenance program is the only treatment approach for narcotic addiction that has been operated under careful (if still imperfect) controls from inception through follow-up; it is the only approach which can show meaningful data about results.

The attractiveness of the methadone approach stems from several factors. It is the only "new" concept that has been offered recently and data have been supplied to indicate this approach is successful for some portion (not yet well-defined) of the addict population. Methadone maintenance also does not require the longer periods of more expensive residential care that are required by other treatment programs.

NACC currently has underway a research program that is designed to provide clarification of the crucial matter of methadone maintenance's range of applicability using NACC's methadone program at the Cross Bay Rehabilitation Center.

It is the "aftercare" resources of NACC that are most directly involved in getting addicts back into the community and providing them with whatever support they might need in "returning to useful lives." Most centers actually offer little in supportive services to the people assigned to aftercare. Too often, elements of the program are inoperative because of a shortage of professional personnel and because of a breakdown in supervision resulting from the large caseloads. As a result, it is in this aftercare phase of treatment that the vast majority of abscondences from NACC facilities take place. From April 1967 through January 1971, there were 1,670 abscondences from intramural facilities and 4,937 abscondences from aftercare programs. Because of the pressure for NACC residential treatment beds, a large number of certificants have been transferred to aftercare who were apparently not ready when they were released from the security of the residential program, and without adequate supporting services they abscond in large numbers.

Preventive Education

Preventive education as conceptualized and practiced by NACC is essentially a *drug awareness program*. NACC was given responsibility for providing public education on the potentialities of prevention; it was also charged with disseminating "information relating to public and private services and facilities in the state available for the assistance of narcotic addicts and potential narcotic addicts," and it was essentially this latter drug awareness function that NACC understandably concentrated on in its first years. Most of this effort has been carried out by the staffs of the sixteen community Narcotic Education Centers, and the Narcotics Guidance Councils. As of October 30, 1970, approximately 250 councils were established, with 140 more proposed. NACC reimburses 100 percent of the administrative expenses of an NGC in its first year up to $1,000 and shares in 50 percent of the program costs of an NGC up to a maximum of $10,000.

NACC's Education Centers and Guidance Councils have provided a sense of community presence and they are reaching some of the addict population through the petitioning assistance given in the Education Centers.

Impact of the extensive public relations program—lectures, publications, etc.—is always difficult to judge. However, there is evidence of much continuing skepticism among judges, lawyers, and addicts themselves about NACC's ability to help the addict.

Underlying the spirit of the NGC legislation is the idea that the Narcotic Guidance Councils would be able to communicate with the youth in the community who face the perils of drug abuse. NGCs often have a difficult time relating to individuals with drug problems because they lack youth membership and back-up treatment facilities.

Both these shortcomings were items covered by amending legislation in 1970. Persons under 21 were specifically authorized as council members and a $65 million appropriation was authorized for a 50-50 state-local sharing of financing for youth treatment centers. Local reaction to both these provisions has been slow in developing.

The Laws of 1967, amended in 1970, authorize the Commissioner of Education to establish a continuing program for critical health problems. The basis of this new program was originally intended to be a curriculum on Sociological Health, Drugs and Narcotic Education ("Strand II") that was completed in 1967 and available for grades 4-12. Strand II was conceived along traditional lines—information, presumably "authorita-

tive," was to be given students in lectures by teachers. Strand II has been applied minimally and is being revised to allow more student participation in the presentation of material dealing with drug abuse.

The Education Department in 1970 launched an extensive set of programs to prepare teachers, administrators and students for involvement in future drug education classes in which the utilization of innovative materials and student participation would be stressed. During the summer of 1970, 89 teachers received two weeks of training in one program, and 189 others completed the first course in a part-time Master's Degree sequence. Other future community teachers are supposed to come from a College Volunteer and School-Community Team program. With the exception of pilot projects, as of January 1, 1971 there has been almost no feedback into schools from specially trained leaders.

The size and scope of the programs of the State Education Department were relatively small scale and experimental through 1969-70. The Department has proceeded slowly, apparently recognizing that it had to develop and substantiate a drug prevention curriculum, and prepare teachers to use such a curriculum before any large-scale program could be launched.

Funding Preventive Education

The Legislature in 1970 appropriated $65 million for NACC to provide State aid for drug abuse treatment programs that are designed primarily for 16 year olds and younger and that provide inpatient services. The initial application guidelines distributed by NACC in May 1970 did not allow expenditures for education programs. The original conception of this program was in terms of treatment projects at the county government level with a county agency responsible for the program. It was suggested that the treatment and rehabilitation program might be administered either by the community mental health board, the Department of Mental Health, a specially constituted narcotic and drug abuse commission, or a county narcotic guidance council. This concept was well-directed, but the people and resources necessary for its implementation could not be mobilized.

The original guidelines for this program were changed in August 1970 so significantly that these revisions constitute an extension or reinterpretation of the original intent of the Youthful Drug Abuse Treatment legislation. On the basis of these revised guidelines, the State Education Department, in conjunction with NACC, explained that a school's expenditures for health and drug education could be utilized as a part of a community's contribution in the application for funds; in other words, the education program itself did not need to have an integral treatment component; it would be sufficient that treatment resources existed or were planned for the community. The message of these revised guidelines is clear. The strong treatment component of the Youthful Drug Abuse Treatment program has been extended to include a standard educational component.

There exists considerable pressure to use these funds under revised Youthful Drug Abuse Treatment program guidelines. School districts have hurriedly prepared applications under the threat of impending deadlines. There has been a flurry of activity accompanied by little meaningful planning (e.g., ASA models distributed to all city school districts). This dramatic increase in available funds makes it even more essential that any educational program be carefully tested before it is implemented statewide.

Summary

Three key premises were basic to the narcotic drug control programs approved by the Legislature in 1966 and thereafter: (1) there exist demonstrated, reasonably effective treatment procedures for narcotics addiction, (2) there exists an effective criminal justice system to insure either compulsory commitment to NACC for treatment or the imposition of legal penalties sufficient to discourage the sale or use of narcotics, and (3) there exists a tested, satisfactory curriculum plan upon which to base preventive education. This study has shown that none of these important elements are accomplished facts even today. In fact, the New York State narcotic drug control program as it is now constituted is still basically an experimental program.

Urgent programs—and *narcotics* is an example—often must be initiated before all the prerequisites are available. Such programs should continue to be regarded as *experimental*—in that controls, records, research and evaluation must be carried out continually to document the most advantageous methods and programs. In programs of this type, substantial initial outlays might be necessary to assure that fair and full tests will be available.

At the same time, the continuation or extension of such outlays should be dependent upon demonstration that careful controls are being applied and

that some criteria have been established and are being utilized to distinguish and select the more promising approaches.

Since the dimensions of the narcotics problem are still unknown, it does make a significant difference in a State hard pressed for revenue as to whether the same essential results can be accomplished in an outpatient program costing $56 or $146 per patient per month or a residential program costing $440 or $969 per patient month and more importantly, if any of them are doing the job.

The New York State program to control narcotic abuse is a worthy experiment. This experiment has not yet had sufficient time to indicate what performance standards might be achievable, and it should therefore be continued. There is no evidence, however, that this experiment thus far has been hindered for lack of funds, and further increases should be conditioned upon NACC and other departments and agencies supplying plans founded on documented performance records.

FOOTNOTES

CHAPTER II

[1] New York State, Temporary Commission of Investigation, *Ninth Annual Report*, February 1967, p. 50.

[2] *Ibid*., pp. 53-55.

[3] Laws of 1966, Ch. 192, Sec. 1.

[4] New York State, Governor, *Message to the Legislature*, January 5, 1966, p. 6.

[5] Laws of 1966, Ch. 192, Sec. 4.

[6] Temporary Commission of Investigatio.., pp. 54-55.

CHAPTER III

[7] For a summary of the New York State laws, see Appendix B.

[8] United States, President's Commission on Law Enforcement and dministration of Justice, *Task Force Report: Narcotics and Drug Abuse* (Washington, D.C.: Government Printing Office, 1967).

[9] Albany (N.Y.) *Knickerbocker News-Union Star*, December 8, 1970, p. 5A.

[10] See Exhibit X.

[11] President's Commission, p. 219.

[12] See Exhibit X.

[13] See above, Chap. II, p.

[14] *The New York Times*, December 13, 1970, p. 26.

CHAPTER IV

[15] See section 913-e to 913-r of present Code of Criminal Procedure. The comparable provisions in the new Criminal Procedure Law, which will become effective September 1, 1971, are contained in sections 720.05 to 720.70.

[16] 22 N.Y.2d 545, 293 N.Y.S.2d 531, 240 N.E.2d 29 (1968).

[17] 370 U.S. 660 (1962).

[18] 24 N.Y.2d 292, 300 N.Y.S.2d 102 248 N.E.2d 17 (1969).

[19] 32 A.D.2d 969, 303 N.Y.S.2d 759 (1969).

[20] 35 A.D.2d 703, 314 N.Y.S.2d 815 (1st Dept. 1970).

[21] 62 Cal.2d 280, 42 Cal.Rptr. 199, 398 P.2d 391 (1965).

[22] First Annual Statistical Report of NACC, Albany, 1968, Table 7, p. 7.

[23] Second Annual Statistical Report of NACC, Albany, 1969, Table 8, p. 8.

[24] Second Annual Statistical Report of NACC, Albany, 1969, Table 45, p. 76.

[25] Executive Budget, State of New York, 1968-1969, p. 722.

[26] See Exhibit XII.

[27] Similar figures on narcotic misdemeanor convictions in the State Supreme Court in New York City apparently are not available. Consequently the table shown does not present a complete picture of the number of convicted narcotic misdemeanants certified to NACC in New York City. Indeed a comparison of the figures in the table with the total number of convicted narcotic misdemeanants certified in New York City reveals that more are certified by the Supreme Court than by the Criminal Court, which means that most certified misdemeanants were arrested and charged for a felony but "copped a plea" to a misdemeanor in Supreme Court.

[28] See Exhibit IX.

[29] See table in NACC Response pp.00 for updated figures.

CHAPTER V

[30] Laws of 1966, Ch. 192, Sec. 2.

[31] State of New York *Executive Budget for the Fiscal Year April 1, 1970 to March 31, 1971*, p. 560.

[32] *Ibid.*, p. 553.

[33] Donald B. Louria, "The Role of Voluntary Agencies," *The Antidote* April 1970.

[34] Charles Wineck, "Research Planning at the New York Association of Voluntary Agencies on Narcotic Addiction and Substance Abuse", mimeo, p. 1.

[35] William R. Martin, M.D., "Commentary on the Second National Conference on Methadone Treatment," *The International Journal of the Addictions*, September 1970.

[36] *Ibid.*

[37] *Ibid.*

[38] *Ibid.*

[39] "Methadone Maintenance Treatment Program — Progress Report of Evaluation through March 31, 1970", p. 3.

[40] Vincent Dole, *The International Journal of the Addictions*, September 1970, p. 362.

CHAPTER VI

[41] Mental Hygiene Law, Sec. 204 (4) (5) (6).

[42] General Municipal Law, Sec. 239-u.

[43] Section 213-a of the Mental Hygiene Law was amended by Chapter 49, Laws of 1971 to permit those changes.

[44] New York State Commissioner of Education, "Progress Report — Statewide Program For Drug Education," September 25, 1970, pp. 6-7.

LIST OF EXHIBITS

Exhibit 1

NACC Annual Expenditures by Purpose

Purpose	1967-68	1968-70	1969-70	Total Authorized 1970	Expended Sept. 30 1970-71
Administration and Support Services	$6,335,919	$3,083,184	$4,731,072	$7,174,800	$2,550,470
Scientific Research	1,580	916,730	1,952,207	1,297,059	227,607
Methadone Maintenance Treatment [1]	—	—	-	12,375,000	2,216,021
Treatment and Rehabilitation Centers [2]	10,372,958	18,141,235	29,928,293	45,593,134	12,965,223
Community Based Centers	160,084	1,038,056	3,192,797	6,502,090	2,235,472
Treatment and Rehabilitation Contracted Services	3,252,092	8,978,963	9,158,841	10,533,600	2,111,385
Education and Prevention	616,760	1,058,141	572,180	1,669,800	355,502
Total	$20,739,393	$33,216,309	$49,535,390	$85,146,124	$ 22,661,660

[1]Expenditures for Beth Israel Methadone Program budgeted under Contract Services through 1969-70.
[2]Includes Centers operated by the Department of Correction, Mental Hygiene and Social Services.

SOURCE: NACC Budget Reports, Audit and Control Report, September 30, 1970

Exhibit II

NACC Budget and Expenditure Comparisons (1967-1971)

	1967-68	1968-69	1969-70	1970-71
Original Budget Request (Executive Recommendation)	$45,879,841	$55,542,500	$58,830,413	$85,000,000
Total Available (Adjusted Appropriation)	35,000,000	38,442,500	52,368,207	85,146,124
Total Expenditures	20,739,393	33,216,309	49,535,390[1]	22,661,659[2]

[1]Includes expenditures of the Department of Mental Hygiene

[2]As of September 30, 1970

SOURCE: Executive Budgets
NACC Budget Reports
Audit and Control Report, September 30, 1970

Exhibit III

NACC Census Statistics[1] by Legal Status

Legal Status of Subjects on the Books

	1968	1969	1970	1971[4]
Section 206 (self)	354	1147	1867	3124
Section 206 (other)	793	1101	2605	4062
Section 210	1171	1382	1566	1579
Section 208.4 (a)	810	1700	2344	3408
Section 208.4 (b)	91	335	639	1423
Section 209	17	66	174	289
Detained	87	73	291	700
TOTAL	3623	5804	9486	14,585

NACC Status of Subjects on the Books

In Residence or on leave	2976	3405	4944	6141
Abscondence	429[3]	992	1899	3299
Police Custody Charged	30	129	276	311
Police Custody Pending Return	—	2	1	25
Transfer Out	—	103	146	159
Certified Admission Pending	29	170	108	27
In Aftercare Programs	188	1003	2332	4623
TOTAL	3652	5804	9706[2]	14,585

[1]From: NACC Monthly Report Figures are Cumulative totals, i.e., each year includes prior years.

[2]Includes April 1970

[3]Includes Transfers Out for 1968

[4]Report to January 31, 1971

SOURCE: Annual Statistical Reports, NACC, 1968 and 1969
Monthly Census Reports, NACC, April — January 1971

Exhibit IV

Medical Examinations and Certifications
by Area of Residence

	1968		1969		1970		1971 **	
	Positive Exams	Certifi-cations	Positive Exams	Certifi-cations	Positive Exams	Certifi-cations	Positive Exams	Certifi-cations
Total	6559	3569	6720	2335	10,998	4033	13,086	6022
N.Y.C. areas	6247	3396	6294	2122	10,289	3715	12,295	5637
N.Y.C.	5910	3187	5768	1914	9409	3306	11,251	5156
Long Island	249	129	341	131	476	171	665	278
Westchester	88	80	185	77	404	238	379	193
Upstate	186	133	294	185	401	278	531	378
All Others*	126	40	132	28	306	40	210	7

*Includes County Unknown, Out of State, Out of County and Unascertained
**To January 31, 1971
SOURCE: Annual Statistical Reports, NACC
Monthly Census Reports, NACC April 1970 — Jan. 1971

Exhibit V

NACC Operated Resident Treatment Facilities
Total Expenditures by Facility

Facility	1967-68	1968-69	1969-70
Arthurkill	—	$ 22,024	$ 2,050,104
Bayview	$ 1,109,657	1,664,911	2,068,784
Edgecombe	1,855,533	2,109,508	2,841,174
Iroquois		316,065	990,488
Manhattan	1,649,211	2,272,585	2,858,493
Masten Park	245,900	867,191	1,193,820
Mid-Hudson[1]	1,245,453	2,338,199	2,610,513
Queensboro	10,240	15,897	1,295,331
Sheridan	26,692	107,624	2,683,620
Woodbourne[1]	1,501,894	3,733,913	4,228,705
Cross Bay	626,351	785,288	401,751
Ridge Hill	1,013,811	688,112	237,355
Brooklyn Central	212,519	115,507	—
Cooper[2]	137,308	823,114	—

[1]Includes expenditures by Department of Correction.

[2]Converted to CBC — September 1968.

SOURCE: NACC Financial Reports.

Exhibit VI

Community-Based Facilities
Total Expenditures per Facility

NACC CBC	1967-68	1968-69	1969-70	1970-71 Appropriation	Expended as of Sept. 1970
Brunswick	$ 10,133	$ 5,001	$ 420,911	$ 1,258,068	$ 402,641
Cooper*		269,177	977,903	1,870,149	657,373
Fulton	41,713	33,549	69,957	752,097	165,332
Melrose	70,229	409,499	937,590	1,479,563	554,262
Mt. Morris	38,009	312,670	570,899	953,366	364,837
Masten Park		3,671		314,141	43,934

*Converted from IMS — September 1968

SOURCE: NACC Financial Reports

Exhibit VII

Average Monthly Costs, Voluntary Agencies

AGENCY	Period	Total Payments Applicable to Period	Census* Applicable to Period	Cost per Patient Month
Addicts Rehabilitation	4/1/68-3/31/70	$ 423,514.47	1,485.0	$285.19
Civic Center Clinic	7/1/68-3/31/70	90,533.20	393.5	230.07
Exodus House	7/1/68-3/31/70	533,345.46	1,130.5	471.78
Greenwich House	4/1/68-3/31/70	598,346.68	10,737.0	55.73
Lower Eastside S.C.	7/1/68-3/31/70	660,490.25	4,718.0	139.99
Van Etten	4/1/68-4/30/70	351,950.97	1,707.0	206.18
Beth Israel	4/1/68-3/31/70	3,896,250.84	24,479.5	159.16
Reality House	10/1/68-3/31/70	152,867.21	2,143.5	71.32
Odyssey House	10/1/68-3/31/70	453,664.11	1,197.5	378.84
Quaker Committee	7/1/68-3/31/70	529,957.99	5,390.5	98.31
Samaritan (Day)	4/1/68-3/31/69	48,719.74	214.0	227.66
Samaritan (Night)	8/1/68-3/31/70	273,851.13	905.5	302.43
Daytop Village	4/1/68-3/31/70	1,547,637.46	5,432.0	284.91
Salvation Army	7/1/68-4/30/70	342,715.74	1,650.0	207.71
Village Haven	10/1/68-3/31/70	194,619.28	582.5	334.11
Nassau County	1/1/69-12/31/69	319,232.40	9,022.5	35.38
Westchester County	1/1/69-12/31/69	80,003.08	666.5	120.03
Hope House	12/1/69-3/31/70	4,004.00	23.0	121.33
TOTAL:		$10,501,705.01	71,888.0	

Total Average Monthly Cost — $146.08

Total Annual Average Cost — $1,752.95

*Patient months

SOURCE: NACC Budget Office

Exhibit VIII

Average Monthly and Per Diem Costs for Commission and Contract Facilities

April 1, 1969 - March 31, 1970

NACC Facility	Appropriation Charge	Resident Months Of Care	Average Monthly Cost	Average Per Diem
Masten Park	$ 1,193,820	1,431	$ 834.26	$27.35
Bayview	2,068,784	2,541	814.16	26.69
Edgecombe	2,841,174	2,931	969.35	31.78
Manhattan	2,858,493	3,096	923.29	30.27
Sheridan	2,683,620	2,785	963.60	31.59
Mid-Hudson	2,610,513	4,183	624.08	20.46
Woodbourne	4,228,705	7,584	557.58	18.28
Queensboro	1,295,331	1,113	1,163.82	38.16
Iroquois	990,488	1,286	770.21	25.25
NACC TOTAL AND AVERAGE	$20,770,928	26,950	$ 770.72	$25.27
Correction Facility				
Albion	328,206	329	997.59	32.71
Great Meadow	2,155,429	5,875	366.88	12.03
Green Haven (NACC)	1,188,247	2,096	566.91	18.59
Green Haven (Prison)	246,583	1,573	156.76	5.14
Matteawan	858,767	1,251	686.46	22.51
Reality House	112,462	(7,448)	15.10	.50
CORRECTION TOTAL AND AVERAGE	$ 4,889,694	11,124	$ 439.56	$14.41
TOTAL AND AVERAGE NACC AND CORRECTION	$25,660,622	38,074	673.97	$22.10
FACILITIES WITH REDUCED OPERATION PENDING PHASE II DEVELOPMENT				
Cross Bay	401,751	14	—	—
Arthurkill	2,050,104	1,149	—	—
Ridge Hill	237,455	-0-	—	—
TOTAL	$2,689,310	1,163	—	—
TOTAL AND AVERAGE	$28,349,932	39,237	$ 722.53	23.69
ALLOCATED TO OTHER STATE AGENCIES				
Social Services	21,500	79	272.15	8.92
Mental Hygiene	$ 1,556,861	2,647	588.16	19.28
GRAND TOTAL	$29,928,293	41,963	$ 713.21	23.38

SOURCE: NACC Budget Office

Exhibit IX
Narcotic Arrests by Drug Type For New York City

Comparison of Total Narcotic Arrests (Includes Felony and Misdemeanor Arrests) 1966-1970

Drug Type	1966 Total Narcotic Arrests	1966 Per Cent of Total	1967 Total Narcotic Arrests	1967 Per Cent of Total	1968 Total Narcotic Arrests	1968 Per Cent of Total	1969 Total Narcotic Arrests	1969 Per Cent of Total	1970 Total Narcotic Arrests	1970 Per Cent of Total
Opium & Derivatives (Heroin & Morphine)	9,055	59.4	9,722	55.3	13,461	60.0	23,698	67.4	38,790	73.9
Cocaine	143	0.9	285	1.6	391	1.8	660	1.9	884	1.7
Cannabis Marijuana & Hashish	3,944	25.9	5,222	29.7	4,695	20.9	5,236	14.9	5,743	11.0
Synthetic Opiates	22	0.2	53	0.3	65	0.3	17	–	27	—
Depressant & Stimulant[1]	1,095	7.2	1,044	5.9	1,197	5.3	1,926	5.5	2,482	4.7
Hallucinogenics[2]	23	0.2	48	0.3	143	0.6	49	0.1	51	0.1
Hypo Syringe, Needles	950	6.2	1,206	6.8	2,476	11.0	3,592	10.2	4,502	8.6
Glue (Offense)	6	—	11	0.1	12	0.1	—	—	—	—
TOTAL	15,238	100.0	17,591	100.0	22,440	100.0	35,178	100.0	52,479	100.0

[1]Effective 1/1/66

[2]Effective 7/1/65

SOURCE: City of New York Police, Statistical Report, Crime Analysis Section, Annual Reports.

Exhibit X
Narcotics Arraignments[1] (1969)
Criminal Court of the City of New York

		Misdemeanors		Felonies[2]
Total Arraignments		20,560		13,374
General Disposition				
(a) Discharged	10,301		2,587	
(b) Transferred	149		39	
(c) Held for Grand Jury	216		4,464	
(d) Convicted	5,210		-	
Totals	15,876		7,090	

Breakdown of (a) - Discharged Cases

	Misdemeanors	Felonies
Acquitted after trial	679	-
Dismissed	5,789	1,599
Dismissed on motion of D.A.	3,761	984
Certified to NACC	72	4
Totals	10,301	2,587

Breakdown of (d) - Misdemeanor Convictions	
(1) Fined	153
(2) Workhouse and Straight Sentences	3,598
(3) Reformatory	11
(4) Certified to NACC	194
(5) Discharged - unconditional	178
(6) Discharged - conditional	660
(7) Probation	416
Total	5,210

Breakdown of (2) - Workhouse and Straight Sentences for Misdemeanors	
1 - 30 days	777
31 - 60 days	646
61 - 90 days	992
over 3 months - 6 months	823
over 6 months - 1 year	352
suspended	7
Total	3,598

[1]Term "narcotics arraignments" includes arraignments for non-narcotic dangerous drug offenses as well as narcotic offenses.

[2]Breakdown of felony convictions not compiled by State Supreme Court.

SOURCE: Annual Reports for 1969.
Criminal Court of the City of N.Y.

Exhibit XI

Narcotic Arrest Statistics for New York City[1]

Comparison of Arrests for Opium and Derivatives
to Total Narcotic Arrests 1966-1970

Total Narcotic Arrests	1965	1966	1967	1968	1969	1970
Total	13,880	15,238	17,591	22,440	35,178	52,479
Heroin		9,055	9,722	13,461	23,698	38,790
Heroin arrests as a % of total	(2)	59.4	55.3	60.0	67.4	73.9
Percent of increase: (over prior year)						
Total Arrests	-	10.0	15.4	27.6	56.8	49.0
Heroin Arrests	-	-	7.4	38.5	76.0	64.5

1 Term "narcotic arrest" includes arrests for non-narcotic dangerous drug offenses as well as arrests for narcotic offenses.

2 Figures not available.

SOURCE: City of New York, Police Statistical Report, Crime Analysis Section, Anr .

Exhibit XII

Legal Status of Persons Certified to NACC

Status	19[illegible] No. of Certificants	19[illegible] % of Total	1969 No. of Certificants	1969 % of Total	1970 No. of Certificants	1970 % of Total	1970* No. of Certificants	1970* % of Total
Total Certificants	3569	100	2335	100	3773	100	3238	100
206 (self)	657	18.4	526	22.5	747	19.8	864	26.7
206 (other)	820	22.9	538	23.1	1525	40.4	1066	32.9
Total Certified in the Civil Courts	1477	41.3	1064	45.6	2272	60.2	1930	59.6
208 (4) (a)	812	22.8	817	35.0	798	21.2	751	23.2
208 (4) (b)	91	2.6	204	8.7	296	7.8	327	10.1
209	17	.5	33	1.4	107	2.8	66	2.0
210	1172	32.8	217	9.3	300	8.0	164	5.1
Total Certified in the Criminal Courts	2092	58.7	1271	54.4	1501	39.8	1308	40.4

*Includes only certifications from April 1-September 30, 1970

SOURCE: NACC Annual Statistical Reports Table 18
Monthly Census reports April-September 1970

Exhibit XIII

Total Narcotics Arraignments*
Criminal Court of the City of New York
1960-1969

Year	Misdemeanors	Felonies	Total
1960	5,696	1,719	7,415
1961	4,734	1,559	6,293
1962	5,088	2,127	7,215
1963	5,766	2,301	8,067
1964	10,557	3,302	13,859
1965	10,137	3,682	13,819
1966	10,538	5,326	15,864
1967	11,670	7,313	18,983
1968	13,456	8,409	21,865
1969	20,560	13,374	33,934

* Term "narcotics arraignments" includes arraignments for non-narcotic dangerous drug offenses as well as arraignments for narcotic offenses.

SOURCE: Annual Report for 1969
Criminal Court of the City of N.Y.

Exhibit XIV

Trends in Narcotic Use: Persons Arrested by New York City Police Who Admit to Using[1] Narcotics[2]

Type of Arrest	1967 Total Arrests	1967 Total Users	1967 % Arrests, Users	1968 Total Arrests	1968 Total Users	1968 % Arrests, Users	1969 Total Arrests	1969 Total Users	1969 % Arrests Users
Felony, Dangerous Drugs	7,199	3,892	54.1	9,626	3,732	38.8	15,431	5,099	33.0
Misdemeanor, Dangerous Drugs	10,381	5,521	53.2	12,802	5,054	39.5	19,747	6,69[illegible]	33.9
Felony plus Misdemeanor, Dangerous Drugs	17,580	9,413	53.5	22,428	8,786	39.2	35,178	11,794	33.5
All Recorded Arrests	163,324	16,779	10.3	187,613	17,039	9.1	228,175	21,786	9.5

[1]An admission of "use is not equivalent to an admission of "addiction," but data in the Statistical Reports (Cf. 1969-1968, p. 13) indicates that 78% of a sample of 2,425 admitted heroin users had a habit of more than one year.

[2]Opiates are the drugs used by 85-90% of those who admit to use (i.e., Statistical Reports employ "narcotic" as a generic term for all dangerous drugs).

SOURCE: Planning Division, City of New York Police, Statistical Report: Narcotics 1969-1968 (n.d.); also, Statistical Report: Narcotics 1968-1967 and Statistical Report: 1967-1966.

Exhibit XV

Employment of Individuals in Aftercare, January and October, 1970

	January		October		Change January to October	
	Number	Per-Cent	Number	Per-Cent	Number	Change in Relative Share
Employed Full-Time (more than 30 hours)	793	39.2	958	31.3	+165	-7.9
Employed Part-Time (30 hours or less)	67	3.3	546	17.8	+479	+14.5
Housewives or Students	108	5.3	457	5.6	+349	+.3
Not Employed	749	37.0	762	33.1	+13	-3.9
Not Reported	307	15.2	338	12.2	+31	-3.0
TOTAL	2,024	100.0	3,061	100.0	+1,037	—

SOURCE: NACC Monthly Statistical Reports

APPENDIX A
CAPITAL CONSTRUCTION

The legislative beginning of NACC construction is found in Chapter 192, Section 26 of the Laws of 1966. This legislation appropriated $75 million out of the general fund to the Mental Hygiene Facilities Improvement Fund for the costs of establishing narcotic addiction rehabilitation centers at the request of NACC. These costs were to include construction, rehabilitation and alteration of buildings, purchase of furnishings and equipment, acquisition of property by purchase, lease, or transfer, and engineering or architectural costs. NACC facilities could include hospitals, withdrawal centers, aftercare clinics, vocational training schools, employment and guidance centers, halfway houses, special housing, vocational training summer camps, research facilities, and automotive equipment centers.

The above legislation was augmented by Chapter 90, Sections 4 and 13, 1967, for $34.7 million and $87.5 million respectively. (Chapter 90, Section 13 was a first instance appropriation.) Considering amounts repealed, the total sum of money appropriated for NACC Capital Construction is presently $159,353,000. Of this approximately $35 million is unallocated.

NACC obtains facilities in the following ways: (1) purchase and renovation or rehabilitation of an existing structure; (2) new construction; (3) operating agreement (e.g., Hart Island, Iroquois Center); and (4) use of other State agency buildings (e.g., Woodbourne Correction, Green Haven). The majority of facilities operated by NACC were obtained by the first two methods of acquisition. A building was either rehabilitated or new construction was completed and that facility was then turned over to NACC for operation.

Playing a crucial role in this area is the Health and Mental Hygiene Facilities Improvement Corporation (HMHFIC). Indeed, it operates as NACC's builder; a responsibility given to it in Chapter 192, Section 26, 1966. Commencing in 1966, the Corporation was faced with deadlines in terms of providing facilities for NACC's use. (Initial facilities were to be ready in October, 1966.) The beginning of the program found little specified in terms of building type: design architecture for a NACC facility was indefinite. Little organized design information was available for facilities to house narcotics treatment programs. Given this situation, HMHFIC turned to under utilized existing facilities for quick renovation and rehabilitation. Construction guidelines were general, incorporating the major areas that were to be provided.

NACC's physical requirements stem basically from the intramural and community based (aftercare) treatment programs. Under the intramural treatment program, NACC provides residential treatment care for certified addicts in its own facilities and others operated by State agencies under contract. An interdisciplinary approach is followed by NACC which finds a physical need for the following activities:

1. Education (classrooms);
2. Vocational rehabilitation (workshops) and work techniques;
3. Individual and group counselling (counselling facilities);
4. Recreation (gymnasium facilities).

The intramural facility, in certain cases, has a bed capacity of 650. The resident population in intramural facilities as of November 1, 1970, was 3,889.

The community based (aftercare) treatment program attempts to prepare addicts for independent community living The aftercare center is generally designed to provide service for 800 addicts; 50 on a residential basis, 150 on a day-care basis, and 600 on field service status. Addicts in residence at a community based center are involved in the same activities as those in treatment facilities; namely education, vocational rehabilitation, counselling, and recreation. Addicts on field service status live at home and either have jobs or are involved in educational or vocational programs in

the community. Witnout detailed architectural treatment, many facilities were established with physical areas "roughed out," anticipating specification and completion as the addiction program required. Many physical difficulties had their origin in this early history.

The realities of operating relationships among organizations involved find NACC working in close partnership with the Division of Budget and HMHFIC. Once the initial decision to establish a facility is made by the NACC chairman, a very detailed procedure for the acquisition and construction of NACC facilities commences. This procedure involves various Division of Budget authorizations, Department of Mental Hygiene acquisition of any real property, and HMHFIC engaging an architect and constructing the facility.

Throughout this process, NACC is involved in approvals of the various steps being taken by others and the requests for continuation. During the design phase of a facility, the policy of HMHFIC is to meet every two weeks at corporation offices in Manhattan to iron out design problems and discuss progress. These meetings have in attendance a NACC representative, generally from the Bureau of Facilities Development. The architect develops a space programming construction cost estimate. NACC and Division of Budget approval of the space program and estimate follow. NACC, on the Division of Budget approval of the space program estimate, requests HMHFIC to issue a construction budget and proceed with the design of the facility. Approval of the final design, made by NACC, results in HMHFIC's bidding on the project. A request of the Division of Budget for allocation for construction of the facility is made by HMHFIC.

The construction is completed by HMHFIC and the facility is then turned over to NACC for operation. Throughout this entire process NACC relies on the Division of Budget and HMHFIC cooperation and involvement to accomplish its own objectives. NACC's facilities development staff serves principally as a monitoring component and coordinator between the three agencies involved in the planning, design and construction of a facility. Upon completion of new construction or rehabilitation of an existing structure, HMHFIC's involvement ceases. The operation and continued maintenance of the facility becomes the responsibility of NACC.

With respect to HMHFIC's involvement regarding the $200 million capital appropriation for drug abuse program, an administrative difficulty is apparent. (Chapter 607, Laws of 1970.) The mechanics of the financing find HFA requiring that capital projects from first instance funds be lined out in the budget. (HMHFIC, Chapter 359, Section 9[illegible].) Though no specific projects have been requested utilizing these funds, NACC intends to proceed in its regular manner dealing with HMHFIC when such a request is made. It is anticipated that HMHFIC would carry the project with capital that had been appropriated on a lump sum basis. Any problem that might result, would then be negotiated with the Division of Budget for deferred payment. NACC, to satisfy the HFA requirement, would line out the project in the deficiency budget. (The youthful drug abuse program is more fully discussed in the preventive education section of this audit.)

Table I
NACC Capital Construction Appropriations

Chapter 192/26/66		$ 75,000,000
repealed -6,802,000		(68,198,000)
Chapter 90/4/67		21,315,000
Chapter 90/4/37		13,440,000
Chapter 90/13/67		87,500,000
repealed -22,500,000		
-16,500,000		(56,400,000)
added + 7,900,000		
Total NACC funds available for capital construction		$159,353,000
Unallocated:		
Chapter 90 (line 047)	$ 9,245,581	
Chapter 90 (line 048)	110,648	
Chapter 90/13	25,905,951	
Chapter 192	164,237	
TOTAL	$35,426,447	

SOURCE: NACC Memorandum, October 22, 1970, "Capital Construction Fund Expenditures."

Table II
NACC Facilities - Costs - Capacity

Facility	Authority	Purpose	Cost	Bed Capacity Treatment	Bed Capacity Special
Albion Rehabilitation Center	Chapter 192	Construction	1,172,111	95	5
	Chapter 90	Design/Const	307,822		
			1,479,933		
Arthur Kill Rehabilitation Center	Chapter 192	Construction	12,046,803	600	50
	Chapter 90	Equip/Const	1,942,802		
	Chapter 90	Acquis/F.S.	1,764,931		
			15,754,536		
Bayview Rehabilitation Center	Chapter 192	Const/Acquis	3,912,389	190	6
	Chapter 90	Equip/Arch	42,639		
			3,955,028		
Brooklyn Central Rehabilitation Center	Chapter 192	Const/Acquis	3,592,905	404	20
	Chapter 90/13	First instance	7,821,021		
			11,413,926		
Cross Bay Methadone Treatment Center	Chapter 192	Acquisition	5,142,763	228	8
	Chapter 90	Architect	17,397		
	Chapter 90	First instance	1,551,399		
			6,711,559		
Edgecombe Rehabilitation Center	Chapter 192	Const/Acquis	4,133,446	50	150
	Chapter 90	Equipment	6,650		
			4,140,096		
Green Haven Rehabilitation Center	Chapter 192	Construction	394,380	186	12
	Chapter 90	Const/Equip	1,826,399		
			2,220,779		
Iroquois Rehabilitation Center	Chapter 90	Equipment	91,390	150	4
	Chapter 50/2/69	Construction	103,119		
	Chapter 90	Heating	2,675		
			197,184		

NACC Facilities - Costs - Capacity (Cont.)

Facility	Authority	Purpose	Cost	Bed Capacity Treatment	Special
Manhattan Rehabilitation Center	Chapter 192	Const/Acquis	6,281,334	375	26
	Chapter 90	Const/Equip	432,526		
			6,713,860		
Masten Park Rehabilitation Center	Chapter 192	Const/Acquis	1,690,038	125	25
	Chapter 90	Equipment	1,615,807		
	Chapter 90	Design/F.S.	223,539		
			3,529,384		
Matteawan Rehabilitation Center	Chapter 192	Construction	1,586,953	133	12
Mid-Hudson Rehabilitation Center	Chapter 90	Elect/Plumbing	60,290	303	16
	Chapter 68/2/68	Elevator	1,344		
			61,634		
Queensboro Rehabilitation Center	Chapter 192	Const/Acquis	3,670,518	207	27
	Chapter 90	Equipment	328,172		
	Chapter 90	Construction	58,759		
			4,057,449		
Ridge Hill Rehabilitation Center	Chapter 192	Const/Acquis	7,152,030	611	85
	Chapter 90/13	First instance	15,919,389		
	Chapter 90/4	Construction	1,605,120		
			24,676,539		
Sheridan Rehabilitation Center	Chapter 192	Const/Acquis	5,769,662	336	30
	Chapter 90	Const/Equip	294,214		
	Chapter 68/2/68	Telephone space	750		
			6,064,626		
Woodbourne Rehabilitation Center	Chapter 192	Construction	680,657	583	58
	Chapter 90	Construction	3,132,715		
			3,813,372		
NACC Testing and Research Lab	Chapter 90	First instance	2,952,698		

NACC Facilities - Costs - Capacity (Cont.)

Facility	Authority	Purpose	Cost
Bushwick Community Based Center	Chapter 90	Equip/Design	159,468
	Chapter 90	Acquis/apprais	2,840,471
			2,999,939
Cooper Community Based Center	Chapter 192	Const/Acquis	3,122,282
	Chapter 90	Equip/F.S./ Scale drawing	73,765
			3,196,047
Fulton Community Based Center	Chapter 192	Acquisition	100,000
	Chapter 90	Equipment	179,081
	Chapter 90	Construction	3,712,271
			3,991,252
Melrose Community Based Center	Chapter 192	Const/Acquis	904,267
	Chapter 90	Architect/Improv.	240,692
	Chapter 90	Construction	1,615,520
			2,760,479
Mt. Morris Community Based Center	Chapter 192	Construction	1,011,036
	Chapter 90	Improv.	16,869
	Chapter 90	First instance	65,920
	Chapter 90	Construction	271,222
			1,365,047

SOURCE: Health and Mental Hygiene Facilities Improvement Corporation, Controller's Office.
NACC Memorandum, "Capital Construction Fund", November 10, 1970
Executive Budget, various years.

APPENDIX B
NEW YORK STATE DRUG CONTROL LAWS AND CRIMINAL OFFENSES

Principal Statutes

The statutory provisions controlling dangerous drugs in New York State and setting forth criminal offenses and penalties are contained, with a few exceptions, in two main bodies of law, Articles 33, 33-A, and 33-B of the Public Health Law and Article 220 of the Penal Law. Articles 33 and 33-A of the Public Health Law contain closely parallel provisions regulating the manufacturers, distributors, and dispensers of narcotic drugs (Art. 33) and depressant and stimulant drugs (Art. 33-A). Articles 33 and 33-A are further implemented by extensive administrative rules and regulations promulgated by the Commissioner of Health pursuant to authority granted to him by Secs. 3302 and 3372 of the Public Health Law.[1] Article 33 is based on the Uniform Narcotic Drug Act approved in 1932 by the National Conference of Commissioners on Uniform State Laws, and was adopted by New York in 1933. All except two states have adopted the Uniform Act in one form or another. Article 33-A dealing with depressant and stimulant drugs is patterned closely after Article 33, and was enacted in 1965. Article 33-B, enacted in 1967, deals with two relatively minor drug offenses.

The other main body of law controlling dangerous drugs is Article 220 of the Penal Law, which sets forth the rather complex structure of criminal penalties for the unlawful possession and sale of dangerous drugs. The complete revision of the Penal Law in 1965, which became effective on September 1, 1967 and resulted in the consolidation of most drug offenses in Article 220, did not substantially change the penalties for drug offenses although it did reorganize the penalties into a uniform, but still complicated, structure.

Besides the two main bodies of law mentioned, miscellaneous drug offenses are included elsewhere in the statutes such as in the Mental Hygiene Law and Article 240 of the Penal Law.

The principal bodies of law mentioned, the Public Health Law and the Penal Law, although largely independent, duplicate one another to some extent and are dependent upon one another in important respects. For instance, the illegal possession or sale of dangerous drugs can be and often is prosecuted as an offense under both the Public Health Law and the Penal Law. Both articles contain the same general statement that a violation of a provision in the article shall be punishable as provided in the Penal Law.[2]

The New York State statutory provisions controlling dangerous drugs should be considered together with the comparable federal statutory provisions, because of the interstate and international character of the dangerous drug traffic and the extensive cooperation among federal, state, and local law enforcement officials.

Administrative and Enforcement Agencies

The agency primarily responsible for administering the regulatory provisions of Articles 33 and 33-A of the Public Health Law is the Bureau of Narcotic Control in the New York State Department of Health. This agency promulgates the administrative rules and regulations on behalf of the Commissioner of Health, as authorized by statute, and processes the applications for licenses and certificates of approval to manufacture, distribute, and dispense narcotic drugs under Article 33 and depressant and stimulant drugs under Article 33-A. Suspected violations of these articles are referred to the special Narcotics Unit in the New York State Police for investigation and possible arrest.

Prior to 1968, the Bureau of Narcotic Control in the Department of Health exercised full enforcement powers by investigating suspected violations and making arrests. In that year, however, a controversy arose over the exercise of full police powers by the Bureau's employees, whereupon the Governor, through a reorganization and budgetary

transfer, shifted enforcement powers to the State Police, even though he was unsuccessful in repealing the statutory provision granting the full powers of a peace officer to representatives of the Commissioner of Health.[3] So the employees of the Bureau of Narcotic Control in the Department of Health still possess nominally the powers of police officers, but the actual investigations and arrests for violations of Articles 33 and 33-A are carried out by the State Police, usually after suspected violations are referred to them by the Bureau of Narcotic Control.

As indicated above, the law enforcement agency at the State level which is primarily responsible for enforcing the criminal laws relating to drug offenses is the New York State Police, especially the special Narcotics Unit in the Bureau of Criminal Investigation.

CONTROL OF NARCOTIC, DEPRESSANT AND STIMULANT DRUGS

The term "narcotic drugs" is defined in Article 33 to include, among others, opium, coca leaves, marihuana, pethadine, and opiates or their compound, manufacture, salt, alkaloid, or derivative.[4] The statue goes on broadly to include every substance, however prepared, which is neither chemically nor physically distinguishable from the named substances. The definition sums up the term "narcotic drugs" as being those designated in the federal narcotic laws and specified in the administrative rules and regulations promulgated by the Commissioner of Health. The classification of drugs comprises a major part of the administrative rules and regulations, and the Commissioner relies on the federal designations in performing this function. Among the well-known drugs classified as narcotic drugs in the rules and regulations are morphine, heroin, cocaine, Demerol, and methadone.[5]

The most controversial inclusion in the above definition of "narcotic drugs" is marihuana. Its classification as a narcotic drug is responsible in large part, of course, for the present severe criminal penalties for its possession and use in Article 220 of the Penal Law.

The term "depressant or stimulant drug" is defined as including the barbiturates, amphetamines, or

> any drug which contains any quantity of a substance which the commissioner, after investigation, has found to have, and by regulation designates as having, a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinatory effect; except that the commissioner shall not designate any substance that is a narcotic drug as defined in article thirty-three of the public health law.[6]

As can be seen, this definition goes beyond the commonly accepted meaning of the term "depressant or stimulant drug", especially insofar as it includes the hallucinogens which are usually classified separately. In effect, the definition is a catch-all for dangerous drugs not controlled by Article 33. Further evidence of this is apparent in checking the classification of depressant and stimulant drugs in the rules and regulations, where one finds, besides the common barbiturates ("downs") and amphetamines ("ups") such well-known hallucinogens as LSD, DMT, mescaline, and peyote.

The Commissioner is authorized to exempt by regulation any depressant or stimulant drug from the application of all or part of Article 33-A if its regulation is not necessary for the protection of the public health.[8]

Basic Statutory Prohibition

All of the controls in Articles 33 and 33-A can be summed up in the following general statutory prohibition which appears in each statute in identical language, except for the kind of drug:

> It shall be unlawful for any person to possess, have under his control, sell, prescribe, administer, dispense or compound any narcotic (depressant or stimulant) drug, except as authorized in this article.[9]

This prohibition encompasses practically all of the potential violations in each statute, covering all the principals who participate in the life of a drug from the manufacturer through the wholesaler or distributor and pharmacist to the physician or hospital and, finally, the individual consumer.

This statutory prohibition ties in directly with the dangerous drug offenses of possession and sale in Article 220 of the Penal Law since the unlawfulness of those offenses is defined in part by reference to Articles 33 and 33-A.[10]

Manufacture and Distribution of Drugs

In order to produce or prepare narcotic, depressant, or stimulant drugs, or to possess or supply them as a manufacturer or wholesaler, a person must obtain a license from the Department of Health.[11] An applicant must furnish satisfactory proof that he is of good moral character and that

he is equipped to carry on properly the business described in his application.[12] Once he has obtained the license and paid the original fee of $25.00, he must register biennially with the Department of Health and pay a fee of $10.00. Licenses may be suspended or revoked for cause by the Commissioner.[13]

A duly licensed manufacturer or wholesaler may sell narcotic, depressant, or stimulant drugs only to those persons who are qualified by law to possess them in connection with a business or profession defined in Article 33 or 33-A, and then only if a written record of the sale is made.[14] A manufacturer who sells or dispenses a narcotic, depressant, or stimulant drug must clearly label the package to show the name and address of the vendor and the quantity, kind, and form of drug contained therein. A wholesaler must do the same if he prepares the package.[15]

Sales of Drugs by Pharmacists

A pharmacist may, in good faith, sell and dispense narcotic, depressant, or stimulant drugs to any person upon a prescription.[16] If the drug is a narcotic, the prescription must be written, although the administrative rules and regulations allow for a telephone order by a physician or other practitioner in an emergency provided that a written prescription is supplied before delivery is made.[17] The statutes impose certain filing, labelling, and other requirements upon the pharmacist.[18] In addition, the rules and regulations spell out in considerable detail various other requirements concerning prescriptions such as who may issue and fill them, manner of filling, restrictions upon refilling and partial filling.[19] Understandably, the requirements concerning narcotic drugs are somewhat more stringent than those for depressant and stimulant drugs.

Article 33 authorizes pharmacists to sell at retail without a physician's prescription certain specified medicinal preparations containing small quantities of narcotics, such as codeine cough syrup, provided that no more than four fluid ounces is sold to any one person on any one day.[20] Several conditions are imposed upon such sales to protect against abuse of the exception.

Violation of Articles 33 or 33-A may be grounds, not only for criminal prosecution under the Penal Law, but also for suspension or revocation of a pharmacist's license to practice his profession. Narcotic addiction by a pharmacist himself is a related ground for suspension or revocation of his license.[21]

Professional Use of Drugs

The extent to which physicians and other professional medical personnel can "treat" narcotic addicts by prescribing narcotic drugs has for a long time been a source of controversy among persons holding different views concerning how to deal with narcotic addiction. Some have contended that narcotic addiction is primarily a medical problem, and, therefore, that doctors should have a relatively free hand in treating addicts according to their honest professional judgement, even if that includes maintaining a confirmed addict on a regular dosage of narcotics. Others have contended that narcotic addiction is primarily a legal or non-medical problem, and, therefore, that maintaining an addict on a regular dosage of narcotics is not proper medical practice, but may constitute instead a violation of the narcotic laws.

Historically, the chief proponent of the latter view was the federal Bureau of Narcotics (now the Bureau of Narcotics and Dangerous Drugs in the U.S. Department of Justice), and its interpretation of the Harrison Anti-Narcotic Act of 1914 through its administrative rules and regulations prevailed to the extent that few doctors ventured to treat addiction by administering narcotics for fear of federal prosecution. The federal Bureau's position remains essentially the same in its current regulation[22] which, under the new federal drug law, continues in effect until modified, superseded, or repealed.[23]

Nonetheless, continuing pressure from members of the medical profession and others appears to be causing stirrings of change at the federal level. Explicit provision is made in the new federal law for the Secretary of Health, Education, and Welfare, after consultation with the Attorney General and national organizations, to determine appropriate methods of professional practice in the medical treatment of narcotic addiction of various classes of narcotic addicts, and to report thereon from time to time to Congress.[24] Moreover, some relaxation of the Bureau's former position is evident in the proposed guidelines for methadone maintenance programs, which were published in June 1970.[25] Reportedly the final version of these rules and regulations will be published soon.

Article 33 of the Public Health Law of New York State is relatively non-committal on the question whether physicians can prescribe narcotics for addicts.

> A physician or a dentist, in good faith and in the course of his professional practice only,

may prescribe, administer and dispense narcotic drugs, or he may cause the same to be administered by a nurse or intern under his direction and supervision.[26]

The Department of Health, however, in rules and regulations promulgated in April 1970, is not non-committal in its interpretation of Sec. 3330.[27] These rules provide that the administration of narcotic drugs to narcotic addicts or habitual users of narcotics is prohibited, except in the following circumstances:

(1) for bona fide patients suffering from incurable diseases;
(2) for aged and infirm, or severely ill, addicts for whom withdrawal of narcotics would be dangerous to life;
(3) to relieve acute withdrawal symptoms—separate rules detail requirements for both institutional withdrawal treatment and for ambulatory withdrawal treatment;
(4) for interim treatment of an addict on a waiting list for admission to a narcotic facility; and
(5) for treatment of addicts certified for an authorized methadone maintenance program—requirements for methadone maintenance programs are set forth in a separate rule.[28]

Both Sec. 3330 and the rules and regulations make clear that a physician or other authorized practitioner, by virtue of his professional license, may prescribe narcotic drugs to non-addicts in the normal course of his practice. Article 33-A contains similar general authority to prescribe depressant or stimulant drugs.[29]

Various housekeeping requirements are imposed upon physicians and other practitioners by the statutes and regulations: using written order forms to order narcotic drugs;[30] labelling container when dispensing drugs;[31] and reporting names and addresses of habitual users of narcotic drugs to Commissioner of Health.[32]

Similar to pharmacists and other professional licensees, physicians risk suspension or revocation of their licenses to practice when they violate the provisions of Articles 33 and 33-A. Also similar to pharmacists and other professionals, physicians may lose their licenses if they are narcotic addicts.[33]

Possession and Use of Drugs by Institutions

A hospital, laboratory, maternity home, maternity hospital, nursing home, convalescent home, or home for the aged may apply to the Department of Health for a certificate of approval for the possession and use of narcotic, depressant, or stimulant drugs.[34] To qualify an applicant must furnish satisfactory proof that he is of good moral character and is equipped to carry on properly the business described in his application.[35] The original fee for the certificate of approval is $10.00, and the fee for biennial registration with the Department is $5.00. The Commissioner may revoke or suspend the certificate of approval for cause.[36]

Possession of Drugs by Individuals

Articles 33 and 33-A each contain relatively brief provisions stating that an individual who has lawfully received a narcotic, depressant, or stimulant drug from a physician or other authorized person may lawfully possess it only in the container in which it was delivered to him by the person selling or dispensing it.[37]

Provisions in each article restricting the possession and control of drugs do not apply to the following categories of persons: common carriers or warehousemen lawfully engaged in transporting or storing drugs; public officers or employees whose official duties require possession or control of drugs; employees or agents of persons lawfully entitled to possession.[38]

Record-Keeping Requirements

Extensive record-keeping requirements are imposed upon virtually all of the persons authorized to handle narcotic, depressant, or stimulant drugs.[39] Such records are required to be kept for a period of two years from the date of the transaction, and to be open to inspection only to federal, state, county, and municipal officers whose duty it is to enforce drug laws.[40] Records of drugs received and disposed play a key role in enforcement of the drug laws, often providing the only evidence or indication of wrongdoing. The interrelationship between state and federal laws is shown by the provision in Articles 33 and 33-A that compliance with federal laws requiring the same information as the state laws constitutes compliance with the state laws.[41]

Enforcement and Penalties

It has already been pointed out that the regulatory provisions of Articles 33 and 33-A are administered and enforced by the Department of Health through its Bureau of Narcotic Control; and that, even though representatives of the Health Department still possess by statute all the powers

of peace officers, such powers are actually exercised by state and local police in enforcing criminal violations of these statutes. Of course, the Health Department employees render assistance to the state and local police in the course of criminal investigations which usually originate with information supplied by the Health Department.

With minor exceptions, neither Article 33 nor Article 33-A sets forth a specific penalty for violation of the article. Each article, however, contains a provision that a violation of the article is punishable as provided in the Penal Law.[42] This provision presents no problem in ascertaining the penalty when the charge is unlawful possession or sale, since the penalties for these charges are spelled out in Article 220 of the Penal Law in terms defined by reference to Articles 33 and 33-A. Criminal possession and sale are the most prevalent drug offenses. If, however, the violation of Articles 33 or 33-A is not criminal possession or sale, then neither the Penal Law nor Articles 33 or 33-A seems to answer the question as to what the penalty is. The complete revision of the Penal Law in 1965 deleted a section in the old Penal Law which established a general penalty for all violations of the Public Health Law, for which no specific punishment was prescribed.[43]

The statutes authorize the seizure, forfeiture, and destruction of narcotic, depressant, or stimulant drugs when their lawful possession cannot be established, or when they have been received or obtained from or by an unauthorized source or means, or their title cannot be ascertained.[44] Article 33 also authorizes the seizure and forfeiture of vehicles, vessels, or aircraft used unlawfully to conceal or transport narcotic drugs.[45]

The interrelationship between state and federal laws, already commented upon, is further illustrated by a provision in each state statute that no person shall be prosecuted for violation of the state law if he has already been prosecuted under the federal laws for an act or omission which would constitute a violation of the state law.[46]

Department of Health's Administrative Functions

There follows a brief summary of the New York State Department of Health's administrative duties and activities under Articles 33 and 33-A. Most of these functions have been mentioned previously, but it may be of some assistance to consolidate them.

(1) *promulgate rules and regulations*, including the classification of narcotic, depressant, and stimulant drugs, relying almost entirely on the federal classifications;
(2) *process applications for licenses and certificates of approval;*
(3) *police licenses and certificate holders* for compliance with statute;
(4) *suspension, revocation, and reinstatement of licenses and certificates of approval;*
(5) *inspect records and premises to insure compliance with statute;*
(6) *refer suspected criminal violations of statute to state and local police for investigation and possible arrest.*

CRIMINAL PENALTIES FOR UNLAWFUL POSSESSION AND SALE

The criminal penalties for the unlawful possession and sale of dangerous drugs are set forth almost entirely in Article 220 of the Penal Law.[47] Statutes fixing penalties for the possession and sale of apparatus used in taking drugs, such as hypodermic needles, are considered latter. With a few relatively minor exceptions, the *use* of a dangerous drug by itself is not a criminal offense. The criminal law reaches the user and others by punishing for the unlawful possession and sale of dangerous drugs.

In the complete revision of the Penal Law accomplished in 1965, the formerly separate and disorganized statutes on criminal possession and sale were brought together in Article 220 and restructured into a unified but complex scheme.[48] Several changes of substance were made, but the main accomplishment was the reorganization of the offenses into two principal ones, each presented in a degree structure: "criminal possession of a dangerous drug" and "criminally selling a dangerous drug." With the 1969 amendments[49] which added two new offenses at the top of each degree structure, there are now six degrees of criminal possession and four degrees of criminal sale. The first degree offense in each structure is the most serious crime and carries the most severe penalty. The degree of the offense in most cases depends upon the kind of drug and the quantity possessed or sold.

The offenses range from criminal possession in the sixth degree (any quantity of any dangerous drug),[50] which is a class A misdemeanor (one year maximum term), to criminal possession or sale in the first degree (16 ounces or more of heroin, morphine, cocaine, or opium),[51] each of which is a

class A felony (mandatory maximum term of life imprisonment). The 1969 amendments for the first time made the most serious drug offenses class A felonies with the mandatory maximum life term. This exactly doubled the total number of class A felonies, since the only ones previously were murder[52] and kidnapping in the first degree.[53] Although the 1969 amendments became effective in September 1, 1969, reportedly no one was sentenced to the mandatory maximum life term for a drug offense until November 1970. The Governor's message approving the 1969 amendments stressed that they were aimed at the large-scale sellers or pushers.[54]

"Dangerous drug" is defined in Article 220 to mean any narcotic drug, depressant or stimulant drug, or hallucinogenic drug.[55] "Narcotic drug" and "depressant or stimulant drug" in turn are defined in terms of their definitions in Sections 3301 and 3371 respectively of the Public Health Law.[56] "Hallucinogenic drug" is defined in terms of its definition in Section 229 (See 429) of the Mental Hygiene Law.[57] There appears to be an inadvertent duplication or overlap with respect to the definition of "hallucinogenic drug" since the term "depressant or stimulant drug" is defined broadly enough in Section 3371 of the Public Health Law to include hallucinogenic drugs. Marihuana is included in the definition of "narcotic drug" in the Public Health Law. The definitions show the interdependence between Article 220 of the Penal Law and Articles 33 and 33-A of the Public Health Law and how the Department of Health's classification of new drugs in its rules and regulations affects the criminal penalties for unlawful possession and sale.

This interdependence is further evident in the definition of "unlawfully" in Article 220. "Unlawfully" is defined to mean in violation of Articles 33, 33-A, or 33-B of the Public Health Law or Section 229 (See 429) of the Mental Hygiene Law.[58] A person is not guilty of any possession or sale offense in Article 220 unless he "knowingly and unlawfully" possesses or sells the dangerous drug in question.

In those offenses in Article 220 in which the degree of the crime depends upon the quantity of the drug possessed or sold, it is worth noting that no minimum percentage of the pure dangerous drug is required. These sections only require that the total matter or substance in question satisfy the quantity requirement and that it contain *some* of the dangerous drug. One of the provisions in the former Penal Law[59] required that the substance contain at least one per centum of the dangerous drug. This requirement was eliminated in the revision because of the time-consuming quantitative analysis needed in addition to the usual qualitative analysis made to determine the presence of the narcotic drug. Moreover, a study showed that only a small percentage of samples contained less than one per centum of the narcotic drug.[60]

Offenses For Unlawful Possession

Following are the six degrees of criminal possession set forth in Article 220 of the Penal Law arranged from least serious to most serious:[61]

Degree	Quantity and Other Requirements	Classification of Crime
Sixth degree (Sec. 220.05)	any quantity of any dangerous drug	class A misdemeanor (one year maximum)
Fifth degree (Sec. 220.10)	any quantity of any dangerous drug plus intent to sell the same	class E felony (four years maximum)
Fourth degree (Sec. 220.15)	(a) any quantity of any narcotic drug plus intent to sell the same; or (b) following quantities of different narcotic drugs: marihuana (cannabis, sativa) — 25 cigarettes or more or ¼ ounce or more; heroin, morphine, or cocaine — 1/8 ounce or more; opium — ½ ounce or more; other narcotic drugs — ½ ounce or more	class D felony (seven years maximum)

Degree	Quantity and Other Requirements	Classification of Crime
Third degree (Sec. 220.20)	following quantities of different narcotic drugs: marihuana (cannabis, sativa) — 100 or more cigarettes or 1 or more ounces; heroin, morphine, or cocaine — 1 or more ounces; opium — 2 or more ounces; other narcotic drugs — 2 or more ounces	class C felony (fifteen years maximum)
Second degree (Sec. 220.22)	8 ounces or more of heroin, morphine, cocaine, or opium	class B felony (twenty-five years maximum)
First degree (Sec. 220.23)	16 ounces or more of heroin, morphine, cocaine, or opium	class A felony (mandatory maximum of life imprisonment)

As stated before, all of the foregoing quantity requirements are satisfied if the substance possessed contains any of the dangerous drugs mentioned.

The unlawful possession of all dangerous drugs other than narcotic drugs — i.e., depressant, stimulant, or hallucinogenic drugs — is punishable only under Section 220.05 (sixth degree) or 220.10 (fifth degree) since the first four degrees apply only to narcotic drugs. Hence a four-year prison sentence is the maximum possible punishment for unlawful possession of any non-narcotic drug, no matter what the quantity.

Although a person unlawfully possessing any quantity of any narcotic drug with an intent to sell it normally is charged at least with a fourth degree offense (Sec. 220.15) carrying a possible maximum sentence of seven years imprisonment, the fifth and sixth degree offenses are worded broadly enough to be convenient lesser offenses for purposes of plea bargaining which is extensive in this area of the criminal law.

The only statutory presumption in Article 220 provides that every person in an automobile containing a dangerous drug is presumed to knowingly possess it, except that the presumption does not apply: (a) to a duly licensed operator for hire; (b) when one person, who is not under duress, lawfully possesses the drug; or (c) when the drug is concealed upon the person of one of the occupants.[62]

Offenses For Unlawful Sale of Dangerous Drugs

The definition of "sell" goes well beyond the ordinary meaning of the word.

> "Sell" means to sell, exchange, give or dispose of to another, or to offer or agree to do the same.[63]

Practically any transfer qualifies as a sale under this definition.

On the following page are the four degrees of criminal sale of dangerous drugs set forth in Article 220 of the Penal Law arranged from least serious to most serious.[64]

As stated before, both of the foregoing quantity requirements are satisfied if the substance sold contains some of the drug mentioned.

It is quickly evident that the unlawful sale of small quantities of any dangerous drug is more severely punished than the unlawful possession of similar or even larger quantities. Similarly, the unlawful sale of a small quantity of any narcotic drug (Sec. 220.35) carries a potential penalty more than twice as severe as the intent to sell the same quantity of the same narcotic drug (Sec. 220.15). At the first and second degree levels, however, the quantity requirements and the potential penalties are the same.

Criminal Penalties for Unlawful Possession and Sale of Marihuana

Perhaps the greatest controversy concerning the criminal penalty structure of Article 220 relates to the penalties for the unlawful possession and sale of marihuana. No extensive discussion of the State laws relating to marihuana is undertaken here as this subject has been studied and reported on by the Temporary State Commission to Evaluate the State Drug Laws.

Degree	Quantity and Other Requirements	Classification of Crime
Fourth degree (Sec. 220.30)	any quantity of any dangerous drug	class D felony (seven years maximum)
Third degree (Sec. 220.35)	any quantity of any narcotic drug	class C felony (fifteen years maximum)
Second degree (Sec. 220.40)	(a) sells any quantity of any narcotic drug to a person under 21; or (b) sells 8 ounces or more of heroin, morphine, cocaine, or opium	class B felony (twenty-five years maximum)
First degree (Sec. 220.44)	16 ounces or more of heroin, morphine, cocaine, or opium	class A felony (mandatory maximum of life imprisonment)

As noted above, marihuana is included in the definition of "narcotic drug" in Article 33 of the Public Health Law, which, of course, means that the unlawful possession and sale of marihuana subjects the offender to the more serious penalties attaching to narcotic offenses generally. For example, the possession of even a small quantity of marihuana with the intent to sell, give, exchange, etc., bears a potential prison sentence of seven years.[65] If a person acts on that intent and gives or otherwise transfers even a single marihuana cigarette to another person, he becomes subject to a possible prison sentence of fifteen years![66] It is not difficult to understand why these offenses are not being enforced in many areas.

Another perspective on the marihuana penalties is to compare them with penalties imposed for the unlawful possession and sale of depressant, stimulant, and hallucinogenic drugs. Most drug experts consider potent hallucinogenic drugs such as LSD, and even many of the so-called "soft drugs" such as the barbiturates and amphetamines, more dangerous than marihuana. Yet the sale of one marihuana cigarette risks a prison sentence of fifteen years,[67] whereas the sale of a large quantity of LSD or one of the "soft drugs" is punishable by a maximum prison sentence of seven years![68] Whether or not one believes that the marihuana penalties are too high, one must agree that the relative penalties for marihuana and some of the more potent depressant, stimulant, and hallucinogenic drugs are out of balance.

The classification of marihuana as a narcotic drug in the Public Health Law stems from earlier federal laws which lumped marihuana together with the narcotic drugs. The new comprehensive federal drug legislation still classifies marihuana in Schedule I of the controlled substances together with narcotic drugs such as heroin, but it reduces considerably the penalties for possession and sale by treating it as a non-narcotic drug for punishment purposes.[69] Moreover, the new law establishes a commission to study the marihuana laws and to make a report with recommendations in one year.[70] In the last two or three years, many states, including New Jersey, have reduced the penalties for possession and sale of marihuana, particularly for first offenders.[71]

Miscellaneous Drug Offenses

In addition to the main control scheme in Articles 33 and 33-A of the Public Health Law and the basic penalty structure for the unlawful possession and sale of dangerous drugs in Article 220 of the Penal Law, there are a number of miscellaneous drug offenses located in those articles and elsewhere in the statutes. Some of these provisions duplicate or overlap one another or the provisions in the Public Health Law or the Penal Law already discussed; others are distinct. Most of these miscellaneous offenses are narrow in scope and do not need further explanation. Hence, only a couple of these offenses will be discussed at any length.

These miscellaneous drug offenses include the following:

(1) *Smoking or inhaling opium, or possessing opium pipe or other apparatus for smoking or inhaling opium.*[72] Punishable as provided in the Penal Law.[73] This is one of the rare

statutes making *use* of a dangerous drug by itself a criminal offense. As stated above, most statutes penalize only the *possession* or *sale* of the drug.

(2) *Unlawful possession or sale of hypodermic syringe or needle; or unlawful possession of other instrument for administering narcotic drugs.*[74] Punishable as a class A misdemeanor (one year maximum).[75] According to drug arrest figures prepared by the New York City Police Department, arrests for this offense during the last three years (1968, 1969, and first 9 months of 1970) amount to approximately 10% of the total drug arrests and rank third behind arrests for the possession and sale of heroin and marihuana.[76] Of course, many arrests for the possession or sale of hypodermic instruments probably occur at the same time as arrests for the possession or sale of heroin.

(3) *"Glue sniffing" statute* — unlawful inhalation, use, possession, or sale of glue containing a solvent having the property of releasing toxic vapors or fumes.[77] Sale is punishable as a class A misdemeanor (one year maximum); other offenses are punishable as violations, with a maximum imprisonment of five days and/or a $50.00 fine.[78]

(4) *Growing marihuana without a license.*[79] Punishable as a class A misdemeanor (one year maximum).[80]

(5) *Operation of motor vehicle while ability is impaired by use of a drug.*[81] "Drug" is defined in the Vehicle and Traffic Law to include a depressant, hallucinogenic, narcotic, or stimulant drug essentially as these drugs are designated by the Commissioner of Health under Article 33 and 33-A of the Public Health Law.[82] First offense punishable as unclassified misdemeanor,[83] with a maximum imprisonment of one year and/or $500.00 fine. Second offense punishable as class E felony (four years maximum).[84] Any person who operates a motor vehicle in the State is deemed by law to have given his consent to a chemical test of his breath, blood, urine, or saliva for the purpose of determining the alcoholic or drug content of his blood.[85] If a person is convicted of operating a motor vehicle while his ability is impaired by the use of a drug, his driver's license *must* be revoked and his certificate of registration as an owner *may* be revoked.[86]

(6) *Piloting an aircraft, or serving as a member of the crew, while under the influence of drugs.*[87] This statute also prohibits carrying any person in an aircraft who is obviously under the influence of drugs, except a medical patient under proper care or in case of emergency. Punishable as an unclassified misdemeanor,[88] with a maximum sentence of 90 days and/or a fine of $100.00.

(7) *Operation of a snowmobile while under the influence of narcotics or drugs.*[89] Punishable as a violation with a fine of not less than $5.00 and not more than $100.00.[90]

(8) *Knowingly permitting a child less than 18 years old to enter or remain in a place where illegal narcotics activity is maintained or conducted.*[91] Punishable as a class B misdemeanor (three months maximum imprisonment).

(9) *Loitering for purpose of unlawfully using or possessing a dangerous drug.*[92] Punishable as a class B misdemeanor (three months maximum sentence). This offense is discussed below.

Loitering for Purpose of Using or Possessing Dangerous Drug

The offense of loitering for the purpose of using or possessing a dangerous drug deserves further discussion because arrests for this offense constitute such a large proportion of narcotics and drug arrests in New York City, and the overwhelming number of arrests for this offense are dismissed by the district attorneys. On September 1, 1968 the classification of the loitering offense was raised from a violation (15 days maximum) to a class B misdemeanor (three months maximum). Arrest figures compiled by the New York City Police Department show that there were 33,078 drug arrests on misdemeanor charges in 1969, including 13,304 arrests for loitering. Arrest statistics for the first nine months of 1970 show that both of these figures had already been exceeded.[93] It is estimated that 85-90 percent of the loitering charges are dismissed.[94]

Why do the police make so many arrests for loitering, and why are so many of the charges dismissed? Several reasons have been given. To understand better the position of the police, one should realize the extent of public pressure brought upon them to remove the pushers and addicts from the streets and public places. Police officials stated that the principal and continuing

complaint of the public relates to the public presence of pushers and addicts on the street corners, sidewalks, and public portions of buildings. Charges for unlawful possession and sale based simply on observance of the presence and transfer of drugs from a distance have been difficult to prove in court, and many of such cases have been dismissed. The best way to make such cases is by undercover work in which the policeman or undercover agent makes a purchase from a pusher of drugs. But, undercover work takes time and does not really cope with the public scene described. Under the circumstances, a loitering charge is a natural temptation to the police. Even if the charges are dismissed, the immediate objective of clearing the streets is accomplished.

Whatever the reasons for the vast number of loitering arrests, the New York City Police Department apparently has become convinced that the loitering law was being misapplied, and has issued new guidelines advising the police on how to apply the law.[95] The three-page departmental directive sent to all police commanders stated that the City's prosecutors had reported that

> the vast majority of arrests under Section 240.36 of the Penal Law do not meet the minimum requirements of the statute and consequently do not make out a prima facie case.
>
> Arrests not meeting such standards have been characterized as unwarranted and unlawful by the District Attorneys.[96]

The order stated that the new guidelines were being issued

> to assure the protection of the rights of citizens, to avoid court congestion by eliminating arrests which do not make a prima facie case, to fully cooperate with the District Attorneys of New York City and to conserve Police Department man-hours.[97]

The directive went on to specify the elements that must be present before a policeman can make an arrest for loitering for the purpose of using or possessing a dangerous drug.

> Intention may be inferred only from the presence of dangerous drugs or paraphernalia commonly associated with dangerous drugs, such as a bottle cap, eye dropper, empty glassine envelope, etc., and accompanying circumstances excluding every possibility except intent to use or possess a dangerous drug.
>
> No person should be arrested unless the circumstances are such to exclude every possible reason for his presence except such intent.[98]

Addiction or Excessive Drug Use As Grounds for Revocation or Suspension of Professional Licenses

Closely akin to the criminal penalties considered above is the civil penalty of having one's state or local license to practice a particular profession or business revoked or suspended on account of narcotic addiction or excessive drug use. Although civil in nature, such penalty can be as severe or more severe than a criminal penalty. Several statutes make narcotic addiction or habitual use of a habit-forming drug grounds for revocation or suspension of a license to practice a particular profession or to conduct a particular business.

(a) narcotic addiction as grounds for revocation or suspension:
  (1) physician, osteopath, or physiotherapist;[99]
  (2) pharmacy;[100]
  (3) nursing;[101]
  (4) podiatrist.[102]

(b) habitual use of a habit-forming drug as grounds for revocation or suspension:
  (1) hairdressing and cosmetology or conducting a beauty parlor;[103]
  (2) barbering or conducting a barber shop.[104]

FOOTNOTES FOR APPENDIX ON N. Y. STATE DRUG LAWS

[1] N. Y. Codes, Rules and Regulations, Title 10, Secs. 80.1-80.72 (narcotic control); 81.1-81.92 (depressant and stimulant drug control).

[2] Public Health Law, Secs. 3354(2), 3393(2).

[3] Public Health Law, Sec. 3350(3).

[4] Sec. 3301(38).

[5] N. Y. Codes, Rules and Regulations, Title 10, Sec. 80.48.

[6] Sec. 3371(1).

[7] N. Y. Codes, Rules and Regulations, Title 10, Sec. 81.48.

[8] Sec. 3374.

[9] Secs. 3305, 3373.

[10] Penal Law, Sec. 220.00(6).

[11] Secs. 3310, 3375.

[12] Secs. 3312, 3377.

[13] Secs. 3313, 3378.

[14] Secs. 3320, 3380.

[15] Secs. 3325(1), 3383(1).

[16] Secs. 3322, 3381.

[17] N. Y. Codes, Rules and Regulations, Title 10, Sec. 80.31.

[18] Secs. 3322, 3325(2), 3381, 3383(2).

[19] N. Y. Codes, Rules and Regulations, Title 10, Secs. 80.25-80.33 (narcotics), 8125-8132 (depressants and stimulants).

[20] Sec. 3324.

[21] Education Law, Sec. 6804(1)

[22] Code of Federal Regulations, Title 26, Sec. 151.392.

[23] Pub. Law 91-513, Sec. 705.

[24] Pub. Law 91-513, Sec. 4.

[25] Federal Register, Vol. 35, No. 113 -- Thurs., June 11, 1970, p. 9015.

[26] Sec. 3330.

[27] N. Y. Codes, Rules and Regulations, Title 10, Secs. 80.17-80.23.

[28] *Ibid.*, Sec. 80.19.

[29] Sec. 3385.

[30] N. Y. Codes, Rules and Regulations, Title 10, Sec. 80.15.

[31] Secs. 3325(3), 3383(3).

[32] Sec. 3344.

[33] Education Law, Sec. 6514(2)(b), (c).

[34] Secs. 3311, 3376.

[35] Secs. 3312, 3377.

[36] Secs. 3313, 3378.

[37] Secs. 3331, 3386.

[38] Secs. 3332, 3387.

[39] Secs. 3333, 3388; N. Y. Codes, Rules and Regulations, Title 10, Secs. 81.80-81.87.

[40] Secs. 3334, 3389.

[41] Secs. 3333(9), 3888(7)

[42] Secs. 3354(2), 3393(2).

[43] Penal Law of 1909, Sec. 1740.

[44] Secs. 3352, 3392.

[45] Sec. 3353.

[46] Secs. 3354(3), 3393(3). See *People ex rel Liss v Superintendent of Women's Prison* 282 N. Y. 115, 25 N. E. 2d 869 (1940)

[47] For two exceptions, see Public Health Law, Sec. 3396 ("glue sniffing") and Mental Hygiene Law, Sec. 229 (See 429) (hallucinogenic drugs).

[48] See Practice Commentary for Article 220 in McKinney's Consolidated Laws.

[49] Chs. 787 and 788, Laws of 1969.

[50] Penal Law, Sec. 220.05.

[51] Penal Law, Secs. 220.23, 220.44.

[52] Penal Law, Sec. 125.25.

[53] Penal Law, Sec. 135.25.

[54] For the Governor's message, see McKinney's Session Laws, 1969, Vol. 2, p. 2560.

[55] Penal Law, Sec. 220.00(4).

[56] Penal Law, Sec. 220.00(1), (2). See discussion above.

[57] Penal Law, Sec. 220.00(3).

[58] Penal Law, Sec. 200.00(6).

[59] Penal Law of 1909, Sec. 1751(3).

[60] See Practice Commentary for Sec. 220.15 of the Penal Law in McKinney's Consolidated Laws.

[61] For a complete table of drug offenses arranged by drug and quantity, see Sentence Chart VI in McKinney's Consolidated Laws of New York Annotated, Book 39, Penal Law, 1970-1971 Cumulative Annual Pocket Part, pp. 21-22.

[62] Penal Law, Sec. 220.25.

[63] Penal Law, Sec. 220.00(5).

[64] See complete table of drug offenses referred to in note 61 *supra*.

[65] Penal Law, Sec. 220.15.

[66] Penal Law, Sec. 220.35.

[67] *Id.*

[68] Penal Law, Sec. 220.30.

[69] Pub. Law 91-513, 84 Stat. 1236, Secs. 202, 401.

[70] *Ibid.*, Sec. 601.

[71] See N. Y. Times, November 1, 1970.

[72] Public Health Law, Sec. 3343.

[73] Public Health Law, Sec. 3354(2).

[74] Public Health Law, Sec. 3395; Penal Law, Sec. 220.45.

[75] See Penal Law, Sec. 55.10(2)(b).

[76] See Exhibit IX.

[77] Public Health Law, Sec. 3396.

[78] See Penal Law, Sec. 55.10.

[79] Public Health Law, Sec. 3315.

[80] See Penal Law, Sec. 55.10(2)(b).

[81] Vehicle and Traffic Law, Sec. 1192(4).

[82] Vehicle and Traffic Law, Sec. 114-a.

[83] See Penal Law, Sec. 55.10(2)(c).

[84] See Penal Law, Sec. 55.10(1).

[85] Vehicle and Traffic Law, Sec. 1194.

[86] Vehicle and Traffic Law, Sec. 510(2)(a)(iii).

[87] General Business Law, Sec. 245(7).

[88] See Penal Law, Sec. 55.10(2)(c).

[89] Conservation Law, Sec. 8-0303(1)(c). This statute refers to Sec. 114-a of the Vehicle and Traffic Law for the definition of "drug."

[90] Conservation Law, Sec. 8-0409.

[91] Penal Law, Sec. 260.20(2).

[92] Penal Law, Sec. 240.36.

[93] See Statistical Reports prepared by Planning Division of Crime Analysis Section of New York City Police Department.

[94] See N. Y. Times, November 2, 1970, p. 43.

[95] *Id.*

[96] *Id.*

[97] *Id.*

[98] *Id.*

[99] Education Law, Sec. 6514(2)(c).

[100] Education Law, Sec. 6804(1).

[101] Education Law, Sec. 6911(1)(i).

[102] Education Law, Sec. 7011(1)(c).

[103] General Business Law, Sec. 409(a).

[104] General Business Law, Sec. 441(a)(3).

APPENDIX C
AGENCY RESPONSE

Preliminary draft copies of the program audit, Narcotic Drug Control in New York State, were sent to the agencies primarily involved, the Narcotic Addiction Control Commission and the State Education Department with the request that they make whatever corrections or comments they considered appropriate. Subsequent to the receipt of this information, either changes were made in the text of the report or the comments are included in the pages which follow. This assistance from the agencies involved is indeed appreciated.

No attempt has been made to carry on a debate with the agencies concerning the merits of all the comments. The objective of the audit is to provide material which will be of most assistance in the legislative process. Differences in analysis of materials or degrees of emphasis are frequent where individuals are involved and occasional decisions may be based on "facts" which are not weighted equally by all who view them. This is indigenous to the dynamics of government.

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE OF THE PRESIDENT OF THE UNIVERSITY
AND COMMISSIONER OF EDUCATION
ALBANY, NEW YORK 12224

Friday
March 5
19 71

The Honorable Warren M. Anderson
Chairman, Legislative Commission
on Expenditure Review
111 Washington Avenue
Albany, New York 12210

COPY

Dear Senator Anderson:

In mid-February, Mr. Troy R. Westmeyer, Director of the Legislative Commission, sent me a draft copy of the report on narcotics control. We thank you for the opportunity to make the following comments on the draft copy.

We have commented in three ways. First, in the main body of this letter, I summarize the accomplishments of the State Education Department's Drug Education Program and comment on the overall quality of this study. No summary appears in the study and I believe it is important to have a short statement relating the resources available to the accomplishments. In Attachment A to the letter, we have comments on those portions of the report which deal explicitly with programs administered by this Department. In Attachment B to the letter, we comment briefly on other portions of the report which do not involve our Department as the primary administrator. It is our understanding that you will want to publish the comments of the agencies as part of the final report. We suggest that the letter and both Attachments A and B be published.

We are pleased to report progress in implementing our five-part Drug Education Program. These accomplishments have been made within a very difficult time frame. Even though a lump sum appropriation of $2 million for The Interagency Drug Information Program was made in April of 1970, the allocation to our Department of $1.1 million was not received until June 25, 1970. This made it extremely difficult to launch summer training programs.

Our programs are reaching these targets: (1) 875 individuals were trained in Summer School-Community Team Workshops; (2) Inservice Training of 7500 elementary and secondary teachers is being accomplished this school year through 150 trainers whom we have trained; (3) In-depth Training for 189 health educators was completed last summer and 100 additional individuals are presently in training; (4) College Volunteer Programs are operating on 11 campuses with 300 volunteers participating; and, (5) guidelines and curricular materials are being provided to the elementary and secondary schools of the state. In addition, this same staff has been and is now offering technical assistance and reviewing project applications for educational projects as part of the $65 million program for Youthful Drug Abuse. These programs have been administered by a full-time staff of six persons in the Department.

We commend the Commission staff for its second report. The narrative is clear and understandable. We would suggest that you include a summary section at the close of each chapter as you did in the Manpower Report. In addition, as we suggested in our previous response, it would be useful if the report included recommendations.

Again, thank you for the opportunity to review and comment on your study.

Faithfully yours,

Ewald B. Nyquist

Attachments

cc: Troy R. Westmeyer

ATTACHMENT A

COMMENTS ON PROGRAMS ADMINISTERED BY THE STATE EDUCATION DEPARTMENT

1. On page 60 regarding an erroneous description of "Strand II", we suggest the following substitute: "At the outset the State Education Department was concerned with the development of curriculum for Sociological Health Problems (Strand II) with substrands on alcohol, tobacco and drugs. The curriculum utilized a conceptual framework and espoused a student-centered classroom orientation and peer approach. The National Clearinghouse on Drugs has selected Strand II of the New York State curriculum as one of two outstanding state curricula that they are disseminating nationally. The selection of the New York State materials was made for the National Clearinghouse by an inter-disciplinary group of nationally recognized professionals in the drug area. Current efforts to update Strand II are budgeted at $30,000 and are aimed at improving a good piece of curriculum to make it even better."
2. On page 60, there is a statement that we have reversed our objectives regarding the teaching program for health educators; we feel that the following clarification is necessary. There has been no reversal of the original intent in the training programs for non-health teachers. The retraining of certified teachers is an important initial step in the task of preparing an adequate supply of qualified health instructors. The State requirement that subsidized teachers would have to be involved in two or more health courses in the school was for the purpose of allowing the schools to utilize the services of the newly trained personnel as quickly as possible in a much needed curriculum area.
   Because of limitations of staff availability at the institutions that conducted the program, and the fact that other institutions which might have participated were not prepared to do so, the summer training of the original number of teachers was not possible. The 81 that were trained plus the 60 currently in training was very close to the original number planned.

   Therefore, the fourth paragraph on page 60 should read: "This past summer, 189 teachers were involved in the program and plans are underway to begin the training of additional teachers during the 1970-71 school year. The ultimate objective is to place in each school a person with the expertise of the educator and the content background of a health professional. The State, after September, introduced the additional stipulation that money for the training courses continue to be paid to teachers who had begun their training only if they were involved in two or more health courses a week in their particular school. Requests by teachers to be included in this program have been rapidly increasing, and the State Education Department is seeking to expand the current program by adding six more institutions of higher education to the current six institutions so that there would be a total of 12 institutions of higher education involved with this program. Budget permitting, this program can be easily doubled if not tripled and considerably augment the ranks of qualified health instructors."
3. On page 60, there is a statement "The teachers already trained are not having the impact that was originally projected." Based on our follow-up, we feel that the number of school districts that have not promoted local inservice programs has been minimal. A follow-up is being done to determine why the school administrators made a commitment to send someone for such training and then inhibit the use of such personnel. On the other hand, in the majority of school districts the grant for the use of the trainers is such that the number of teachers to be reached by this program may exceed original estimates.
4. On page 61, the following is provided for clarification purposes regarding the section on school-community workshops.
   The school-community workshop program was not handled by just one organization (Educational Dynamics) as indicated in the report. The various workshops were handled by Syracuse University, the State University College at Plattsburgh, the Title III Unit in New York City, as well as the Educational Dynamics Corporation.

   As far as attempting to evaluate the exact effect and impact of the trained school-community teams on their particular communities, there are no instantaneous cures in drug abuse prevention. However, observations expressed in the submitted workshop reports include the statement that programs developed in the various communities represented were a direct result of workshop inputs. Workshop participants were utilized in many ways such as consultants for organizing and implementing drug abuse preven-

tion programs and panel members for inservice workshops.

5. On page 61 of the draft report, the Commission staff imply a criticism in that the College Volunteer Program has only funded one program in New York City. We are presently supporting one program in Staten Island Community College and anticipate contracting with Pace College in the coming year. The reason for not having more programs is that colleges in that environment are more concerned with rehabilitation and treatment programs than with prevention. Since their interest is such programs, we have centered our efforts on assisting them in getting projects approved through the $65 million program for Youthful Drug Abuse.
6. Page 61 of the.he report indicates that the College Volunteer Program is limited. It must be understood that at the time we began this program there were only ten campuses that were either effectively organized or ready to organize such a program. The development of the programs has been very careful and deliberate. We estimated that we would have 10-20 campuses and 300+ volunteers. In fact, there are 11 campuses with 300 volunteers.
7. On page 61, the staff appears to be questioning the assumptions underlying local projects. It is extremely difficult to establish an easily identifiable pattern or profile of a potential drug user. There is little doubt that the need for peer acceptance and for socialization are important contributing factors in drug use. It is also understandable that youngsters feel more able to communicate with their peers to discuss the problems that trouble them, such as war, poverty, marriage, etc., that are germane to the problem of drug abuse. The peer group technique is effective because students can relate to one another and not have the emotional tensions of the parent/child or teacher/student situation.

   If teaching were simply a matter of imparting information, the educator's task would be relatively simple. Teachers today must be aware of "their students" needs, fears, expectations, capabilities and acquire, through training, a variety of student-centered approaches that will help their youngsters develop positive attitudes and effective modes of behavior for solving their problems in today's complex society.
8. Under the section on Evaluation of the State Education Department Programs, in the last paragraph there is the indication of a prospective 25-fold increase in funding. While this Department hopes this is true, the only indication it has thus far is that the program will be maintained at the previous year's funding level of $1.1 million. The statement, "that any educational program be carefully planned and tested before it is implemented statewide", implies that education programs of this kind have never been in practice in New York State. We have, in fact, had some 25 years of experience with various programs around the State serving as models. This would seem to be sufficient basis for the extension of this program to all schools in the State.
9. On page 8 of the draft report, it is suggested that the following be added for clarification purposes: Second from last paragraph beginning "Since 1966, not only NACC... "add" The Critical Health Problems Law, Chapter 737 of the Laws of 1967 allocated only $200,000 to the State Education Department to support drug education activities, an inadequate sum for a vast undertaking. In 1970-71 the sum of $1.1 million was allocated to the State Education Department, indication of the growing awareness that preventive education for youth should be a major thrust of the total State program."

ATTACHMENT B

COMMENTS ON PROGRAMS NOT ADMINISTERED BY THE STATE EDUCATION DEPARTMENT

1. *Vocational Rehabilitation Portion of NACC's Program*

On page 34 of the draft report, mention is made of the vocational rehabilitation portion of the NACC's Program. Since the Education Department has had such a successful program in this area, NACC has been in touch with us regarding their efforts. They indicate that they lack the capacity to offer a full range of occupational training activities and also the ability to follow up with the individual after he is released from their institutions. Presently, the Education Department is cooperating with NACC in two areas by offering a program for approximately 60 individuals. We would like to expand our programs in this area by housing our counselors in their facilities as we are beginning to do with the Department of Mental Hygiene. The main problem prohibiting us from moving faster is the lack of State funds.

2. *NACC's Education Program*

On page 58 of the draft report the NACC's educational program is discussed. Since their program is prevention oriented as is ours, natural overlap is bound to occur with the State Education Department's program which has the same objective. There is a need, we feel, for a well-focused, comprehensive, and singularly administrated program that addresses the needs of all individuals be they school age, college, adults or parents. Since we already deal with all of these groups and the evidence in the draft report seems to indicate a need for such a comprehensive program, we feel that a consolidation of programs should be considered at this time.

3. *Youthful Drug Abuse Treatment Program*

a. On page iv of the report, the last paragraph is erroneous. It should read: The changes in guidelines to permit a portion of the $65 million NACC appropriation for Youthful Drug Abuse Treatment Program for preventive educational programs in the schools have now, by agreement with NACC, given the Department added responsibility in cooperating with NACC in providing assistance in the development of effective school-community education programs for prevention of drug abuse and in review of applications for such programs. The State Education Department programs have been directed primarily at elementary and secondary school students, and parent and adult education. The focus is on curriculum development, teaching technique development and teacher-training programs in narcotics education.

b. On page 62, the report criticizes the quality of the local educational programs being funded from the $65 million. By agreement with NACC all school drug abuse prevention programs included in proposals submitted to NACC for funding under the $65 million allocation are meant to be reviewed by the State Education Department. Of the proposals are found wanting in any way, the State Education Department notifies NACC and confers with local schools and assists them in developing acceptable proposals. No proposal is recommended by the Department to NACC unless it is well conceived. The Department role is advisory. Decisions are made by NACC.

STATE OF NEW YORK

NARCOTIC ADDICTION CONTROL COMMISSION

EXECUTIVE PARK SOUTH
ALBANY, NEW YORK 12203

MILTON LUGER
CHAIRMAN

March 5, 1971

COPY

Mr. Troy R. Westmeyer
Director
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Westmeyer:

Enclosed is a preliminary response to the Program Audit prepared by the Legislative Commission on Expenditure Review. It is preliminary in the sense that it does not represent a "finished" typing job, nor does it represent a complete reaction to the document. It is expected that additional comments with regard to law enforcement and the courts, as well as specific clarifications and comments on fiscal and other statistical data will be forwarded to you on Monday, March 8, 1971.

It was decided to forward this preliminary response to you today in order that your staff could initiate the review of our reactions as soon as possible.

Sincerely,

Milton Luger
Chairman

ML/pmc

STATE OF NEW YORK
NARCOTIC ADDICTION CONTROL COMMISSION
EXECUTIVE PARK SOUTH
ALBANY, NEW YORK 12203

RAYMOND WICKHAM
FIRST DEPUTY COMMISSIONER

March 8, 1971

COPY

Mr. Troy R. Westmeyer
Director
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Westmeyer:

As indicated in Milton Luger's letter to you dated March 5, I am forwarding additional materials relative to your Commission's report on the Narcotic Addiction Control Commission.

Because of public interest engendered by reports by the New York County District Attorney and Mayor Lindsay's Coordinating Council on Criminal Justice, which focused on the certification process, Mr. Luger requested the Commission's Counsel to prepare an in-depth commentary on Chapter IV of your report, "Certification of Addicts." This commentary and a detailed statement on fiscal and statistical data are enclosed.

Staff members of this Commission are prepared to meet with members of your staff to furnish any additional comment and clarification which you may require.

Sincerely,

Raymond Wickham
First Deputy Commissioner

RW/pmc

REACTIONS TO THE REPORT OF THE LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW

The Report of the Legislative Commission on Expenditure Review is, by and large, a fair and balanced summary which makes for informative and interesting reading. Since the Preface indicates that the report is designed to provide the Legislative Commission with information as to the *current* status and progress of New York State's existing programs dealing with narcotics and other dangerous drugs," it is essential that some of the points made by the report be clarified if it is to represent an accurate and up-to-date description of what NACC is doing today.

The positions taken represent several different orders of inaccuracy. Specifically:

1) Some sections of the report reflect the operation of NACC as of a year ago or even as recently as a half year ago, but do not adequately convey the "current status of activity." It would be important, therefore, for the report to be updated so that it describes what is, in fact, operational today.
2) Other areas do not adequately present the rationale under which NACC is operating. This is expecially true in relation to the kinds of treatment services encompassed by the program: the impression conveyed, for example, is that it is largely a matter of levels of security, that there is only slight variation from facility to facility. The fact is that a very different rationale is being pursued -- namely that of the multi-modality, comprehensive approach to treatment, which would encompass the NACC components, as well as a wide range of funded and accredited agencies in the community, a point which will be clarified in the material which follows.
3) A motif which recurs throughout the report pertains to the lack of knowledge which prevails in the addiction field. While this lack of knowledge reflects the "state of the art" everywhere - it is at times presented as if it were an individual shortcoming of the NACC program. NACC is well aware of the knowledge gaps which exist and is laboring to fill in these lacunae as expeditiously as possible.
4) There are sections which present a very distorted picture and need to be corrected. This is especially true of the discussion of Methadone maintenance.

Need for Updating of the Report

The impression conveyed by the report is that no provision has been built into the NACC treatment program for evaluation both of its own program and those of the funded agencies. Nothing could be further from the truth at this point since the basis for very careful evaluation and follow-up has been laid. In fact, neither the primary data system nor the required reports from the private agencies can be characterized as providing a lack of "hard data other than basic demographic statistics."

The following is a description of the Commission's statistical system which has unique components far exceeding typical demographic systems:

1) NACC Primary Data System - The current NACC data system has four interrelated components which characterize the addiction-rehabilitation-outcome process. These four components... the intake personal history, the intramural involvement/ adjustment history permit the Commission to describe its program participants, its interventions and the outcomes of these efforts more fully than any other large scale system. Models for such a system did not exist in 1966 nor could one have been constructed without the accumulation of experience servicing clients in a compulsory civil commitment program and without the acquisition and wedding of mature systems developers and professional drug researchers/clinicians. The significant elements within each of the four components are as follows:
   a) Personal History (Intake)
      Age; sex; ethnicity, place of birth; permanent residence; occupation; social security number; marital status; education; religion; previous treatment history; arrest history; drug use history; medical history; etc.
   b) Intramural Involvement Adjustment
      Duration and extent of individual counseling and group counseling; indices of emotional state and psychiatric disorder; assessments of interpersonal relations, ability to work with others and reactions to adverse situations: histories of behavior on passes and work release programs; assessments of the level of understanding of past behaviors; assessments of various psychosexual factors; results from educational and vocational testings; I.Q.; pre-release plans; any un-

usual incidents; prognosis; etc.

c) Aftercare Adjustment

Every three months, reports are forwarded for each rehabilitant which include the amount and types of contacts; the reporting schedule and record; an indication of involvement in NACC sponsored programs; current residence; residential situation; employment situation; drug usage (suspected, reported and/or confirmed); arrest situation; etc.

d) Follow-up

The NACC system has been defined to include a follow-up of *all* decertified clients through the major data systems in the state, i.e., NYSIIS; Mental Hygiene; etc. In addition, all decertified individuals will be "at risk" for a physical follow-up which will assess the client's major role constellations: work, family, criminality, drugs, peers, etc.

At the present time, five scientists and four support staff (cut of 25 1/2 positions in the Narcotic Control Commission's research bureau) have the maintenance of these systems and the analyses of the data which has been outlined, as their primary tasks. While not all of the four components were fully operational at the time of the Legislative Commission on Expenditure Review survey, components "a" and "b" were operational, "c" was in a pretest phase and "d" was designed and discussed with the legislative commission's investigators.

Standardized psychological testing for all newly-certified addicts began 3/1/71 and will be a significant addition to component "b". A social psychological battery is undergoing a pretest which includes aspiration and motivation scales for possible use as future screening discriminators.

2) Funded Agency Data Inputs - The current reporting forms required of all private agencies receiving monies from NACC reflect major revisions instituted more than six months ago. These revisions were made in collaboration with research directors from some of the larger agencies specifically to get beyond the collection of bookkeeping statistics.

In addition to the standard demographic attributes (age, sex,race, etc.), the revised intake forms pursue with some depth the drug history, treatment history and criminal involvement of the clients. At the time of termination, the agencies prepare a form indicating the various types and extent of services provided the client.

These two data inputs provide the base for the statistical evaluation of each agency's efforts. These two new inputs became necessary when an initial statistical evaluation was attempted and found lacking.

It would appear appropriate to indicate that the Commission's evaluation of these agencies shortly will include three additional components: the completion of a standardized questionnaire by each agency wherein they can indicate their perceptions of their service, any uniquenesses which it may contain and the successes/problems they have encountered; the physical follow-up of a sample of their successes/failures by bureau of research scientists (its standard follow-up procedures and instruments will be utilized); and a team of independent non-aligned observors will assist in the review of all three sets of data and in determining levels and types of outcomes.

3) Multi-modality Rationale—In evaluating programs a major NACC mission is the development of a comprehensive treatment approach with a variety of modalities and a determination of which individuals will have the highest probability of success in which program. The primary data system instituted will provide a basis for the eventual realization of this goal and the development of objective effective criteria for the screening and referral of patients. This mission has been reinforced by placing clients within definable cohorts by comparable exposures. Thus, the Commission's research bureau is currently following the careers of rehabilitants in a number of cohorts such as those described below, which will be compared with all other cohorts:

a) All rehabilitants released to the aftercare phase during each six month period become a cohort, and each cohort is compared with all others.

b) Rehabilitants have been randomly placed in the intramural program, the half-way house program and directly to aftercare thereby becoming cohorts who received initial exposure at various places on the "continuum of care" provided by the Commission.

c) Individuals have been placed in the Methadone maintenance modality with a highly selective protocol and with no selection criteria.

d) All age, sex, race and types of drug user groups become standardized cohorts.
e) Rehabilitants have been placed in cohorts defined by treatment attributes; length of time in the intramural phase, amount of formal therapy/counseling, etc.

Analytic techniques include multivarient, factor, configural, correlational and process analyses. In brief, an appropriate data system has been defined and isolated comparative cohorts established as a basis for accumulating the analytical skills to accomplish the mission of delineating the appropriate modalities for different kinds of clients.

Areas Requiring Further Clarification

On Page 36, the report mentions that "it is difficult to consider the NACC treatment and rehabilitation programs as composed of several separate and distinct treatment modalities. It would be more accurate to think of NACC's treatment improvements as a broad continuum ranging from the highly structured and very secure setting of a NACC—Department of Correction interdisciplinary approach in operation in several correctional institutions to the relatively open and work-oriented program at the Iroquois Rehabilitation Center at Medina. All other treatment programs conducted at intramural facilities are located along this continuum and vary in the "mix" of counseling, vocational and educational training and recreational activities and in the security of the facility."

While a treatment continuum does exist, the report's emphasis misrepresents the actual rationale by which NACC is being guided. As indicated earlier, the goal being pursued is that of a comprehensive, multi-modality approach to treatment increasingly being accepted by various programs throughout the country—including those operated or funded by the NIMH, the State of California, the cities of Chicago and New Haven and others—as the "model" approach to treatment today. In brief, this rationale derives from the concept that there is no such universal as "the addict", but rather a variety of addicts with differing social and psychological characteristics and varying ages, ethnic and class backgrounds, stages of involvement in the addiction system and states of readiness for help. The evaluation strategy is to determine what characteristics, psychological and social, lend themselves to help under the different treatment approaches, and to develop objective criteria for the eventual screening and referral of all patients. After an initial interview, a patient would be referred to the treatment modality best equipped to help him—whether a residential center, religious approach, narcotics antagonist, Methadone maintenance or any other technique or combination of techniques, depending on the patient's needs. This rationale insures the development of a comprehensive approach which draws upon the entire range of treatment programs. It also ensures that the various approaches can end the internecine struggle which has existed in the past.

NACC is implementing this approach today since it encompasses a variety of modalities not only within the State program itself, but by funding other modalities such as ex-addict-directed therapeutic communities, day centers, semi-religious approaches, cyclazocine and other narcotics antagonists, programs for youthful drug abusers, Methadone maintenance and various out-patient centers.

The report suggests that effective programs for treating addicts do not exist. This is not true, to start with, and the issue is more complex. Under the multi-modality approach, it is apparent that not every treatment modality will be of equal weight: that is, patients will find certain modalities more acceptable than others. This has indeed been true in the case of Methadone maintenance and less so in the case of therapeutic communities which entail a long commitment to communal living away from the community. This need not interfere with our schema for developing screening criteria nor undermine our rationale since, even if an approach is effective with only 5-10% of the addict population, it may still be the treatment of choice for some and should be continued. This was true, for example, of the Christian Damascus Church in the South Bronx several years ago, which proved to be particularly effective with lower class or lower-middle class Puerto Rican patients amenable to a Fundamentalist Pentecostal religious approach. Cyclazocine was effective with "hidden drug abusers", i.e. middle-class, motivated patients; and we need to learn how to extend its effectiveness to other segments of the addict population. Some modalities with limited application might be appropriate to sustain even if its costly to do so on a unit basis.

Areas Reflective of the General "State of the Art" Rather Than of Specific Individual NACC Problems

As the report indicates, the primary public concern for many years was with the narcotics problem alone—perhaps because it constituted a primary social problem contributing to the inner-city decay and "crime in the streets." It is only

very recently, in 1965, that the Federal Government enacted control legislation regulating soft drugs; and that we began to address ourselves to the question of devising creative and innovative programs for such users. It would be helpful if the report stressed that the number of programs in the country specifically directed to these "new areas" of soft drug abuse and the problem of younger drug abusers can be counted on the fingers of one hand.

Another aspect to be stressed is the fact that new problems are emerging continually; apart from the abuse of newer drugs such as doriden, valmid, darvon, etc. new species of drug abusers emerge continuously—such as the multiple drug user who is abusing a variety of drugs including heroin. Although the original mandate for the State "*Narcotics* Addiction Control Commission" was primarily for narcotics, room was left open for educational and preventive approaches in relation to the soft drugs. The NACC has moved strongly into the area of soft drug abuse and has been encouraging, through education and funding, the development of innovative programs, with evaluation built in to determine their effectiveness and gain experience and knowledge. The field of prevention and education reflects the same lack of understanding of how to develop effective educational programs. Until very recently, the emphasis was largely on scare techniques, which it is now agreed do not act as a deterrent and often have a "boomerang effect."

The Commission's bureau of program planning has been actively engaged in preparing position statements in the areas of soft drug and youthful drug abuse as well as preventive education and thinking through a range of programs to deal with them. Through a variety of publications by various staff members, public attention is being directed to the seriousness of these problems and how the development of needed programs might be facilitated.

Another area in which blame seems to be directed to NACC, but which reflects the prevailing state of knowledge nationally is that of incidence and prevalence data. Unfortunately, little attention was devoted to accumulating such data until recently, and we are only now beginning to come to closer grips with this. NACC has been aware of the need to obtain this data for the State and has just completed a major epidemiological assessment of all types of drug use within the general population. The data from this survey are being analyzed and will be available very shortly for public dissemination.

Accuracy of Presentation

There are positions assumed in the report with which the Commission would differ—as in the discussion of Methadone maintenance; and we shall outline our questions seriatim:

1) On page 51, it is stated that "the Methadone program is probably the most controversial approach to the problem of narcotics addiction currently being tried in this country. The controversial nature of the Methadone Treatment stems primarily from the fact that Methadone itself is an addictive drug. . ." This statement, as it stands, is misleading since there are aspects of Methadone programming which are still controversial or better a matter for further research; and others which are well established, and it would be important to make those distinctions. In terms of a broad public health approach, for example, we believe it can be said that Methadone maintenance is by far the most effective treatment approach devised for hard-core, long-term narcotic addicts since it has helped a high percentage to give up their heroin addiction and return to productive social functioning. In saying this, an attempt is not being made to represent Methadone maintenance as an "ideal" program since it is questionable that there are any ideal programs. The importance of Methadone maintenance nevertheless looms large, the more so, perhaps, because the therapeutic communities, as the report itself indicates, have not fulfilled the hopes held out for them and have returned only very small numbers of rehabilitated patients to the community.
2) On page 52, the report confuses the issues by failing to distinguish sufficiently between non-tolerant individuals and addicts stabilized on Methadone. It stresses the danger of making individuals dependent on large doses of Methadone and deplores the withdrawal syndrome which occurs if the drug is not received. The report does not specify that every Methadone program explains to patients that Methadone is, in itself, a synthetic narcotic and that when used for maintenance purposes it creates a state of narcotic dependence. Further, the withdrawal syndrome from Methadone does not constitute a serious problem, particularly if compared to barbiturate or alcohol withdrawal. Indeed, since 1953, the Public Health Service Hospitals and every other reputable detoxification

facility have used Methadone as the drug of choice to withdraw addicts from opiates since it is the most moderate and mildest drug available for this purpose.

3) On page 52, it is stated that the "dependence producing property of Methadone dictates this result (patients continuing in the program). It must be remembered that physical dependence forces them to remain in the program just as physical dependence on heroin causes them to seek illicit narcotics." This represents a misunderstanding and false emphasis in that one of the primary problems in treating addicts has been retaining them in program. Methadone does indeed become a powerful structuring device for keeping patients in treatment to the point where they become fully engaged and are able to function satisfactorily. Indeed, the use of "rational authority", a concept implicit in the application of civil commitment procedures, constitutes a recognition of the "lack of motivation" and apathy of many addicts and the need to provide powerful incentives and structuring to help them come into and remain in treatment. In short, what is a plus in Methadone treatment emerges as a negative in the report.

4) Re toxicity, etc. the report does not mention that part of the research of every Methadone program calls for periodic liver and blood studies to insure that there are no long-term physical or toxic effects from the drug. It might be added that addicts are known who used Methadone as their exclusive drug of choice for from 10 to 15 years with no toxic or other untoward long-term effects observed.

5) Regarding the role of ancillary treatment services, the Beth Israel complex and other programs following this model, on the basis of their clinical experience, are aware of at least three categories of patients in Methadone who require different kinds of service. Up to a third may respond to Methadone alone with a small assist; the large middle section, probably the majority, need more intensive individual counseling and group therapy; and some 20% as the report indicates, seem to represent the sociopathic hard core who require more intensive help. NACC staff have conceptualized a "multimodality" approach to Methadone treatment in which more flexible use may be made of Methadone, ranging from a first step of ambulatory or in-patient detoxification, to low-dose, to high-dose Methadone, to a combined therapeutic community-Methadone maintenance facility, and approaches which build in rational authority if required. Such programs already exist both in Chicago and at the Bronx State Hospital. By building in evaluation, it is hoped to learn what Methadone approach can be most helpful for particular kinds of patients and what ancillary services need to be provided for these different categories.

6) The report states—"It has been suggested that the ex-addict would be more useful and his role clearer if, in addition to his experience, he had formal training in counseling, vocational training, or in the social and behavioral sciences." And further "Still other people have suggested that the ex-addict is not a proven success so long as he is in the narcotics treatment field because he has not left the program. . .The critics maintain that, in order to be successful, the addict must seek a job outside the narcotics rehabilitation profession even if only for a few years."

To comment on this question: the NACC program does not have any guided belief in the "ex-addict mystique". Ex-addicts, like other staff, need to be screened and used very carefully in relation to the particular setting and program where they will be used in terms of the individual qualifications they bring to treatment. For example, we have questions about the role ex-addicts are playing in education and prevention; great selectivity is required to ensure that erroneous information is not being imparted and that they do not serve as a model of having led a dangerous and glamorous life.

However, there is fairly general agreement that ex-addicts can play an important role in treatment. The need for ex-addicts is abetted by the fact that middle-class professionals often do not know how to talk to lower class, minority groups and have different concepts of time, goals, and standards. Ex-addicts who are graduates of particular programs represent these programs ably since they have been through it themselves and offer visable evidence of its effectiveness. In the Beth Israel complex, the "Ras" (Research Assistants) serve as role models but are also felt to have special antennae and sensitivity to patients which professionals, especially those without experience, can lean on and use effectively until they themselves

acquire more expertise. They are also "bridges" between professionals and patients. Graduates of ex-addict directed therapeutic communities carry out the "concept" and may also be experienced as leaders of "encounters" as well as in the overall management of a therapeutic community program. While it is important to help addicts find their way out of the "addiction system" and back to the conventional world, it is important to understand the benefits inherent in their remaining in the system and helping others. The sociological concept of differential association stresses that in the process of helping others, you may be helping yourself as well. It thus becomes an essential ingredient of the addict's own rehabilitation. It is our feeling that this is a valid concept and that it helps reinforce the rehabilitation of addicts in the later phases of treatment. This idea is built into the therapeutic community "concept." The directly operated NACC program provides similar opportunities to qualified former narcotic abusers.

7) On page iv it is stated that "Methadone maintenance gained acceptance because it maintained records, control and follow-up". This is a surprising statement and hardly a reason for its widespread acceptance. Historically, the Methadone program evolved gradually, starting with a small group of carefully observed and controlled patients, then expanding and by now proliferating greatly as indicated earlier. It has become an important treatment of choice for many hard core drug addicts and seems to be most acceptable to them for a variety of reasons, including the fact that it does not involve any long-term commitment to a residential center for two years or more. The patient can be stabilized very quickly within a six week period. Increasingly, this is being accomplished on an ambulatory basis so that he can remain within the community. The real reasons for Methadone success, therefore, have to do with the programs' effectiveness and acceptability rather than with records, control and follow-up, which are alien to the understanding and interest of most addicts.

8) Some of the statistics which the report utilizes are erroneous. They apparently were based on the NACC monthly statistical report which is a preliminary document, is never current, and must be used with that understanding. For example, the legislative commission on expenditure review cites that, during the first six months of 1970, the rate of criminal certifications was 5.5% of the total. More complete statistics reveal that it actually ran from 30-40% which is fairly constant and consistent with the previous year. Other statistical statements are in error. It is indicated on page 37 that there are 2-3 month delays before patients are moved from intramural facilities to aftercare. This has rarely been the case, unless we consider the point where staff first initiated a request for pre-release information. There is no such delay in actual movement. Elsewhere, the average intramural stay formerly is cited as from 9-15 months. Rarely has a stay reached 15 months. The average intramural stay formerly was 10.2 months. The NACC employment statistics used in the report are incomplete and do not reflect the actual situation in July 31, 1970. At that time 61% of NACC rehabilitants were constructively occupied or employed full-time.

9) The report, in addressing vocational issues, fails to include a discussion of aftercare placement services and on-going relationships with NYSES, MDTA, MCDA, DVR, etc.

10) The report indicates that the funded agencies have had their money allocations increased without adequate evaluation of their programs, and lists the budget of the Beth Israel Methadone Maintenance Program, along with others, to help make the point. Demonstration grant increases mostly reflect increased operational costs for maintaining the program at its prior level. The large expansion of Beth Israel funds reflects a commitment to expand Methadone services in response to data accumulated. In addition, the funded agencies have been under continuous review although it is conceded that the rapid expansion of Methadone maintenance and the youthful drug abuser program during the period which coincided with the legislative commission review greatly taxed NACC field staff and limited the intensity of their contact with the agencies they oversee.

Conclusion

This discussion has attempted to delineate a number of areas in which it was felt the report to the Legislative Commission on Expenditure Review was misleading or else failed to reflect what is actually operational or projected in the Narcotic Commission today. It is hoped that the various points discussed will allow for a more accurate

picture of the *current* status and progress of the NACC program to be presented.

COMMENTS ON CHAPTER IV "CERTIFICATION OF ADDICTS" OF THE PROGRAM AUDIT REPORT OF LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW

General Comments

sically, the report writers have accepted the position, which is broadly about, that NACC is part of the Criminal Justice System. By so doing the failures of that system attorn to the Commission as though it were a cause of its failures. We can only be characterized as part of the Criminal Justice System if we are considered a dispositional resource of the system. However, such a characterization is improper. NACC is a treatment agency and not a dispositional resource, for, if we were the latter, then the caveat spelled out by the Court of Appeals in the Fuller decision, to wit:

> "If compulsory commitment turns out in fact to be a veneer for an extended jail term and is not fully a developed and comprehensive effective scheme, it will have lost its claim to be a project devoted solely to curative ends. It will take on the characteristics of normal jail sentence, with a side order of special help. The moment that the program begins to serve the traditional purposes of criminal punishment, such as deterrence, preventive detention, or retribution, then the extended denial of liberty is simply no different from a prison sentence. . ." People v. Fuller 24 N.Y. 2d 292, pp 302-303

would become operative, and the stringent requirement applicable to a criminal will be applicable to the certification process. It is the fact that we are not part of the Criminal Justice System which permits the certification process to be less stringent than the criminal trial process.

Specific Comments

Page iv.

The comparison of the initial expenditure $21,000,000 to the $50,000,000 in 1969-70, without a corresponding statement as to the number of addicts under care between the years in question tends to create the unfortunate impression that costs have increased without a corresponding increase in services.

Pages 20 through top of 21 concerning Medical Examinations.

This entire section of the report should be modified in order to again provide certain needed background by which the statements therein, though sometimes attributed to others, can be placed in proper perspective. The adequacy or inacequacy of medical examinations does not depend, as the impression is created, solely upon the quality or the number of doctors available. The deficiency of the medical examination process are stated to be: (a) insufficiency of the medical report because it does not include urinalysis: and (b) reliance upon the statements of the alleged addict. What the report should state is that, except in those rare instances where a physician can observe withdrawal, there is practically no other absolute proof of addiction. Urinalysis, unless the sample is taken within 48 hours of ingestion of an opiate drug, will not provide supporting evidence. A positive finding is merely proof of use within the past 48 hours. As noted at page 6 of the report of the Mayor's Criminal Justice Coordinating Council "(a) about a third of the people who died from overdose last year, some of them immediately upon injecting heroin, had negative urinalysis." Granted that the presence of a positive finding coupled with the physical examination evidence of track marks and perhaps an admission by the addict would provide adequate evidence for determining addiction, the point to be made is that the absence of a positive urinalysis is not conclusive evidence of non-addiction. Therefore, the question to be raised is: should a urinalysis be made for all persons examined even though we can predict, with reasonable certainty, that in a great number of cases the urinalysis will be negative?. We can have such certainty whenever the sample would be taken more than 48 hours after possible injection. This is particularly true with respect to the individual who has been detained after arrest and whose order for a medical examination is made more than 48 hours after the start of detention.

On the issue of whether the doctors should place reliance upon the statements of the alleged addict, the question to be raised is what else is available? If withdrawal is not observed by the physician, then the remaining potential sources of evidence are: the addict himself; a positive urinalysis; track-marks; and testimony of those including correction officers who may have observed the alleged addict undergo withdrawal. For the arrested alleged addict the testimony of others, relatives, friends, or correction officers is usually not sought. This lack

may explain why civil certification proceedings, where such testimony, usually from the petitioner exists, has a better success rate. The observations contained in the report may be engendered by the discrepancy between accepted common knowledge of widespread addiction, and the failure of proof in a particular situation.

In other sections of the report a contrast is made between those arrested for dangerous drug offenses and those who are admitted users. Necessarily since the report also talks about the number of persons who are certified as addict the comparison or grounds for comparison is thereby planted. It is an unfortunate ground for comparison. For admitted users are not admitted addicts; nor are admitted users all admitted heroin users. A factor which should be pointed out concerning the physicians employed by NACC to conduct medical examination is that they have more than one year on the job experience, and as indicated in the table attached to the Mayor's Criminal Justice Coordinating Council's report, during the first nine months of 1970 the percentage of those examined and found addicted by the doctors rose from a low of 35.2% to 62.9% in September whereas the highest rate during the entire year of 1968 was 38.9%.

Pages 23 through top of 24

This section contains certain major data errors. The conclusions and characterizations drawn from the erroneous data are of course regrettable. If the data used by the report writers was derived from the monthly statistical reports prepared by the Commission, especially the old ones, then we must share part of the blame for the errors. It is to the credit of the Expenditure Review Commission therefore that it has submitted its draft report to us for comment.

Page 26, Waiting Period For Admission to NACC Facilities.

This section with its reliance upon the data developed by the Mayor's Coordinating Council almost refutes the information and the data used in other sections to demonstrate the alleged breakdown of the criminal certification process. Furthermore, since the Coordinating Council was making a case, reliance upon its data will carry the selectivity bias of that group. The presence of a large number of certified addicts in the Houses of Detention does not necessarily mean that they have been there for months and months as the Coordinating Council would like people to believe. A study of the subjects in the Houses of Detention from April 1 through December 31, 1970, indicates that whereas the average stay after certification was 50 days in the April-June quarter it dropped to 25 days in the October-December quarter despite an increase in the number of persons certified. Further, whereas 7.5% were moved within the first 15 days during the April-June quarter, 32.1% were moved within the first 15 days of certification in October-December quarter. It should also be noted that not only did the percentage rise but the raw number also went up from 22 in the April-June quarter to 172 in the October-December quarter. Furthermore, the average stay developed through this analysis did not exclude the period between the date of certification and the actual date we were notified that an individual was certified, which averaged 4 days—it took 80 days before we were notified for one individual—nor did the computation of average stay exclude those periods during which a certified individual was held because he was recovered in the infirmary, or because another commitment order was outstanding which precluded a NACC pick-up. Attached hereto is a table showing the average stay in days of those certified addicts who were held by the New York City Correction Department during the period April through December 1970.

Page 26

This item indicates that NACC agreed to reduce the number of those detained with a view to "phasing them out entirely". NACC never agreed to a complete phase-out because no substitute detention facility is available for NACC to use. It should also be pointed out that for the days the individuals are cared for by the City Correction Department we have agreed to pay at the usual $5.00 per day rate. Furthermore we have established an orientation program through our own team of counsellors to provide services to persons being detained pending their assignment to full treatment placement. We have done so at Rikers' Island and have suggested to Commissioner McGrath that, if it can be arranged, we will do the same for the individuals held at the various Houses of Detention, even though we would prefer one location. We are informed that adequate space may be available at Rikers.

Page 27

Table 3 should be amended to include figures for December and January which would reflect NACC's effort to alleviate the situation as presented.

Page 36

It should be noted that since the time when visits were made to facilities, practically all shops are substantially completed and equipped.

Page 37

It should be noted that the reasons for variations in caseloads include large numbers of unfilled vacancies and assignment of personnel to other than directed aftercare facilities.

Page 38

It should be noted that since the preparation of the report, NACC has established a sampling policy for urine testing.

New York State
Narcotic Addiction Control Commission

LENGTH OF STAY FOR CERTIFIED SUBJECTS IN NEW YORK CITY HOUSES OF DETENTION FROM DATE OF CERTIFICATION TO DATE OF ADMISSION TO NACC PROGRAM*

For the Period April 1, 1970 thru December 31, 1970

NUMBER OF DAYS	TOTAL SUBJECTS FOR THE PERIOD		DATE OF CERTIFICATION 1970 April 1 - June 30		1970 July 1 - Sept 30		1970 Oct. 1 - Dec. 31	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Subjects	1212	100.0	294	100.0	382	100.0	536	100.0
15 Days or Less	274	22.6	22	7.5	80	21.0	172	32.1
16 Days or More	938	77.4	272	92.5	302	79.0	364	67.9
Average Stay in Days	34		50		35		25	

* Information contained in this report does not: (1) exclude the periods between dates of certification and actual dates of notice to NACC that subjects were certified.

(2) exclude periods during which certified subjects were being held for other court actions which precluded pick-up by NACC.

PREPARED BY: NACC Bureau of Management Information Services Date: March 3, 1971