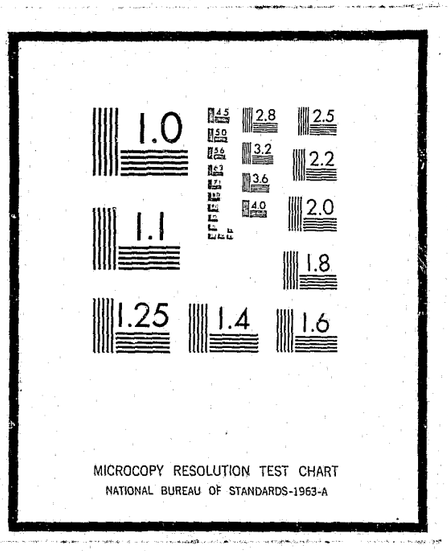

A STUDY OF NARCOTICS-ADDICTED OFFENDERS AT THE D.C. JAIL

1971

Final Report

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A STUDY OF NARCOTICS ADDICTED OFFENDERS AT THE D.C. JAIL*

A study was conducted at the D.C. Jail between January 18 and January 30, 1971 in an effort to assess the parameters of heroin use in the District of Columbia. Findings of the study are based on responses to interview schedules personally administered by a team of research assistants.

METHOD

Interview schedules were completed on the total population of 150 new admissions admitted to the D.C. Jail during the time the study was conducted. In addition, urine specimens were collected from 133 of those interviewed. Seventeen of the new offenders attempted but were unable to produce urine specimens. All interviews were completed and all urines taken within 24 hours of admission to the Jail.

*The authors wish to acknowledge the contributions of Charles Rodgers, Superintendent of the D.C. Jail, and his staff for their cooperation and assistance in this study and to the research assistants for their unremitting effort to collect data under extraordinary conditions.

RESULTS

Drug Use

Among the 150 offenders interviewed, 68 percent were identified as heroin users. Forty-seven percent admitted using heroin and being addicted to it, i.e. using heroin daily for at least two weeks. An additional 21 percent admitted using heroin on a non-daily basis but reported they were not addicted to it. Three percent of the total sample - 4 offenders - reported never having used heroin, but had positive urinalysis results for morphine and/or quinine the components of heroin (Table 1).[1] Thus, 47 percent of all persons admitted to the D.C. Jail can be described as addicted to heroin and an additional 21 percent can be described as periodic heroin users -- "chippers" (Table 1a).

Among offenders not-using heroin, 17 percent reported themselves as having used drugs at some time in the past (Table 2). Of these, most (7 of 8) had first used marijuana. At the same time, slightly more than half of the addicts and almost two-thirds of the chippers stated that marijuana was the first drug they had ever used. However, about two-fifths of the addicts and one-third of the chippers started with heroin.

Marijuana: The majority of self-reported addicts (73%) had used marijuana, most (57%) had used it prior to their nineteenth birthday (Tables 3 and 3a). Similarly, 63 percent of the offenders chipping had used marijuana before they turned 19 years old. Of those using marijuana, more than half of the offenders addicted and two-thirds of the offenders chipping reported themselves still to be using marijuana at least once a week (Table 3b). Of marijuana users, twenty-seven percent of those

[1]The 4 offenders reporting never having used heroin, but producing positive urinalysis for the components of heroin, were excluded from the data analysis due to the unreliability of their reports.

addicted and 23 percent of those chipping had used marijuana within the 48 hours prior to their arrest (Table 3c).[2] Moreover, 16 percent of the self-reported addicts and 14 percent of the chippers who smoke marijuana had consumed one stick or more within 24 hours of arrest (Tables 3d and 3e).

Cocaine: Only 4 percent of the non-using offenders had ever used cocaine. Seventy-one percent of the self-reported addicts and 44 percent of the chippers had used cocaine (Table 4). Typically, use was initiated prior to their 22nd birthday (Table 4a). Of those using cocaine about two-thirds of the addicts and one-half of the chippers reported having used it at least once a week (Table 4b). Thirty-two percent of the addicts using cocaine had used it within 48 hours prior to arrest (Table 4c). Almost one-fourth of these addicts had used cocaine within 24 hours of arrest (Table 4d). Of these, the majority used two bags of cocaine or more (Table 4e).

Amphetamines: Amphetamines have been used by 23 percent of the self-reported addicts, 16 percent of the chippers, and 4 percent of the offenders not-using (Table 5). Like cocaine, amphetamines were usually first tried before the user had reached 22 years of age (Table 5a). Forty percent of the addicts using amphetamines do so on a daily basis (Table 5b). Notably, 33 percent of those addicts using amphetamines had consumed two caps or more within 24 hours of arrest (Tables 5c, 5d, and 5e).

Opiates: Nine percent of the self-reported addicts and 13 percent of the chippers admitted having used opiates (other than heroin or methadone gotten illicitly). However, most of those that admit to having used opiates reported using several times a month or less frequently (Tables 6 and 6a).

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[2] Some mention should be made of the occasional inconsistencies shown by offenders in their reports of usual frequency of drug use as compared to their reports of actual last use of the drug in question. Reports of last actual use are subject to such factors as availability of drugs and finances whereas usual frequency of drug use assumes that those factors are under control.

Barbiturates: Like opiates, barbiturates have been used by 9 percent of the addicts and 13 percent of the chippers. However, of those using barbiturates most reported using it less than once a week (Tables 7 and 7a).

Hallucinogens: Only six percent of the self-reported addicts and 13 percent of the chippers mention having used hallucinogens (Tables 8 and 8a).

Illegal Methadone: Among self-reported addicts, 6 percent mentioned having used methadone obtained from the street. Only one of the chippers reports having used illegal methadone. Street methadone had been used less frequently than any other drug (Tables 9 and 9a).

Heroin: By definition, all of the self-reported addicts and chippers have used heroin (Table 10). In terms of age, half of the addicts and three-fifths of the chippers had used heroin for the first time before they were 20 years old (Table 10a). Ninety-five percent of the self-reported addicts and 38 percent of the chippers had used heroin 48 hours before arrest (Table 10b). Indeed, 94 percent of the addicts and 34 percent of the chippers had "injected" or "snorted" within 24 hours of arrest (Table 10c). Fully thirty-nine percent of the addicts had used five or more bags at that time (Table 10d). Addicts reported using heroin on a daily basis for periods of less than a month to 5 years or more before arrest (Table 10e). Moreover, while none of the chippers were using heroin daily for at least two weeks more than half of them reported having been addicted to heroin at some prior time for periods ranging from two weeks to 2 years (Tables 10f and 10g).

Heroin Addiction Treatment Status

Present and Prior Treatment Status: Only 9 percent of the addicts and 6 percent of the chippers were enrolled in narcotics treatment programs at time of arrest (Table 11). Each of these offenders reported himself as having used heroin while enrolled in treatment. Fifty-three percent of the addicts and 34 percent of the chippers reported prior

treatment but not at time of arrest. Thus, 38 percent of the addicts and 59 percent of the chippers reported never having been in treatment. Half of those reporting to be in treatment at time of arrest had been enrolled for less than one month (Tables 11a and 11b).

Methadone Treatment: The six addict-offenders in treatment at time of arrest were receiving methadone, the 2 offenders chipping were abstinent. Ninety-four percent of heroin addicts and 10 of 11 offenders chipping, all with prior treatment, reported using methadone to overcome illegal drug use (Table 12).

Prior Treatment Program Activity: The addicts and chippers with previous treatment reported last enrollment in seven different treatment facilities in the Washington, D.C. area (Table 13). One third of those addicted and with prior treatment, admitted previous enrollment in two to as many as four treatment programs (Table 13a). An average of 3.4 months in treatment was reported by the addicts with 22 percent being enrolled for one month or less (Table 13b). Twenty-nine percent of those addicted offenders who left treatment reported that they did so because they "wanted to stay on heroin." Twenty-three percent said it was "inconvenient to attend treatment."

An additional seventeen percent of these addict-offenders left treatment because they were "removed from the program" while 14 percent felt themselves "to have been rehabilitated." The remaining 17 percent reported they "didn't like aspects of the treatment program" (nine percent) or could give no reason for discontinuing treatment (Table 13c).

Forty percent of those addicted -- and never in treatment -- reported they "didn't want to stop using heroin" and 20 percent reported they "could quit using heroin on their own" as their reasons for never having gotten involved in treatment. An additional 28 percent reported "treatment as being an inconvenience" while the remaining 12 percent reported that they "did not feel any need to quit heroin" (eight percent) or could give no reason for never having gotten involved in treatment (Table 13d).

Alcohol Use

Among the 146 offenders whose interviews were analyzed fifty-eight percent of those addicted, 78 percent of those chipping, and 81 percent of those not-using reported consuming some alcohol on a regular weekly basis (Tables 14 and 14a). The average age reported for first alcohol use -- 15.2 years -- was very similar among the addict-offenders, offenders chipping, and offenders not-using heroin (Table 15).

Hard Liquor: Hard liquor was consumed by far more offenders not using heroin -- 73 percent -- than any other alcoholic drink, they consumed an average of 1.5 pints per week (Table 16). Half of the offenders chipping used hard liquor weekly, consuming an average of 0.6 pints per week. Only 24 percent of the addicts used hard liquor, consuming an average of only 0.2 pints per week (Table 16).

Wine: Among the offender groups, 36 percent mentioned consuming wine weekly. On the weekly average, the heroin chippers consumed 2.2 pints of wine. One pint of wine more per week than the addict-offenders and/or the offenders not using heroin (Table 17).

Beer: Beer was consumed by more addict-offenders -- 50 percent -- than any other alcoholic drink. However, on the weekly average, the addict-offenders consumed 1.3 quarts of beer, still less than offenders chipping and 3 quarts less than offenders not-using heroin (Table 18).

Wine was consumed by addict-offenders in larger quantities than any other alcohol in the 24 hours preceding their arrests (Table 19).

Alcohol and/or Drugs: Approximately 80 percent of those offenders either addicted to, or chipping heroin reported themselves as having used alcohol before using illicit drugs (Table 20). While 48 percent of the offenders not-using heroin reported having consumed alcohol within 24 hours of their arrests, only 24 percent of the addict-offenders report having consumed alcohol and all of these

used alcohol in combination with other drugs. Forty-six percent of the offenders chipping heroin consumed alcohol alone or in combination with illicit drugs 24 hours before arrest (Table 21).

Tobacco Use

Eighty-eight percent of the offenders reported smoking cigarettes, an additional 2 percent reported smoking other forms of tobacco (Table 22). The overall average age of first tobacco use was 14.8, there was little difference between the three offender groups (Table 22a). There was also little difference between the three offender groups in terms of the reported average number of packs of cigarettes smoked per day - typically 1.1 packs per day (Table 22b).

Personal and Social Characteristics

Age and Education: The average age of offenders not using (29.2 years), was 5 years older than the addict-offenders (24.1 years) and 7 years older than the offenders chipping (22.3 years) (Table 23). The average grade completed was slightly higher for the younger offenders chipping (11.0 years) compared to addict-offenders (10.8 years) and offenders not using (10.0 years) (Table 23a).

Parents: Fifty percent of the addict-offenders, 62 percent of the offenders chipping, and 65 percent of the offenders not using were reared to the age of 16 in families with both of their parents present. At the same time, a greater number of addicts (18 percent) and chippers (16 percent) were reared by other than their biological parents (relatives, guardians, or orphanage) than were offenders not using heroin (6%) (Table 24).

Birth Place: Sixty-one percent of the offenders were born in the District of Columbia, Maryland or Virginia areas, with an additional 21 percent being born in the Carolinas (Table 25). Notably, more addict-offenders (74%) had spent most of their childhood in the District of Columbia than had offenders not-using heroin (52%) (Table 26).

Marital Status: The majority of the offenders are single. However, the heroin chippers, a younger age group, had even fewer individuals married than those addicted or those not-using heroin (Table 27).

Residence: Forty-eight percent of the addict-offenders and 46 percent of the offenders chipping have resided at the same home for the past four years or more, as compared to the seemingly more mobile offenders not using heroin with 27 percent residing at the same home that period of time (Table 28). At the same time, the offenders chipping report themselves as residing with their mother only, father only or both parents more often (56%) than addict-offenders (33%) or offenders not-using heroin (16%) (Table 29).

Employment Status: More offenders not-using heroin reported themselves as employed at time of arrest (67%) than did offenders using heroin (44%) (Table 30). Of those employed, the average weekly income was $104.00 (Table 30a).

Military Service: Approximately 25 percent of the addict-offenders and offenders not-using heroin served in the military. Offenders not-using heroin tended to have more years of service than did the offenders using heroin (Tables 31 and 31a).

Criminal Offenses

Prior Arrest: Addict-offenders and offenders not-using heroin reported having more arrests than the somewhat younger heroin chippers. The average number of arrests for addict-offenders and offenders not-using was 5.8, as compared to 3.7 for the offenders chipping (Table 32). By their own report the average age of first arrest was 19.1 years for all offenders (Table 32a).

Prior Convictions: Offenders not-using heroin on the average had more convictions (2.2) than addict-offenders (1.2) or offenders who were chipping heroin (0.7) (Table 33). At the same time, addict-offenders, on the average, were first convicted at a slightly younger age (18.8 years) than

those chipping or those not-using heroin (both 21.7 years) (Table 33a). By virtue of their greater numbers of convictions, addicted-offenders and offenders not-using heroin had more time in prison (22.4 months and 20.0 months respectively) than those of offenders chipping (5.7 months) (Table 33b).

Present Offenses: In terms of present offenses, addicts and chippers are charged with more crimes against property than are offenders not-using heroin. Offenders not-using heroin are charged with more crimes against people as compared with addicts or chippers. The most frequent crimes with which addicts and chippers are charged are violations of the narcotics laws, possession of implements of crime, and larceny; offenders not-using heroin are more likely to be chaged with robbery, assault, and violation of the National Firearm Act (Table 34).

A COMPARISON OF ADDICTED-OFFENDER 1969 AND ADDICTED-OFFENDERS 1971

In the jail study conducted in 1969 among 225 offenders, 45 percent were identified as addicted to heroin, as compared to 47 percent of the 150 offenders surveyed in 1971 (Table 35). A dramatic increase occurred between 1969 and 1971 among offenders reporting themselves to be using heroin on an occasional or non-daily basis (chipping) only. While only 2 percent of the non-addicted offenders in 1969 could be viewed as chipping heroin, a surprising 21 percent of offenders in the latest study admit to chipping.

Corresponding percentages were reported among addict-offenders in terms of marijuana use for 1969 (75%) and 1971 (73%). There was a large increase in amphetamine use between 1969 (13%) and 1971 (23%). A decline was reported in the use of cocaine between 1969 (85%) and 1971 (71%), barbiturates (18% in 1969 and 9% in 1971), and illegal or street methadone (16% in 1969 and 6% in 1971) (Table 36).

One further point of comparison is the increase in percent of addict-offenders reporting themselves as having received treatment for their addiction. While only 38 percent of the addict-offenders in 1969 recall ever receiving treatment, 62 percent of addict-offenders in 1971 reported themselves as having been in treatment.

In terms of offenses with which addict-offenders were charged, a larger percentage of offenders in 1971 were charged with violation of narcotics laws (34%) than was true in 1969 (15%) (Table 37).

TABLE 1

POSITIVE URINALYSES FOR MORPHINE AND/OR QUININE AND SELF-REPORTED HEROIN DEPENDENCE

Urinalyses and Self-Reports	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Interview positive; urine positive	(45)	64%	(14)	44%	(0)	0%	(59)	39%
Interview positive; urine negative	(14)	20	(16)	50	(0)	0	(30)	20
Interview positive; no urine	(7)	10	(2)	6	(0)	0	(9)	6
Interview negative; urine positive	(4)	6	(0)	0	(0)	0	(4)	3
Interview negative; urine negative	(0)	0	(0)	0	(40)	83	(40)	27
Interview negative; no urine	(0)	0	(0)	0	(8)	17	(8)	5
Total	(70)	100%	(32)	100%	(48)	100%	(150)	100%

TABLE 1a. OFFENDERS' USE OF HEROIN

Heroin Use	Number	Percent
Addicted	70	47%
Chipping*	32	21
Not-Using	48	32
Total	150	100%

*Chipping is defined as any reported use of heroin on a non-daily basis within six months of the time study was made.

TABLE 2

FIRST ILLICIT DRUG USED

Illicit Drugs	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Marijuana	(36)	54%	(20)	63%	(7)	15%	(63)	43%
Heroin	(26)	39	(11)	34	(0)	0	(37)	25
Opium	(1)	2	(1)	3	(0)	0	(2)	1
Cocaine	(2)	3	(0)	0	(1)	2	(3)	2
Amphetamines	(1)	2	(0)	0	(0)	0	(1)	1
None	(0)	0	(0)	0	(40)	83	(40)	28
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 3

PROFILE OF MARIJUANA USE

Used Marijuana	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(48)	73%	(22)	69%	(7)	15%	(77)	53%
No	(18)	27	(10)	31	(41)	85	(69)	47
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 3a. AGE AT FIRST MARIJUANA USE

Age								
13 or under	(3)	6%	(0)	0%	(0)	0%	(3)	4%
14	(2)	4	(4)	18	(0)	0	(6)	8
15	(1)	2	(1)	5	(0)	0	(2)	3
16	(8)	17	(1)	5	(1)	14	(10)	13
17	(7)	15	(3)	13	(2)	29	(12)	15
18	(6)	13	(5)	22	(0)	0	(11)	14
19	(6)	13	(4)	18	(1)	14	(11)	14
20	(4)	8	(0)	0	(0)	0	(4)	5
21	(0)	0	(2)	9	(1)	14	(3)	4
22	(3)	6	(0)	0	(0)	0	(3)	4
23	(2)	4	(0)	0	(0)	0	(2)	3
24	(3)	6	(1)	5	(0)	0	(4)	5
25 and over	(3)	6	(1)	5	(2)	29	(6)	8
Total	(48)[1]	100%	(22)[2]	100%	(7)[3]	100%	(77)[4]	100%

[1]Average Age = 18.5 years
[2]Average Age = 18.1 years
[3]Average Age = 20.7 years
[4]Average Age = 18.6 years

TABLE 3b. FREQUENCY OF MARIJUANA USE

Frequency of Marijuana	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Daily	(10)	21%	(5)	23%	(3)	43%	(18)	23%
Several times a week	(12)	25	(8)	36	(2)	29	(22)	29
Once a week	(4)	8	(2)	9	(0)	0	(6)	8
Several times a month	(4)	8	(1)	5	(1)	14	(6)	8
Once a month	(6)	13	(4)	18	(1)	14	(11)	14
Less than once a month	(12)	25	(2)	9	(0)	0	(14)	18
Total	(48)	100%	(22)	100%	(7)	100%	(77)	100%

TABLE 3c. LAST USE OF MARIJUANA

Last Used Marijuana								
Within past 48 hours	(13)	27%	(5)	23%	(1)	14%	(19)	25%
3 - 6 days ago	(7)	15	(3)	14	(1)	14	(11)	14
1 - 2 weeks ago	(6)	13	(2)	9	(1)	14	(9)	12
3 weeks to 1 month ago	(3)	6	(5)	23	(0)	0	(8)	10
2 - 3 months ago	(2)	4	(1)	4	(0)	0	(3)	4
4 - 6 months ago	(2)	4	(1)	4	(1)	14	(4)	5
More than 6 months ago	(15)	31	(5)	23	(3)	43	(23)	30
Total	(48)	100%	(22)	100%	(7)	99%*	(77)	100%

*Does not equal 100% due to rounding.

TABLE 3d. MARIJUANA USE WITHIN 24 HOURS OF ARREST

Used Marijuana	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(8)	16%	(3)	14%	(1)	14%	(12)	16%
No	(40)	84	(19)	86	(6)	86	(65)	84
Total	(48)	100%	(22)	100%	(7)	100%	(77)	100%

TABLE 3e. AMOUNT OF MARIJUANA USED 24 HOURS PRIOR TO ARREST

1 Bag	(1)	(1)	(0)	(2)	17%
2 Bags	(0)	(0)	(0)	(0)	0
1 Stick	(1)	(0)	(0)	(1)	8
2 Sticks	(3)	(1)	(0)	(4)	33
3 Sticks	(0)	(1)	(1)	(2)	17
4 Sticks	(1)	(0)	(0)	(1)	8
5 Sticks	(1)	(0)	(0)	(1)	8
Over 5 Sticks	(1)	(0)	(0)	(1)	8
Total	(8)	(3)	(1)	(12)	99%*

*Does not equal 100% due to rounding.

PROFILE OF COCAINE USE

Used Cocaine	Offenders Addicted		Offenders Chipping		Offenders Not Using		Offenders Total	
Yes	(47)	71%	(14)	44%	(2)	4%	(63)	43%
No	(19)	29	(18)	56	(46)	96	(83)	57
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 4a. AGE AT FIRST COCAINE USE

Age								
16 and under	(4)	9%	(1)	7%	(0)		(5)	8%
17	(5)	10	(2)	14	(0)		(7)	11
18	(8)	17	(0)	0	(1)		(9)	14
19	(4)	9	(2)	14	(0)		(6)	10
20	(4)	9	(3)	22	(0)		(7)	11
21	(3)	6	(0)	0	(0)		(3)	5
22	(6)	13	(2)	14	(1)		(9)	14
23	(1)	2	(0)	0	(0)		(1)	2
24	(2)	4	(1)	7	(0)		(3)	5
25	(2)	4	(0)	0	(0)		(2)	3
26 and over	(8)	17	(3)	22	(0)		(11)	17
Total	(47)[1]	100%	(14)[2]	100%	(2)[3]		(63)[4]	100%

[1]Average Age = 21.0 years

[2]Average Age = 21.2 years

[3]Average Age = 20.0 years

[4]Average Age = 21.1 years

TABLE 4b. FREQUENCY OF COCAINE USE

	Offenders Addicted		Offenders Chipping		Offenders Not Using	Offenders Total	
Daily	(12)	26%	(1)	7%	(0)	(13)	21%
Several times a week	(11)	23	(3)	21	(2)	(16)	25
Once a week	(7)	15	(3)	21	(0)	(10)	16
Several times a month	(10)	21	(3)	21	(0)	(13)	21
Once a month	(5)	11	(0)	0	(0)	(5)	8
Less than once a month	(2)	4	(4)	29	(0)	(6)	9
Total	(47)	100%	(14)	99%*	(2)	(63)	100%

*Does not equal 100% due to rounding.

TABLE 4c. LAST USE OF COCAINE

Within past 48 hours	(15)	32%	(2)	14%	(0)		(17)	27%
3-6 days ago	(13)	27	(2)	14	(0)		(15)	24
1-2 weeks ago	(5)	11	(1)	7	(0)		(6)	10
3 weeks-1 month ageo	(2)	4	(0)	0	(0)		(2)	3
2-3 months ago	(6)	13	(3)	22	(2)		(11)	17
4-6 months ago	(5)	11	(0)	0	(0)		(5)	8
More than 6 months ago	(1)	2	(6)	43	(0)		(7)	11
Total	(47)	100%	(14)	100%	(2)		(63)	100%

TABLE 4d. COCAINE USE WITHIN 24 HOURS OF ARREST

Used Cocaine	Offenders Addicted		Offenders Chipping		Offenders Not Using	Offenders Total	
Yes	(11)	23%	(1)	7%	(0)	(12)	19%
No	(36)	77	(13)	93	(2)	(51)	81
Total	(47)	100%	(14)	100%	(2)	(63)	100%

TABLE 4e. AMOUNT OF COCAINE USED 24 HOURS PRIOR TO ARREST

Less than 1 Bag	(3)	27%	(0)	(0)	(3)	25%
1 Bag	(1)	9	(0)	(0)	(1)	8
2 Bags	(5)	46	(1)	(0)	(6)	50
3 Bags	(0)	0	(0)	(0)	(0)	0
4 Bags	(0)	0	(0)	(0)	(0)	0
5 Bags	(2)	18	(0)	(0)	(2)	0
Total	(11)	100%	(1)	(0)	(12)	100%

TABLE 5

PROFILE OF AMPHETAMINE USE

Used Amphetamines	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(15)	23%	(5)	16%	(2)	4%	(22)	15%
No	(51)	77	(27)	84	(46)	96	(124)	85
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 5a. AGE AT FIRST AMPHETAMINE USE

Age						
16 or under	(1)	7%	(1)	(0)	(2)	9%
17	(2)	13	(0)	(0)	(2)	9
18	(2)	13	(1)	(0)	(3)	14
19	(1)	7	(0)	(0)	(1)	5
20	(3)	20	(1)	(0)	(4)	18
21	(0)	0	(0)	(0)	(0)	0
22	(2)	13	(1)	(1)	(4)	18
23 and over	(4)	27	(1)	(1)	(6)	27
Total	(15)[1]	100%	(5)[2]	(2)[3]	(22)[4]	100%

[1]Average Age = 21.8 years
[2]Average Age = 20.4 years
[3]Average Age = 24.0 years
[4]Average Age = 21.7 years

TABLE 5b. FREQUENCY OF AMPHETAMINE USE

	Offenders Addicted		Offenders Chipping	Offenders Not-Using	Offenders Total	
Daily	(6)	40%	(0)	(0)	(6)	27%
Several times a week	(1)	7	(1)	(1)	(3)	14
Once a week	(1)	7	(1)	(1)	(3)	14
Several times a month	(2)	13	(1)	(0)	(3)	14
Once a mongh	(3)	20	(0)	(0)	(3)	14
Less than once a month	(2)	13	(2)	(0)	(4)	17
Total	(15)	100%	(5)	(2)	(22)	100%

TABLE 5c. LAST USE OF AMPHETAMINES

Within past 48 hours	(5)	33%	(0)	(0)	(5)	23%
3-6 days ago	(1)	7	(1)	(1)	(3)	14
1-2 weeks ago	(0)	0	(0)	(0)	(0)	0
3 weeks to 1 month ago	(1)	7	(0)	(0)	(1)	4
2-3 months ago	(1)	7	(2)	(0)	(3)	14
4-6 months ago	(4)	26	(1)	(0)	(5)	23
More than 6 months ago	(3)	20	(1)	(1)	(5)	23
Total	(15)	100%	(5)	(2)	(22)	101%*

*Does not equal 100% due to rounding.

TABLE 5d. AMPHETAMINES USE WITHIN 24 HOURS OF ARREST

Used Amphetamines	Offenders Addicted		Offenders Chipping	Offenders Not-Using	Offenders Total	
Yes	(5)	33%	(0)	(0)	(5)	23%
No	(10)	67	(5)	(2)	(17)	77
Total	(15)	100%	(5)	(2)	(22)	100%

TABLE 5e. AMOUNT OF AMPHETAMINES USED 24 HOURS PRIOR TO ARREST

Amount				
1 cap	(0)	(0)	(0)	(0)
2 caps	(3)	(0)	(0)	(3)
3 caps	(0)	(0)	(0)	(0)
4 caps	(1)	(0)	(0)	(1)
5 caps	(0)	(0)	(0)	(0)
6 caps	(1)	(0)	(0)	(1)
Total	(5)	(0)	(0)	(5)

TABLE 6

PROFILE OF OPIATE USE (Other Than Heroin)

Used Opiates	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(6)	9%	(4)	13%	(0)	0%	(10)	7%
No	(60)	91	(28)	87	(48)	100	(136)	93
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 6a. FREQUENCY OF USE OF OPIATES

Daily	(0)	(0)	(0)	(0)	0%
Several times a week	(0)	(0)	(0)	(0)	0
Once a week	(2)	(1)	(0)	(3)	30
Several times a month	(1)	(2)	(0)	(3)	30
Once a month	(1)	(0)	(0)	(1)	10
Less than once a month	(2)	(1)	(0)	(3)	30
Total	(6)	(4)	(0)	(10)	100%

TABLE 7

PROFILE OF BARBITURATE USE

Used Barbiturates	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(6)	9%	(4)	13%	(0)	0%	(10)	7%
No	(60)	91	(28)	87	(48)	100	(136)	93
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 7a. FREQUENCY OF BARBITURATE USE

Daily	(2)	(0)	(0)	(2)	20%
Several times a week	(0)	(1)	(0)	(1)	10
Once a week	(0)	(1)	(0)	(1)	10
Several times a month	(1)	(2)	(0)	(3)	30
Once a month	(2)	(0)	(0)	(2)	20
Less than once a month	(1)	(0)	(0)	(1)	10
Total	(6)	(4)	(0)	(10)	100%

TABLE 8

PROFILE OF HALLUCINOGEN USE

Used Hallucinogens	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(4)	6%	(4)	13%	(0)	0%	(8)	5%
No	(62)	94	(28)	87	(48)	100	(138)	95
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 8a. FREQUENCY OF USE OF HALLUCINOGENS

Daily	(0)	(0)	(0)	(0)
Several times a week	(1)	(1)	(0)	(2)
Once a week	(0)	(0)	(0)	(0)
Several times a month	(1)	(1)	(0)	(2)
Once a month	(0)	(1)	(0)	(1)
Less than once a month	(2)	(1)	(0)	(3)
Total	(4)	(4)	(0)	(8)

TABLE 9

PROFILE OF ILLEGAL METHADONE USE

Used Illegal Methadone	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(4)	6%	(1)	3%	(0)	0%	(5)	3%
No	(62)	94	(31)	97	(48)	100	(141)	97
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 9a. FREQUENCY OF USE OF ILLEGAL METHADONE

Daily	(0)	(0)	(0)	(0)
Several times a week	(0)	(0)	(0)	(0)
Once a week	(0)	(0)	(0)	(0)
Several times a month	(1)	(1)	(0)	(2)
Once a month	(1)	(0)	(0)	(1)
Less than once a month	(2)	(0)	(0)	(2)
Total	(4)	(1)	(0)	(5)

TABLE 10

PROFILE OF HEROIN USE

	Offenders[1] Addicted		Offenders[2] Chipping		Offenders Not-Using		Offenders[3] Total	
Used Heroin	(66)	100%	(32)	100%	(0)	0%	(98)	67%
Never Used Heroin	(-)	-	(-)	-	(48)	100	(48)	33
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 10a. AGE AT FIRST HEROIN USE

14 years or younger	(1)	1%	(0)	0%	(0)		(1)	1%
15 years	(1)	1	(1)	3	(0)		(2)	2
16 years	(3)	5	(3)	9	(0)		(6)	6
17 years	(11)	17	(3)	9	(0)		(14)	14
18 years	(10)	15	(8)	25	(0)		(18)	18
19 years	(7)	11	(5)	16	(0)		(12)	12
20 years	(4)	6	(3)	9	(0)		(7)	7
21 years	(8)	12	(3)	9	(0)		(11)	11
22 years	(7)	11	(0)	0	(0)		(7)	7
23 years	(0)	0	(0)	0	(0)		(0)	0
24 years	(4)	6	(3)	9	(0)		(7)	7
25 years or older	(10)	15	(3)	9	(0)		(13)	13
Total	(66)	100%	(32)	98%*	(0)		(98)	98%*

[1]Average Age = 20.5 years
[2]Average Age = 19.7 years
[3]Average Age = 20.2 years

*Does not equal 100% due to rounding.

TABLE 10b. LAST USE OF HEROIN

Last Use	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offencers Total	
Within past 48 hours	(63)	95%	(12)	38%	(0)		(75)	77%
3-6 days ago	(3)	6	(8)	25	(0)		(11)	11
1-2 weeks ago	(0)	0	(4)	13	(0)		(4)	4
3 weeks to 1 month ago	(0)	0	(2)	6	(0)		(2)	2
2-3 months ago	(0)	0	(3)	9	(0)		(3)	3
4-6 months ago	(0)	0	(3)	9	(0)		(3)	3
More than 6 months ago	(0)	0	(0)	0	(0)		(0)	0
Total	(66)	100%	(32)	100%	(0)		(98)	100%

*Does not equal 100% due to rounding.

TABLE 10c. USE OF HEROIN WITHIN 24 HOURS OF ARREST

Used Heroin	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(62)	94%	(11)	34%	(0)	0%	(73)	50%
No	(4)	6	(21)	66	(48)	100	(73)	50
Total	(66)	100%	(32)	100%	(56)	100%	(146)	100%

TABLE 10d. AMOUNT OF HEROIN USED WITHIN 24 HOURS PRIOR TO ARREST

Less than 1 bag	(4)	6%	(1)	9%	(0)		(5)	7%
1 bag	(11)	18	(3)	27	(0)		(14)	19
2 bags	(22)	35	(4)	36	(0)		(26)	36
3 bags	(1)	2	(2)	18	(0)		(3)	4
4 bags	(0)	0	(0)	0	(0)		(0)	0
5 bags	(9)	15	(1)	9	(0)		(10)	14
Over 5 bags	(15)	24	(0)	0	(0)		(15)	20
Total	(62)	100%	(11)	99%*	(0)		(73)	100%

*Does not equal 100% due to rounding.

TABLE 10e. LENGTH OF DAILY HEROIN USAGE IMMEDIATELY PRIOR TO ARREST

Length of Daily Use	Offenders Addicted	
Less than 1 month	(9)	14%
1 - 2 months	(17)	26
3 - 4 months	(11)	17
5 - 6 months	(8)	12
7 - 9 months	(2)	3
10 - 12 months	(5)	7
1 - 2 years	(11)	17
3 - 4 years	(1)	1
5 years or more	(2)	3
Total	(66)	100%

TABLE 10f. OFFENDERS PRESENTLY CHIPPING WHO HAVE EVER BEEN ADDICTED TO HEROIN

Ever Addicted	Offenders Chipping	
Yes	(17)*	53%
No	(15)	47
Total	(32)	100%

*One offender reported daily heroin use immediately prior to arrest but for less than 2 consecutive weeks.

TABLE 10g. LONGEST PERIOD OF TIME EVER USED HEROIN ON A DAILY BASIS

Longest Period	Offenders Addicted		Offenders Chipping		Offenders Not-Using	Offenders Total	
Less than 1 month	(2)	3%	(17)	53%	(0)	(19)	19%
1 - 2 months	(5)	8	(4)	13	(0)	(9)	9
3 - 4 months	(5)	8	(2)	6	(0)	(7)	7
5 - 6 months	(8)	12	(1)	3	(0)	(9)	9
7 - 9 months	(6)	9	(3)	9	(0)	(9)	9
10 - 12 months	(6)	9	(4)	13	(0)	(10)	10
1 - 2 years	(24)	36	(1)	3	(0)	(25)	26
3 - 4 years	(4)	6	(0)	0	(0)	(4)	4
5 years or more	(6)	9	(0)	0	(0)	(6)	6
Total	(66)	100%	(32)	100%	(0)	(98)	100%

TABLE 11

ADDICTION TREATMENT STATUS AT TIME OF ARREST

	Offenders Addicted		Offenders Chipping		Offenders Total	
In treatment at time of arrest	(6)	9%	(2)	6%	(8)	8%
Prior treatment but not at time of arrest	(35)	53	(11)	34	(46)	47
Never in treatment	(25)	38	(19)	59	(44)	45
Total	(66)	100%	(32)	99%*	(98)	100%

*Does not equal 100% due to rounding.

TABLE 11a. PLACE OF TREATMENT AT TIME OF ARREST

	Offenders Addicted	Offenders Chipping	Offenders Total
Bonabond	(1)	(0)	(1)
Blackman's Development Center	(1)	(0)	(1)
Community Addiction Treatment Center	(1)	(0)	(1)
Drug Addiction Medical Service	(2)	(0)	(2)
Narcotic Addiction Rehabilitation Corps	(0)	(1)	(1)
Narcotic Addiction Rehabilitation Corps/Satellite	(0)	(1)	(1)
Private Physician	(1)	(0)	(1)
Total	(6)	(2)	(8)

TABLE 11b. TOTAL NUMBER OF MONTHS IN TREATMENT AT TIME OF ARREST

Months	Offenders Addicted	Offenders Chipping	Offenders Total
1 month or less	(3)	(1)	(4)
2 months	(1)	(0)	(1)
3 months	(0)	(1)	(1)
4 months	(0)	(0)	(0)
5 months	(2)	(0)	(2)
Total	(6)	(2)	(8)

TABLE 12

USE OF METHADONE IN TREATMENT

	Offenders Addicted		Offenders Chipping		Offenders Total	
In treatment at time of arrest						
Used Methadone	(6)		(0)		(6)	
Did not use Methadone	(0)		(2)		(2)	
Total	(6)		(2)		(8)	
Prior treatment but not at time of arrest						
Used Methadone	(33)	94%	(10)		(43)	93%
Did not use Methadone	(2)	6	(1)		(3)	7
Total	(35)	100%	(11)		(46)	100%

TABLE 13

LAST PLACE OF TREATMENT AMONG THOSE NOT ENROLLED AT TIME OF ARREST

Program	Offenders Addicted		Offenders Chipping		Offenders Total	
Bonabond	(12)	34%	(4)		(16)	35%
Blackman's Development Center	(5)	14	(1)		(6)	13
Community Addiction Treatment Center	(10)	29	(2)		(12)	26
Drug Addiction Medical Service	(4)	11	(1)		(5)	11
Narcotic Addiction Rehabilitation Corps	(4)	11	(0)		(4)	9
Residential Treatment Center	(0)	0	(1)		(1)	2
Last Renaissance	(0)	0	(2)		(2)	4
Total	(35)	99%*	(11)		(46)	100%

*Does not equal 100% due to rounding.

TABLE 13a. NUMBER OF PRIOR TREATMENT PROGRAMS EVER ENROLLED

Number	Offenders Addicted		Offenders Chipping	Offenders Total	
4	(2)	5%	(1)	(3)	5%
3	(1)	2	(1)	(2)	4
2	(11)	27	(2)	(13)	24
1	(27)	66	(9)	(36)	67
Total	(41)	100%	(13)	(54)	100%

TABLE 13b.

TOTAL NUMBER OF MONTHS EVER ENROLLED IN TREATMENT

Months	Offenders[1] Addicted		Offenders[2] Chipping	Offenders[3] Total	
1 month or less	(9)	22%	(5)	(14)	26%
2 months	(7)	17	(2)	(9)	17
3 months	(7)	17	(1)	(8)	15
4 months	(7)	17	(1)	(8)	15
5 months	(5)	12	(0)	(5)	9
6 months	(3)	7	(0)	(3)	5
7 months	(0)	0	(1)	(1)	2
8 months	(2)	5	(0)	(2)	4
9 months or more	(1)	2	(3)	(4)	7
Total	(41)	99%*	(13)	(54)	100%

[1]Average number of months = 3.4
[2]Average number of months = 4.0
[3]Average number of months = 3.6

*Does not equal 100% due to rounding.

TABLE 13c. ADDICTS' REASONS FOR DROPPING OUT OF TREATMENT PROGRAM

Responses	Offenders Addicted	
Felt self to have been rehabilitated	(5)	14%
Didn't like aspects of treatment program	(3)	9
Want to stay on heroin	(10)	29
Inconvenient to attend treatment	(8)	23
Removed from program	(6)	17
Don't know	(3)	8
Total	(35)	100%

TABLE 13d. ADDICTS' REASONS FOR NEVER GETTING INVOLVED IN A TREATMENT PROGRAM

Responses	Offenders Addicted	
Didn't want to stop using heroin	(10)	40%
Does not feel any need to quit heroin	(2)	8
Will quit heroin on his own when he wants to	(5)	20
Treatment an inconvenience	(7)	28
Don't know	(1)	4
Total	(25)	100%

TABLE 14

KINDS OF ALCOHOL CONSUMED PER WEEK

Alcohol	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Wine, beer and hard liquor	(11)	17%	(9)	28%	(14)	29%	(34)	23%
Wine and beer	(9)	13	(2)	6	(1)	2	(12)	8
Wine and hard liquor	(0)	0	(1)	3	(0)	0	(1)	1
Beer and hard liquor	(5)	8	(4)	13	(16)	33	(25)	17
Beer only	(8)	12	(6)	19	(3)	6	(17)	12
Wine only	(5)	8	(1)	3	(0)	0	(6)	4
Hard liquor only	(0)	0	(2)	6	(5)	10	(7)	5
None	(28)	42	(7)	22	(9)	19	(44)	30
Total	(66)	100%	(32)	100%	(48)	99%*	(146)	100%

*Does not equal 100% due to rounding.

TABLE 14a. PROFILE OF ALCOHOL USE

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Wine	(25)	38%	(13)	40%	(15)	31%	(53)	36%
Beer	(33)	50	(21)	66	(34)	71	(88)	60
Hard Liquor	(16)	24	(16)	50	(35)	73	(67)	46
None	(28)	42	(7)	22	(9)	19	(44)	30
Total	(66)	154%*	(32)	179%*	(48)	194%*	(146)	173%*

*Multiple responses

TABLE 15

AGE OF FIRST ALCOHOL USE

Age	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
10 and under	(2)	3%	(1)	3%	(3)	6%	(6)	4%
11	(1)	2	(1)	3	(0)	0	(2)	1
12	(4)	6	(2)	6	(3)	6	(9)	6
13	(7)	10	(2)	6	(2)	4	(11)	8
14	(8)	12	(3)	9	(11)	23	(22)	15
15	(12)	18	(4)	13	(7)	15	(23)	16
16	(13)	20	(8)	25	(7)	15	(28)	19
17	(4)	6	(3)	9	(4)	8	(11)	8
18	(5)	7	(4)	13	(6)	13	(15)	10
19	(1)	2	(0)	0	(0)	0	(1)	1
20	(2)	3	(1)	3	(2)	4	(5)	3
21 and over	(1)	2	(0)	0	(1)	2	(2)	1
Never Drank	(6)	9	(3)	9	(2)	4	(11)	8
Total	(66)	100%	(32)	99%*	(48)	100%	(146)	100%

[1]Average Age = 15.1 years
[2]Average Age = 15.2 years
[3]Average Age = 15.2 years
[4]Average Age = 15.2 years

*Does not equal 100% due to rounding.

TABLE 16

AMOUNT OF HARD LIQUOR CONSUMED PER WEEK

Amount	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(50)	76%	(16)	50%	(13)	27%	(79)	54%
Amounts up to 1/2 pint	(12)	18	(7)	22	(6)	12	(25)	17
More than 1/2 pint to 1 pint	(2)	3	(2)	6	(11)	23	(15)	10
More than 1 pint to 1 quart	(1)	1	(6)	19	(7)	15	(14)	10
More than 1 quart to 2 quarts	(1)	1	(1)	3	(7)	15	(9)	6
More than 2 quarts to 3 quarts	(0)	0	(0)	0	(2)	4	(2)	1
More than 3 quarts to 1 gallon	(0)	0	(0)	0	(2)	4	(2)	1
Total	(66)	99%*	(32)	100%	(48)	100%	(146)	99%*

[1]Average amount consumed per week = .2 pints
[2]Average amount consumed per week = .6 pints
[3]Average amount consumed per week = 1.5 pints
[4]Average amount consumed per week = .7 pints

*Does not equal 100% due to rounding.

TABLE 17

AMOUNT OF WINE CONSUMED PER WEEK

Amount	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(41)	62%	(20)	63%	(33)	69%	(94)	64%
Amounts up to 1/2 pint	(10)	15	(1)	3	(2)	4	(13)	9
More than 1/2 pint to 1 pint	(5)	7	(3)	9	(4)	8	(12)	8
More than 1 pint to 1 quart	(3)	4	(1)	3	(4)	8	(8)	6
More than 1 quart to 2 quarts	(1)	2	(4)	13	(1)	2	(6)	4
More than 2 quarts to 3 quarts	(1)	2	(1)	3	(0)	0	(2)	1
More than 3 quarts to 1 gallon	(4)	6	(1)	3	(3)	6	(8)	6
More than 1 gallon	(1)	2	(1)	3	(1)	2	(3)	2
Total	(66)	100%	(32)	100%	(48)	99%*	(146)	100%

[1]Average amount consumed per week = 1.2 pints
[2]Average amount consumed per week = 2.2 pints
[3]Average amount consumed per week = 1.2 pints
[4]Average amount consumed per week = 1.4 pints

*Does not equal 100% due to rounding.

TABLE 18

AMOUNT OF BEER CONSUMED PER WEEK

Amount	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(33)	50%	(10)	31%	(14)	29%	(57)	39%
Amounts up to 2 quarts	(16)	24	(6)	19	(11)	23	(33)	23
More than 2 quarts to 4 quarts	(9)	14	(7)	22	(7)	15	(23)	16
More than 4 quarts to 6 quarts	(3)	4	(1)	3	(2)	4	(6)	4
More than 8 quarts to 10 quarts	(3)	4	(2)	6	(3)	6	(8)	5
Over 10 quarts	(0)	0	(0)	0	(6)	13	(6)	4
Total	(66)	99%*	(32)	100%	(48)	100%	(146)	100%

[1]Average amount consumed per week = 1.3 quarts
[2]Average amount consumed per week = 2.3 quarts
[3]Average amount consumed per week = 4.9 quarts
[4]Average amount consumed per week = 2.7 quarts

*Does not equal 100% due to rounding.

TABLE 19

AMOUNT OF ALCOHOL CONSUMED 24 HOURS PRIOR TO ARREST

	Offenders Addicted	Offenders Chipping	Offenders Not-Using	Offenders Total	
Wine					
Less than 1/2 pint	(0)	(0)	(0)	(0)	0%
1/2 pint	(1)	(0)	(0)	(1)	8
1 pint	(4)	(1)	(1)	(6)	46
1 quart	(0)	(1)	(1)	(2)	15
2 quarts or more	(2)	(0)	(2)	(4)	31
Total	(7)	(2)	(4)	(13)	100%
Beer					
Less than 1 quart	(6)	(3)	(5)	(14)	58%
1 quart	(1)	(0)	(2)	(3)	13
2 quarts	(0)	(3)	(1)	(4)	16
3 quarts	(0)	(0)	(0)	(0)	0
4 quarts or more	(0)	(0)	(3)	(3)	13
Total	(7)	(6)	(11)	(24)	100%
Hard Liquor					
Less than 1/2 pint	(1)	(1)	(2)	(4)	15%
1/2 pint	(3)	(4)	(9)	(16)	59
1 pint	(0)	(2)	(0)	(2)	7
1 quart	(0)	(0)	(5)	(5)	19
2 quarts or more	(0)	(0)	(0)	(0)	0
Total	(4)	(7)	(16)	(27)	100%

TABLE 20

FIRST USED ALCOHOL OR ILLICIT DRUG(S)

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Alcohol	(52)	79%	(26)	81%	(46)	96%	(124)	85%
Illicit Drug(s)	(14)	21	(6)	19	(2)	4	(22)	15
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 21

DRUG AND ALCOHOL USE 24 HOURS PRIOR TO ARREST

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Alcohol Only	(0)	0%	(10)	31%	(23)	48%	(33)	23%
Alcohol and heroin	(9)	14	(3)	9	(0)	0	(12)	8
Alcohol, heroin and other drug(s)	(7)	10	(1)	3	(0)	0	(8)	5
Alcohol and other drug(s)	(0)	0	(1)	3	(0)	0	(1)	1
Heroin	(35)	53	(6)	19	(0)	0	(41)	28
Heroin and other drug(s)	(11)	17	(1)	3	(0)	0	(12)	8
Other drug(s) only	(1)	1	(1)	3	(1)	2	(3)	2
None	(3)	5	(9)	28	(24)	50	(36)	25
Total	(66)	100%	(32)	99%*	(48)	100%	(146)	100%

TABLE 22

PROFILE OF TOBACCO USE

	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(5)	8%	(4)	13%	(6)	13%	(15)	10%
Cigarettes	(61)	92	(27)	84	(40)	83	(128)	88
Other	(0)	0	(1)	3	(2)	4	(3)	2
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 22a. AGE AT FIRST TOBACCO USE

Age								
10 years and under	(7)	11%	(0)	0%	(4)	10%	(11)	8%
11 years	(2)	3	(3)	11	(4)	9	(9)	7
12 years	(4)	7	(0)	0	(1)	2	(5)	4
13 years	(8)	13	(3)	11	(3)	7	(14)	11
14 years	(6)	10	(3)	11	(6)	14	(15)	11
15 years	(10)	16	(6)	21	(10)	24	(26)	20
16 years	(7)	11	(7)	25	(7)	17	(21)	16
17 years	(5)	8	(3)	11	(2)	5	(10)	8
18 years	(4)	7	(2)	7	(2)	5	(8)	6
19 years	(2)	3	(0)	0	(0)	0	(2)	1
20 years	(3)	5	(0)	0	(3)	7	(6)	5
21 years and over	(3)	5	(1)	3	(0)	0	(4)	3
Total	(61)	99%*	(28)	100%	(42)	100%	(131)	100%

[1]Average Age = 14.8 years
[2]Average Age = 15.2 years
[3]Average Age = 14.4 years
[4]Average Age = 14.8 years

*Does not equal 100% due to rounding.

TABLE 22b. CIGARETTES: NUMBER OF PACKS SMOKED PER DAY

	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(5)	7%	(4)	13%	(6)	13%	(15)	10%
Less than 1/2 pack	(1)	2	(1)	3	(2)	4	(4)	3
1/2 pack	(13)	20	(6)	19	(8)	18	(27)	19
1 pack	(28)	42	(13)	42	(19)	41	(60)	42
1 1/2 packs	(8)	12	(4)	13	(5)	11	(17)	12
2 packs	(10)	15	(3)	10	(2)	4	(15)	11
2 1/2 packs	(0)	0	(0)	0	(0)	0	(0)	0
3 packs	(1)	2	(0)	0	(4)	9	(5)	3
Total	(66)	100%	(31)	100%	(46)	100%	(143)	100%

[1]Average number of packs smoked per day = 1.2 packs
[2]Average number of packs smoked per day = 1.0 packs
[3]Average number of packs smoked per day = 1.2 packs
[4]Average number of packs smoked per day = 1.1 packs

TABLE 23

AGES OF OFFENDERS

Age	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
18 - 21	(25)	35%	(20)	63%	(14)	29%	(59)	39%
22 - 25	(20)	29	(6)	18	(7)	15	(33)	22
26 - 29	(11)	16	(4)	13	(7)	15	(22)	15
30 - 33	(3)	4	(0)	0	(6)	12	(9)	6
34 - 37	(5)	7	(1)	3	(6)	12	(12)	8
38 or older	(6)	9	(1)	3	(8)	17	(15)	10
Total	(70)	100%	(32)	100%	(48)	100%	(150)	100%

[1]Average Age = 24.1 years
[2]Average Age = 22.3 years
[3]Average Age = 29.2 years
[4]Average Age = 25.4 years

TABLE 23a. HIGHEST GRADES COMPLETED BY OFFENDERS

Grade	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
6th grade or less	(0)	0%	(0)	0%	(6)	13%	(6)	4%
7th grade	(2)	3	(0)	0	(4)	8	(6)	4
8th grade	(4)	6	(0)	0	(3)	6	(7)	5
9th grade	(5)	8	(4)	13	(5)	10	(14)	10
10th grade	(9)	14	(9)	28	(4)	8	(22)	15
11th grade	(24)	36	(9)	28	(10)	21	(43)	29
12th grade	(19)	29	(8)	25	(10)	21	(37)	25
13th grade	(1)	1	(0)	0	(3)	6	(4)	3
14th grade	(1)	1	(0)	0	(1)	2	(2)	1
15th grade	(1)	1	(1)	3	(1)	2	(3)	2
16th grade	(0)	1	(1)	3	(1)	2	(2)	1
Total	(66)	99%*	(32)	100%	(48)	99%*	(146)	99%*

[1]Average grade = 10.8 years
[2]Average grade = 11.0 years
[3]Average grade = 10.0 years
[4]Average grade = 10.6 years

*Does not equal 100% due to rounding.

TABLE 24

ADULTS IN HOUSEHOLDS BEFORE AGE 16

Head of Household	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Mother only	(19)	29%	(6)	19%	(14)	29%	(39)	27%
Father only	(2)	3	(1)	3	(0)	0	(3)	2
Both Parents	(33)	50	(20)	62	(31)	65	(84)	57
Other Relatives or Guardian	(12)	18	(5)	16	(2)	4	(19)	13
Other	(0)	0	(0)	0	(1)*	2	(1)	1
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

*Orphanage

TABLE 25

STATES IN WHICH OFFENDERS BORN

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
D.C.	(38)	58%	(14)	44%	(20)	42%	(72)	49%
Maryland	(2)	3	(0)	0	(2)	4	(4)	3
Virginia	(4)	6	(2)	6	(8)	17	(14)	9
Alabama	(0)	0	(1)	3	(0)	0	(1)	1
Arizona	(1)	1	(0)	0	(0)	0	(1)	1
Florida	(2)	3	(0)	0	(1)	2	(3)	2
Georgia	(2)	3	(0)	0	(1)	2	(3)	2
Kentucky	(1)	1	(0)	0	(0)	0	(1)	1
Louisiana	(1)	1	(0)	0	(1)	2	(2)	1
Michigan	(0)	0	(2)	6	(0)	0	(2)	1
New Jersey	(0)	0	(0)	0	(1)	2	(1)	1
New York	(1)	1	(3)	9	(1)	2	(5)	3
North Carolina	(6)	9	(7)	23	(5)	10	(18)	12
Ohio	(1)	1	(0)	0	(0)	0	(1)	1
Pennsylvania	(2)	3	(0)	0	(0)	0	(2)	1
South Carolina	(5)	8	(2)	6	(7)	15	(14)	9
Tennessee	(0)	0	(1)	3	(0)	0	(1)	1
Outside United States	(0)	0	(0)	0	(1)	2	(1)	1
Total	(66)	98%*	(32)	100%	(48)	100%	(146)	99%*

*Does not equal 100% due to rounding.

TABLE 26

STATES IN WHICH OFFENDERS SPENT MOST OF CHILDHOOD BEFORE AGE 16

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
D.C.	(49)	74%	(16)	50%	(25)	52%	(90)	62%
Maryland	(1)	1	(0)	0	(1)	2	(2)	1
Virginia	(2)	3	(3)	9	(8)	17	(13)	9
Alabama	(0)	0	(1)	3	(0)	0	(1)	1
California	(1)	1	(0)	0	(0)	0	(1)	1
Florida	(2)	3	(0)	0	(1)	2	(3)	2
Georgia	(1)	1	(0)	0	(0)	0	(1)	1
Kentucky	(1)	1	(0)	0	(0)	0	(1)	1
Louisiana	(0)	0	(0)	0	(1)	2	(1)	1
Michigan	(0)	0	(2)	6	(0)	0	(2)	1
New York	(2)	3	(3)	9	(2)	4	(7)	5
North Carolina	(2)	3	(5)	16	(4)	8	(11)	7
Ohio	(2)	3	(0)	0	(0)	0	(2)	1
South Carolina	(3)	5	(1)	3	(4)	8	(8)	5
Tennessee	(0)	0	(1)	3	(0)	0	(1)	1
Outside United States	(0)	0	(0)	0	(2)	4	(2)	1
Total	(66)	98%*	(32)	99%*	(48)	99%*	(146)	100%

*Does not equal 100% due to rounding.

TABLE 27

OFFENDERS' MARITAL STATUSES

	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Married	(21)	32%	(5)	16%	(14)	29%	(40)	27%
Single	(45)	68	(27)	84	(34)	71	(106)	73
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 28

LENGTH OF TIME OFFENDERS RESIDED AT HOME IN WHICH LIVING AT TIME OF ARREST

Less than 1 month	(7)	11%	(0)	0%	(7)	15%	(14)	9%
1 - 2 months	(8)	12	(5)	16	(7)	15	(20)	14
3 - 5 months	(3)	5	(4)	13	(5)	10	(12)	8
6 - 11 months	(10)	15	(2)	6	(11)	23	(23)	16
1 - 3 years	(6)	9	(6)	19	(5)	10	(17)	12
4 - 6 years	(8)	12	(3)	9	(2)	4	(13)	9
More than 7 years	(24)	36	(12)	37	(11)	23	(47)	32
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 29

WITH WHOM LIVING AT TIME OF ARREST

With Whom Living	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Spouse	(21)	32%	(3)	9%	(13)	27%	(37)	25%
Alone	(5)	8	(2)	6	(15)	31	(22)	15
Mother only	(12)	18	(7)	22	(3)	6	(22)	15
Father only	(2)	3	(0)	0	(4)	8	(6)	4
Both Parents	(8)	12	(11)	34	(1)	2	(20)	14
Other Relatives, or Guardian	(10)	15	(5)	16	(4)	8	(19)	13
Institution; Halfway House, etc.	(2)	3	(0)	0	(2)	4	(4)	3
Others: (Friends, Girl friend)	(6)	9	(4)	13	(6)	13	(16)	11
Total	(66)	100%	(32)	100%	(48)	99%*	(146)	100%

*Does not equal 100% due to rounding.

TABLE 30

EMPLOYMENT STATUS AT TIME OF ARREST

Employed (Full Time)	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(29)	44%	(13)	41%	(32)	67%	(74)	51%
No	(37)	56	(19)	59	(16)	33	(72)	49
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 30a. WEEKLY INCOMES OF OFFENDERS EMPLOYED FULL TIME

Weekly Income								
$ 60 or less	(1)	3%	(2)	15%	(2)	6%	(5)	7%
$ 61 - $ 75	(5)	17	(4)	31	(2)	6	(11)	15
$ 76 - $ 90	(9)	31	(2)	15	(7)	22	(18)	24
$ 91 - $115	(5)	17	(2)	15	(10)	31	(17)	23
$116 - $130	(4)	14	(2)	15	(3)	9	(9)	12
$131 - $145	(0)	0	(0)	0	(0)	0	(0)	0
$146 - $160	(4)	14	(0)	0	(4)	13	(8)	11
$161 or more	(1)	3	(1)	8	(4)	13	(6)	8
Total	(29)[1]	99%*	(13)[2]	99%*	(32)[3]	100%	(74)[4]	100%

[1]Average weekly income = $100.00
[2]Average weekly income = $ 95.00
[3]Average weekly income = $112.00
[4]Average weekly income = $104.00

*Does not equal 100% due to rounding.

TABLE 31

TOTAL MILITARY SERVICE

Veteran	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Yes	(18)	27%	(7)	22%	(12)	25%	(37)	25%
No	(48)	73	(25)	78	(36)	75	(109)	75
Total	(66)	100%	(32)	100%	(48)	100%	(146)	100%

TABLE 31a. YEARS IN MILITARY SERVICE

Up to one year	(3)	17%	(1)	(0)	0%	(4)	11%
2 years	(8)	44	(4)	(3)	25	(15)	41
3 years	(2)	11	(1)	(5)	42	(8)	22
4 years	(2)	11	(0)	(1)	8	(3)	8
5 years	(2)	11	(1)	(2)	16	(5)	13
More than 5 years	(1)	6	(0)	(1)	8	(2)	5
Total	(18)	100%	(7)	(12)	99%*	(37)	100%

*Does not equal 100% due to rounding.

TABLE 32

NUMBER OF PRIOR ARRESTS

Arrest	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
1	(6)	9%	(6)	19%	(7)	14%	(19)	13%
2	(7)	10	(11)	34	(7)	14	(25)	17
3	(14)	21	(4)	13	(9)	19	(27)	19
4	(5)	8	(5)	16	(2)	4	(12)	8
5	(9)	14	(2)	6	(8)	17	(19)	13
6	(9)	14	(0)	0	(6)	13	(15)	10
7	(2)	3	(0)	0	(0)	0	(2)	1
8	(3)	4	(1)	3	(0)	0	(4)	3
9	(0)	0	(0)	0	(2)	4	(2)	1
10 or more	(11)	17	(3)	9	(7)	14	(21)	14
Total	(66)	100%	(32)	100%	(48)	99%*	(146)	99%*

[1]Average number of arrest = 5.8
[2]Average number of arrest = 3.7
[3]Average number of arrest = 5.8
[4]Average number of arrest = 5.4

*Does not equal 100% due to rounding.

TABLE

TABLE 32a. AGE AT FIRST ARREST

Age	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
12 and under	(8)	12%	(0)	0%	(3)	6%	(11)	8%
13	(3)	4	(0)	0	(0)	0	(3)	2
14	(1)	2	(3)	9	(6)	13	(10)	7
15	(4)	6	(2)	6	(2)	4	(8)	6
16	(11)	17	(5)	16	(2)	4	(18)	12
17	(6)	9	(4)	13	(5)	10	(15)	10
18	(9)	14	(2)	6	(11)	23	(22)	15
19	(4)	6	(2)	6	(0)	0	(6)	4
20	(2)	3	(2)	6	(1)	2	(5)	3
21	(4)	6	(5)	16	(2)	4	(11)	7
22	(2)	3	(1)	3	(2)	4	(5)	3
23	(2)	3	(1)	3	(2)	4	(5)	3
24	(2)	3	(0)	0	(2)	4	(4)	3
25	(3)	4	(1)	3	(0)	0	(4)	3
26	(1)	2	(2)	6	(1)	2	(4)	3
27	(0)	0	(0)	0	(3)	6	(3)	3
28	(0)	0	(1)	3	(1)	2	(2)	1
29	(1)	2	(0)	0	(1)	2	(2)	1
30 and over	(3)	4	(1)	3	(4)	8	(8)	6
Total	(66)	100%	(32)	99%*	(48)	98%*	(146)	100%

[1]Average Age = 18.1 years
[2]Average Age = 19.3 years
[3]Average Age = 20.4 years
[4]Average Age = 19.1 years

*Does not equal 100% due to rounding.

TABLE 33

NUMBER OF PRIOR CONVICTIONS

Number	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
None	(20)	30%	(16)	50%	(16)	33%	(52)	36%
1	(16)	24	(12)	38	(14)	29	(42)	29
2	(8)	12	(2)	6	(6)	13	(16)	11
3	(10)	15	(2)	6	(3)	6	(15)	10
4	(5)	8	(0)	0	(4)	8	(9)	6
5 or more	(7)	11	(0)	0	(5)	10	(12)	8
Total	(66)	100%	(32)	100%	(48)	99%*	(146)	100%

[1]Average number of convictions = 1.2
[2]Average number of convictions = .7
[3]Average number of convictions = 2.2
[4]Average number of convictions = 1.4

*Does not equal 100% due to rounding.

TABLE 33a. AGE AT FIRST CONVICTION

Age	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
13 or under	(4)	9%	(0)	0%	(2)	6%	(6)	6%
14	(1)	2	(2)	13	(4)	13	(7)	8
15	(1)	2	(1)	6	(0)	0	(2)	2
16	(4)	9	(2)	13	(1)	3	(7)	8
17	(4)	9	(2)	13	(2)	6	(8)	9
18	(10)	22	(2)	13	(8)	25	(20)	21
19	(9)	20	(2)	13	(2)	6	(13)	14
20	(2)	4	(0)	0	(0)	0	(2)	2
21	(1)	2	(1)	6	(2)	6	(4)	4
22	(3)	6	(1)	6	(2)	6	(6)	6
23	(2)	4	(0)	0	(1)	3	(3)	3
24	(3)	6	(0)	0	(1)	3	(4)	4
25	(0)	0	(0)	0	(0)	0	(0)	0
26	(0)	0	(1)	6	(0)	0	(1)	1
27	(0)	0	(0)	0	(2)	6	(2)	2
28	(0)	0	(1)	6	(0)	0	(1)	1
29	(0)	0	(0)	0	(1)	3	(1)	1
30 or over	(2)	4	(1)	6	(4)	13	(7)	7
Total	(46)	99%*	(16)	101%*	(32)	99%*	(94)	99%*

[1]Average Age = 18.8 years
[2]Average Age = 21.7 years
[3]Average Age = 21.7 years
[4]Average Age = 20.0 years

*Does not equal 100% due to rounding.

TABLE 33b. NUMBER OF MONTHS INCARCERATED

Number of Months	Offenders[1] Addicted		Offenders[2] Chipping		Offenders[3] Not-Using		Offenders[4] Total	
Less than 1 month	(2)	3%	(0)	0%	(4)	8%	(6)	4%
1 - 5 months	(7)	11	(5)	16	(9)	19	(21)	14
6 - 10 months	(8)	12	(6)	19	(3)	6	(17)	12
11 - 15 months	(7)	11	(2)	6	(6)	13	(15)	10
16 - 20 months	(3)	4	(0)	0	(1)	2	(4)	3
21 - 25 months	(2)	3	(1)	3	(2)	4	(5)	3
26 - 30 months	(4)	6	(1)	3	(0)	0	(5)	3
31 - 35 months	(0)	0	(0)	0	(0)	0	(0)	0
36 - 40 months	(5)	8	(0)	0	(1)	2	(6)	4
41 - 45 months	(2)	3	(0)	0	(0)	0	(2)	1
46 - 50 months	(3)	4	(0)	0	(0)	0	(3)	2
51 - 55 months	(0)	0	(0)	0	(0)	0	(0)	0
56 - 60 months	(2)	3	(1)	3	(1)	2	(4)	3
Over 60 months	(5)	8	(0)	0	(6)	13	(11)	8
None	(16)	24	(16)	50	(15)	31	(47)	32
Total	(66)	100%	(32)	100%	(48)	100%	(146)	99%*

[1]Average number of months incarcerated = 22.4
[2]Average number of months incarcerated = 5.7
[3]Average number of months incarcerated = 20.0
[4]Average number of months incarcerated = 18.0

*Does not equal 100% due to rounding.

TABLE 34

OFFENSE(S) FOR WHICH PRESENTLY CHARGED

Offense	Offenders Addicted		Offenders Chipping		Offenders Not-Using		Offenders Total	
Crimes Against People								
Robbery	(10)	14%	(5)	16%	(14)	29%	(29)	19%
Assault	(7)	10	(3)	9	(12)	25	(22)	15
Homicide	(1)	1	(0)	0	(2)	4	(3)	2
Sex Offense	(0)	0	(0)	0	(2)	4	(2)	1
Property Crimes								
Larceny	(15)	21	(5)	16	(6)	12	(26)	17
Burglary	(2)	3	(2)	6	(5)	10	(9)	6
Receiving Stolen Property	(3)	4	(0)	0	(1)	2	(4)	3
Unlawful Entry	(5)	7	(2)	6	(3)	6	(10)	7
Tampering	(1)	1	(0)	0	(1)	2	(2)	1
Destroying Property	(1)	1	(1)	3	(2)	4	(4)	3
Forgery	(0)	0	(1)	3	(0)	0	(1)	1
Other Crimes								
Violation of Narcotics Laws	(24)	34	(8)	25	(0)	0	(32)	21
Possession of Implements of crime	(14)	20	(5)	16	(2)	4	(21)	14
National Firearm Act	(5)	7	(0)	0	(12)	25	(17)	11
Parole/Probation Violation	(2)	3	(0)	0	(6)	12	(8)	5
Soliciting	(1)	1	(0)	0	(3)	6	(4)	3
Absconding	(2)	3	(0)	0	(1)	2	(3)	2
Present in an Illegal Establishment	(3)	4	(0)	0	(0)	0	(3)	2
Bail Reform Act	(3)	4	(1)	3	(0)	0	(4)	3
Other Offenses	(3)	4	(0)	0	(2)	4	(5)	3
Total	(70)	142%*	(32)	103%*	(48)	151%*	(150)	128%*

*Does not equal 100% due to multiple charges.

TABLE 35
COMPARISON OF ADDICT-OFFENDERS (1969)
AND ADDICT-OFFENDERS (1971)

	Heroin Users 1969 (N=225)		Heroin Users 1971 (N=150)	
Daily Heroin Use	(100)	45%	(70)	47%
Non-daily Heroin Use	(4)	2	(32)	21
Total Heroin Use	(104)	47%	(102)	68%

TABLE 36
OTHER DRUGS EVER USED

	Addicts 1969 (N=96)		Addicts 1971 (N=66)	
Cocaine	(82)	85%	(47)	71%
Marijuana	(72)	75	(48)	73
Amphetamines	(12)	13	(15)	23
Barbiturates	(17)	18	(6)	9
Illegal Methadone	(15)	16	(4)	6

TABLE 37
OFFENSE FOR WHICH CHARGED

	Addicts 1969 (N=100)		Addicts 1971 (N=70)	
Violation of Narcotics Laws	(15)	15%	(24)	34%
Crimes Against People				
Homicide	(3)	3	(1)	1
Assault	(5)	5	(7)	10
Weapons	(5)	5	(5)	7
Robbery	(13)	13	(10)	14
Property Crimes				
Burglary	(6)	6	(2)	3
Larceny	(21)	21	(15)	21
Other Thefts	(7)	7	(0)	0
Receiving Stolen Property	(3)	3	(3)	4
Other Crimes				
Possession of Implements of Crime	(5)	5	(14)	20
Other	(11)	11	(20)	29
Total	(100)	100%	(70)	143%*

*Exceeds 100% due to multiple charges.

LEAA-OLEP-159
(Rev. 6-1-70)

Report #6

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
OFFICE OF LAW ENFORCEMENT PROGRAMS

~~70-DF-046~~ DF-71-925
DISCRETIONARY GRANT PROGRESS REPORT

1. Grantee: District of Columbia, Office of Criminal Justice Plans and Analysis	4. Grant No. ~~70-DF-046~~ ~~71-DF-925~~ 1/15/73 5. Date of Report: / / April / / October / X / Other
2. Implementing Subgrantee: District of Columbia, Department of Human Resources	6. Grant Amt. $2,000,000 7. Character of Report: / / Interim / X / Final
3. Title or Character of Project: Selected Addiction Program Development and Expansion	8. Covering Period: July 1, 1971 to December 31, 1972

To: / / Cognizant Regional Office
Law Enforcement Assistance Administration

/X/ State Planning Agency, State of District of Columbia

Submitted herewith is the grantee's progress report for the period shown above:

Robert L DuPont

Project Director (signature)
Robert L. DuPont, M.D., Admin.
Narcotics Treatment Administrat

(Typed Name and Title)

Discretionary Grant 71-DF-925 "Selected Addiction Program Development and Expansion" for $2,000,000 was awarded to the Narcotics Treatment Administration (NTA) to cover a period from July 1, 1971 to June 30, 1972. On June 14, 1972, OCJP&A approved an extension of this grant to September 30, 1972. On October 25, 1972, LEAA approved a second extension through December 30, 1972. One major reprogramming was approved by the grantor on April 26, 1972. This reprogramming was effected to absorb the cost of the "Clearinghouse for National Identification Project" and to reallocate funding for individual components necessitated by programmatic changes resulting from operational experience and savings from reductions in service contracts.

The funds under this grant enabled NTA to open a Phase I, II Detoxification-Abstinence Clinic, to open Central Medical Intake, to open an Outpatient clinic and Therapeutic Community in FEATS, to provide needed administrative and vocational

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rehabilitation personnel, to allow Central Information System to move to a permanent site. The grant also allowed the continuation of operations of the Drugmobile a Phase I Maintennace Clinic, and an Outpatient Clinic at FEATS, and the initiation of the Unique Identifier Pilot Project. Each of these components' activities over the past eighteen months will be discussed individually on the following pages.

However, there is some general information which applies to all of the components funded by Grant 71-DF-925. Three major reorganizations of NTA occurred during the period funded by this grant. In September, 1971, the NTA Executive Committee attended a three day conference in Virginia to discuss program and organizational problems resulting from NTA's rapid expansion. As a result of this conference, it was decided to reorganize NTA and introduce a new level of management, the Bureau Chiefs, in order to reduce the number of individuals reporting directly to NTA top management.

During the third quarter (January 1, 1972 thru March 31, 1972), the Bureau of Treatment Services was established to provide medical guidance for all treatment services performed for NTA patients, including giving technical supervision to the medical staff. The Bureau of Youth Coordination was, in turn, dissolved; the specialization of treatment to youthful heroin addicts and technical guidance to all youth programs was incorporated into the new Bureau of Treatment Services. The Drugmobile (Component #3) was transferred from the defunct Bureau of Youth Coordination to the Bureau of Special Services; the Division of Vocational and Employment Programs (Component #8) was transferred from the Bureau of Special Services to the Bureau of Treatment Services.

During the fifth quarter of the grant (July 1, 1972 through September 30, 1972), NTA underwent another reoganization pending final approval by the Director of DHR. The Bureau Chiefs' positions were eliminated and NTA was reorganized into three major Bureaus headed by Associate Administrators who reported directly to the NTA Administrator.

The Bureau of Treatment Services was to coordinate and supervise all treatment efforts within NTA. The concept of geographical division into distinct and separate areas headed by Area Chiefs responsible for coordinating the treatment within their own area was abolished in favor of a centralized bureau with the responsible for providing a total coordinated effort for the entire city. To increase the speed and efficiency of administrative support functions, all management functions were centralized into the Bureau of Managment Services. Central Information and Research were to be placed within this Bureau. The Bureau of Special Services remained basically the same except that all prevention and education functions were assigned to this Bureau.

As was stated previously, this reorganization was pending the final approval by the Director of DHR. Although NTA operated under that organizational plan for approximately five months, it was never officially approved by the Director of DHR. During the months of November and December another reorganizational plan has been discussed. This reorganizational plan is an attempt to bring the organization of NTA into line with the organization of the other administrations composing the Department of Human Resources. It is not known at this time the exact format that reorganization will take.

Component #1: Administration

A. Activities and Accomplishments

The objective of this component of the grant was to add 21 positions to the central office of NTA to correct some of the operational deficiencies and to absorb the additional administrative workload required by the program expansion made possible by this grant. As a result of the September 1971 reorganization, NTA received approval to transfer one Administrative Assistant (GS-7) and one Clerk (GS-5) from the Central Information System (Component #2A) to this component to provide additional support capability.

The program expansion and resultant additional personnel made possible by this grant had impact on the Department of Human Resources (DHR), particularly in terms of the administrative support services (e.g. budget, finance, procurement, personnel, etc.) Therefore, nine of the 21 positions were transferred to DHR. These positons were as follows: Personnel Management Specialist, Personnel Processing Clerk, Procurement and Supply Technician, Supply Clerk, Budget and Finance Technician, Position Classifier, Personnel Clerk-Typist, Supply Clerk, nd Budget Analyst.

It was orginally scheduled that hiring for this component would be completed on or around October 15, 1972. By that time five (56%) of the nine DHR positions had been filled; 36% of the NTA positions had been filled. By the end of December, 1972, all but one (89%) of the DHR positions had been filled while 64% of the NTA positions had been filled. By the end of the grant period all the DHR positions had been filled. One NTA position remained unfilled, the Training Specialist.

B. Program Problems

One problem that NTA has had to face during the entire period of the grant was the difficulty in finding qualified applicants and the lengthy time delays in personnel processing. In an attempt to resolve these problems, a number of steps were taken during the grant period. The Deputy Director of NTA undertook a documentation of delays and participated in numerous meetings with the staff of DHR personnel. A sub-committee of the NTA Executive Committee was appointed to work with the NTA Deputy Director to investigate this problem. All project administrators were asked to keep a file of applicants and to refer likely candidates for jobs to the personnel department. The names of likely candidates were kept on file in the central NTA office. All of these ctions seemed to help improve the situation.

The NTA encountered a number of difficulties in trying to hire an individual to fill the Training Specialist position. During the first two quarters of the grant, efforts to recruit were difficult because of the apparently low grade offered for

this positions, i.e. applicants qualified for higher grades. One applicant was identified during the third quarter; he completed all processing but was unwilling to accept the grade offered. A second applicant was identified and approved by NTA's screening committee at the end of December. However, the new Director of DHR placed emphasis upon training and career development. During the third quarter of the grant, the decision was made to centralize DHR training; all applicants for training positions had to be approved by DHR. The applicant identified and approved by NTA's screening committee at the end of December was not approved by the DHR Office of Training and Career Development and consequently was not hired. On March 9, 1972, NTA was informed that applicants could be identified from the Civil Service Commission roster and that the decision on centralized training had been shelved.

During the fourth quarter, there was a freeze on hiring outside DHR so that those individuals affected by job abolishment as a result of reorganization could be absorbed into other administrations. Generally, this freeze had no adverse effect except in some specialist positions, for example, the Training Specialist. At the end of the fourth quarter, NTA was given the authorization to hire for this position outside DHR. An applicant previously identified and interviewed by NTA indicated continued interest in this position. However, the centralization of training into DHR again became an issue. No one could be hired until this issue was clarified. The decision has now definitely been made that training will be centralized in DHR.

C. Financial Statement

See Form LEAA OLEP - 157 (not attached).

D. Management Commentary

The vacancy in the Training Specialist position hampered NTA' plan to centralize its wide variety of training resources and to develop a comprehensive program based upon career concepts. Although the Training Specialists position was never filled, a training plan for NTA was directed by the Chief of the Bureau of Special Services during the period of the grant.

The Psychiatric Institute (PI) conducted three sessions of a training course during the period of this grant. A ten week training program for 60 GS-4 to GS-7 NTA counselors began March 20, 1972. The counselors received four hours of training per week. Supervisors received a preliminary course which consisted of the same training in a condensed form for four days. A similar training course was given for counselors

of NTA contract programs and twelve NTA counselors. There were two sessions of three hours each per week for five weeks. The third session began during the fourth quarter for 50 NTA counselors and some first line supervisors.

During the third quarter, a four hour session for timekeeping was given to all administrators. Two more detailed eight hour sessions were provided to timekeepers and alternate timekeepers.

DHR developed an intensive course for GS-1 through GS-3 counselors. NTA participated in the development of this course. The core course included the basic concepts necessary to perform the counseling functions (aspects of human behavior), community services (information on available agencies), the counseling role (interviewing, communicating), use of supervision, and a service plan to assess needs and develop a plan to achieve satisfaction. A three day training course covering the same areas was to be presented to Clinic Administrators and Chief Counselors.

During the fifth quarter of this grant, meetings were held with representatives of Public Service Careers (PSC) to develop a one year program which would upgrade the skills of Grades 2 to 5 staff to provide for upper mobility. In conjunction with PSC, a training outline was developed. This outline was submitted to contractors in order to elicit proposals.

During the fifth quarter, the individual filling one of the NIMH FEATS funded training positions was utilized by the Associate Administrator (formally Bureau Chief) of the Bureau of Special Services. This FEATS trainer developed a training program for parole officers in the Department of Corrections who were supervising narcotics caseloads. He also worked in the clinics to identify needs for in-service training. He then worked with clinic administrators to provide the necessary in-service training.

During the last quarter of the grant, DHR provided expanded opportunities for training for all levels of clinical staff. NTA provided training on the theories of counseling and counseling techniques to the staff of newly opened clinics. NIMH also provided training courses for clinical and central office staff.

Component #2A: Central Information System

A. Activities and Accomplishments

Grant Adjustment Notice #6 dated April 26, 1972, approved the transfers of one Intake Technician (GS-6), one Supervisory Information Technician (GS-6), and four Information Technicians (GS-5) to Central Medical Intake; also approved were the transfers of one Administrative Assistant (GS-7) and one Clerk (GS-5) to the Administration component, and the conversion of one Clerk (GS-5) position to a Research Analyst (GS-5) position. The transfer of six positions to Central Medical Intake was to implement the decision made during the first quarter of the grant to separate the technical processing of data from the initial intake process, i.e. initial interviews with patients and I.D. care make-up. The transfers to the Administration component were to provide additional support capability at a different organizational level. The conversion of a Clerk to a Research Analyst was to provide additional staff for the research operation in Central Information.

In accordance with the objective cited in the grant (p.B-9) that NTA establish a "permanent", expandable" system, a permanent site was acquired at 717 6th Street, N.W. The Central Information System moved into this site on November 19, 1971.

Initially, this facility had problems with staff morale, inadequate staffing, ineffective and underutilized reports, paperwork bottlenecks, and an overall lack of direction and purpose. At the end of the first quarter, a "development program" was established that outlined a plan for insuring the timely intergration of expanded capabilities and services within one year. The following activities were directed toward implementation of this plan.

1) During the first quarter, a supervisor was selected for each of the three shifts thus relieving the Chief, his Manager, and the Systems Analyst of involvement in day-to-day operations.

2) At the end of November, 1971, a production control network was established which allowed Central Information to anticipate and plan for peak periods of activity and allowed visibility into the daily production of each employee.

3) A quality control system was established at the begining of December, 1971. The level of acceptability of entry into the computer base of every readable activity slip was set at greater than 99% accu[illegible] and comp[illegible]ss.

4) Requirements analyses were performed on many functional areas of NTA which resulted in the production of new reports intended to present data in a manner allowing managers to take corrective action.

5) A systems description handbook was prepared during the third quarter. This handbook described the information system, data entry into the file and the computer system, and identified the general production, trend, and profile reports being produced.

6) During the fourth quarter, a set of work standards clearly identifying the duties and responsibilities of each employee in Central Information, was published and distributed to each Information Technician.

During the second quarter, it became apparent that the current computer facilities were not capable of delivering analytical and statistical reports. A total of seven proposals were received in response to a Request for Proposal sent to various soft-ware companies. A cost benefit evaluation was developed; it was upon that basis than an award was made to Creative Computer Services Corp. of New York. The final design document was presented during the fifth quarter; a contract to implement the desired new system was let during the sixth quarter.

Two amendments were negotiated with Medical Information Technology Inc. during the period of the grant. The first was to insure storage capabilities for a patient population growth up to 20,000. The second enabled the implementation of new input and output procedures for the urinalysis contractor. These procedures increased both input and output speed and report time; one problem during part of the grant period had been that urinalysis reporting had fallen behind in turn-around time from 30 hours to three or four days.

Staff training has always been a top priority for Central Information. Through the grant period Central Information staff attented DHR sponsored classes, public and private seminars, and weekly in-house training sessions conducted over a period of several months.

Central Information has been quite involved with outside efforts for unified and standardized data collection and patient registry functions. Representatives have attended meetings sponsored by SAODAP and the D.C. Council of Governments, negotiating policies and procedures to be followed if such efforts are implemented.

B. Program Problems

One problem that had to be dealt with during the grant period was machine down-time. One cause of this problem was the facility's heating & cooling system which frequently failed during the winter and summer. Drastic temperature fluctuations created hardware problems. During this quarter, Central Information relocated to larger quarters within the Office of the Administrator at 613 G Street, N. W. ; machine down-time has not created difficulties at this location.

A backlog of treatment data is ever present. The implementation of various management techniques, e.g. production control network, and authorization of minimal amounts of overtime have kept the problem manageable.

At the end of the grant, three positions had never been filled: two Research Assistants (GS-7) and one Research Analyst (GS-5). These vacancies hampered the program analysis and evaluation effort to develop meaningful measures of effectiveness for overall program performance.

C. Financial Statement

See Form LEAA OLEP - 157 (not attached).

D. Management Commentary

During the first quarter, the Central Information System identified several stages of analysis necessary to the development of a systems model to serve as a basis for the NTA information system. The net result of this effort was the implementation of several modifications designed to make what was then the current system, more responsive to the needs of the program and its managers. Some of those modifications are outlined below:

1. Publication of training and information documents;

2. Establishment of employee work standards;

3. A redesign of the urine system;

4. Expanded report and tracking mechanisms to include Criminal Justice clients;

5. The design of expanded productiom reports and the inclusion of statistical reports for management; and

6. The publication of a variety of program analysis .

Having established goals and objectives for the information system, a contract was let with Creative Computer Services Corp. to develop a design for a new NTA system consonant with these goals and objectives. The final design produced by that effort was presented in a series of briefings; NTA management endorsed its concepts. A second contract was then let with Creative Computer Services Corp. to effect implementation of the approved design. The key concepts designed into this new system included the primary one of methadone accountability. To achieve this end, the system treated all aspects of the methadone delivery system as an integral unit and blended pharmacy operations with clinic operations. Some of the key aspects of this system are as follows:

1. The Methadone System enables control of methadone from the point of preparation and pouring by the pharmacy to the actual dispensing to the clients. Accurate dosage level labels are prepared for each client and a concomitant work sheet provides the detailed audit trail for accoutability.

2. The Urine System provides prepared labels and corresponding work sheets for clinic records as well as a turnaround document for the testing laboratory. Thus, clerical errors will be minimized. Turnaround time should also be optimized.

3. The Counseling System provides patient scheduling capability for the counselors and incorporates new, more penetrating methods of recording counseling sessions and results.

4. The Management/Research System enables Central Information to develop on-demand management reports with only minimal amounts of programming effort required.

Component #2B: Clearinghouse for National Identification (Unique Identifier Project)

The goal of this project is to demonstrate the feasibility of using a footprint as a unique identifier for validating the admission of clients for treatment and rehabilitation. The structure of the project is being evolved as a prototype for possible replication on a national scale. Grant Adjustment Notice No. 6 on April 26, 1972, enabled NTA to proceed with this project.

A. Activities and Accomplishments

A total of 2,425 footprints have been taken since inception of the project on June 5, 1972 through December 16, 1972. The rate of footprints however has declined from the average 30 per day reported on June 26, 1972 to around 11 per day. This reduction in intake is also noted in the Central Medical Intake report (Component #4).

With this decrease in the rate of intake, it has been possible to set up a competitive data collection system which uses a footprint card and pad different from that originally used. The system, advanced by 3M Corporation, is similar to the present approach in that inkless technology is used to capture prints with disposable pads discarded after each print is taken. A comparative evaluation of both systems will be reported upon completion of the testing.

Color slides depicting footprint data collection have been developed. These slides serve as a visual aid in the training of future personnel and as an information tool to interested audiences. Further development of such aids are being explored.

The Unique Identifier Project continues to operate out of the NTA Central Medical Intake facility at 20 H Street, N.E., and in the headquarters of the Bureau of Research and Development at 1400 Q Street, N.W. The Intake facility is used for footprint data collection and the storage of personal patient records relating to the footprint operation. The latter location is used as the site of the Admissions Clearinghouse, the central repository for the storage processing of all prints. This structure insures the confidentiality of the patients and models the probable structure of a national system.

B. Program Problems

The distribution of footprints shows that a high percentage of prints are clustered in two classification categories. for a voluminous file, this could present difficulties in discriminating prints and retrieval efficiency. The print expert at the National Bureau of Standards continues to work with the file and the classification system is still under review.

C. Financial Statement

See Form LEAA OLEP - 157 (not attached).

D. Management Commentary

Operation of the Clearinghouse project has proved efficient. As mentioned in previous reports, there has been no lack of patient cooperation and no difficulty in capturing footprints due to physical reasons. The National Bureau of Standards continues to judge the quality of printing to be excellent and of the more than 2,000 footprints collected only 45 have been rejected for quality control. The majority of rejections were due to poor foot conditions, e.g. severe callouses located in areas vital to classification.

Despite the fact that the Project quota calls for a total of six positions, only three are currently filled. However, with the present intake rate, the manpower level has been sufficient to handle the workload effectively. In February, moreover, a second operation will be established in the Veterans Administration Hospital in Washington, D. C. in order to check duplicate registrations between NTA and another drug abuse program.

The Unique Identifier Project is included in the Selected Addiction Program Development and Expansion Grant (Part I) No. 71-DF-925 which terminated December 31, 1972. However, NTA has been informed by the Special Action Office for Drug Abuse Prevention that it wishes the project to be extended for an additional six months. Because recent budget data is not available at this time to determine the exact amount expended for the present project under the current funding grant, the Department of Human Resources has requested inclusion of the project under the Selected Addiction Program Development and Expansion, Part II, Grant No. 71-DF-925 (S-1) for a second six months of operation in order that four major tasks still remaining may be completed. These tasks, required to document the technology, are:

1. The testing and evaluation of alternative footprinting systems (see "Activities and Accomplishments");

2. The coding, for machine search, of prints on file and the development of automatic search retrieval techniques;

3. The writing of manuals for the purpose of documenting accomplishments and describing in detail operating procedures; and

4. The footprinting of clients at the D. C. VA Hospital and in the Alexandria Drug Abuse Program in order to discover the extent of multiple registration. As noted above, this is expected to begin in the hospital during February.

A total of $27,848 of the $42,000 alloted to the Evaluation Component has been requested for continuation of the clearinghouse as described above.

Component #3: Drugmobile

The Drugmobile program was initially made possible through a modification of LEAA Discretionary Grant No. 70-DF-046 and the loan of a trailer from the Chrysler Motor Corporation. Continuation of the program was ensured through funds from Grant No. 71-DF-925.

The purpose of the program was to provide drug abuse prevention through education, and the focus has been primarily on students and parents. During the regular school year the mobile unit visits most of the city's Junior and Senior high schools at least twice, giving students, teachers and other school personnel the opportunity to examine its materials, watch movies and above all, join in "rap" sessions with its staff of three trained counselors. This staff also conducted educational programs in school auditoriums and class rooms on specific request. On other occasions, the unit moved throughout the city, visiting recreation and shopping centers, libraries, etc. as the need arose. On an average day, the drugmobile would carry its message to approximately 400 persons.

A. Activities and Accomplishments

During the first quarter (September -December, 1971), the Drugmobile's staff of three counselors were assigned to the Community Relations, Education and Prevention Service (CREPS) of NTA's Bureau of Youth Coordination. Its schedule included visits to 30 different schools, the Washington Technical Institute, American University and Catholic University. The staff also visited the Women's Detention Center on a weekly basis. During October, the unit attended the Peace Demonstration for two days and made three trips to HUD. An estimated 13,000 persons were reached by the program.

Activities during the second quarter (January - March, 1972) were expanded to include weekly two-hour seminars with Lorton inmates attending the Lawyers Correction for Rehabilitation Program at American University, and a weekly class at the Bruce Community School (elementary). Staff appeared twice on WFAN-TV's "D.C. Government Reports", four times on WOOK-Radio, once on WTOP-TV's "Harambee" show and once on WUST-Radio's one and one-half hour "Opinion Line" question-and-answer period. Approximately 11,000 persons were reached at 23 schools, Howard University, Washington Technical Institute, the Opportunities Industrial Corporation headquarters, Junior Village, three area libraries and the Northwest Health Center.

The third quarter (April through June) saw a further expansion of Drugmobile Activities. In April, for example, approximately 900 persons visited the unit when it was stationed at the one-day Health Fair at the Clifton Terrace Apartment complex. This successful appearance kicked-off a cooperative venture with the Model Cities Program in which the unit began to visit concentrated shopping areas, housing and apartment complexes, churches and other places and events primarily for adults at the specific request of Model Cities officials. The unit was also used on June 17 in the opening of the city's summer youth program, at which time Mayor Walter Washington and his Director of Youth Programs complimented this NTA service. Approximately 15,000 persons used the services of the Drugmobile during this quarter. Among facilities visited were 37 public schools, nine recreation centers, four churches' and three Model Cities multi-service centers.

In September, 1972, CREPS was assigned to NTA's Bureau of Special Services and the Drugmobile Program was made directly responsible to the Community Organization Specialists under the CREPS Chief. During this period the unit worked closely with the Summer-in-the Parks Program, the Model Cities Information Center, the D.C. Public Libraries and the Recreation department. The total number of persons taking advantage of the Drugmobile's education programs numbered around 14,000.

The fact that some 17,000 persons learned about drug abuse through its efforts during the last quarter is ample proof that its services continue to be needed. This quarter was marked again by an increase in requests. For example, the staff was asked to participate in the planning of Youth Safety Week, November 12-18, and beginning November 16, the Drugmobile was stationed near the main entrance of the D.C. Armory as an adjunct to the CREPS drug-abuse education booth within the building. The mobile unit was in the repair shop during the latter half of October, enabling staff to use this time to appear at special school assemblies. In November and December, the unit visited shopping centers in each quadrant of the city in addition to meeting its regular school commitments.

B. Program Problems

The primary problem faced by Drugmobile staff during its 18 months of funding has not been in being accepted by the Washington community but by its overacceptance. In other words, as presently staffed, it has been impossible to meet all commitments and provide as thorough and viable an educational program as had been conceived of 18 months previously.

C. Financial Statement

See Form LEAA OLEP 157 (not attached).

D. Management Commentary

The Drugmobile program will continue its present level of operations in 1973 by means of District funding. While NTA had hoped to expand its entire educational and prevention program to include store-front operations and an innovative placement of NTA counselors within the school system, because of a slashing of other outside funding sources, this will not be possible. Fortunately activities of the Drugmobile staff are well known to the community and it is expected that they will be called upon with increasing frequency to participate in meaningful drug-prevention activities as well as to continue their regular schedule to the schools, recreation areas, libraries, etc.

Component #4: Central Medical Intake

This centrally located facility examines and processes all new and re-admitted patients entering treatment with NTA. The staff consists of medical, counseling and administrative support sections. The medical staff is responsible for blood studies, (i.e. micro-hematrocrit, sickledex test (optional) twelve blood chemistries, and serology), urine collection for dip stick and drug content, an X-ray medical history, and a brief "hands-on" examination. Most testing is done off-site through contract laboratories and DHR Bureau of Laboratories but reports are sent from Central Medical Intake to the patient's record at the treatment clinic. The counseling intake section is responsible for assisting each individual patient in completing the personal, employment, and drug history forms, orienting each patient to the resources available through NTA and various modes of treatment, and arriving at a decision about the appropriate treatment and clinic to which the patient is referred. The counseling staff also provides the patient with an embossed photo ID card, and processes all paperwork necessary to create a medical record for the CMI file, the treatment clinic, and registration with the Central Information System. The administrative support section maintains the file system at CMI, forwards laboratory reports to the clinics, processes all requisitions and personnel actions, and provides secretarial support.

A. Activities and Accomplishments

In the eighteen months under this grant, CMI has met all objectives initially set forth in the grant and has become an integral part of the NTA system. The original building (at 20 H Street, N.E.) which is central to city-wide transportation and a high drug use area is still being used. Modifications and maintenance problems have been overcome so that the space is now quite satisfactory. The staff consists of twenty-four full time and three part-time (M.D.) positions.

Intake has been relatively heavy, fluctuating between an average of 30 and 45 patients per day for the first 10 months of operation. There was, in fact, an imposed limitation in late summer, 1972, because clinic capacities had been exceeded. This was eventually lifted when intake began to decline and new clinics were opened; in fact, intake continued to decline the rest of the grant period. This allowed new emphasis to be placed on catching up with annual physical examinations of all patients -- a component of the original grant plan that was postponed during the period of peak patient intake. A total of 7,648 patients were examined and referred to clinics during 15 full operating months of the grant (the first three months were not tabulated). The peak came in March, 1972, with 918 patient completing the CMI process, and the low in December when there were only 196 patients in intake.

The relation of new to readmitted patients has just reversed itself in fifteen months. In October of 1971, 60% of applicants

were new and 40% were seeking reinstatement. By December, 1972, only 35% were and 65% has been in treatment with NTA previously.

An analysis of the first year of operation revealed that treatment modalities to which patients were referred also varied with the percentages of readmissions. Overall, approximately 60% of the first years' patients were abstinence, but 72% sought detoxification in March, 16% elected maintenance and 12% were referred to abstinence. In September when readmission rates began climbing, only 39% chose detoxification, 37% desired and were eligible for maintenance and 24% received abstinence counseling.

There were 258 referrals to hospitals and clinics during the fifteen months of CMI operation in addition to a number of informal referrals made to mental health and alcoholism clinics where no consultation sheet was sent.

Statistics on patients referred for emergency medication were not kept at CMI until February of 1972. From February to December 1972, there were 1174 dosages of emergency medication prescribed by CMI for administration at a nearby clinic. Approximately 50% of these patients returned to join NTA within 3 days of the emergency dosage.

An EMIT urine system, providing 6-minute results, tests for morphine derivatives, methadone, cocaine, amphetamine derivatives and barbiturates was set-up at CMI in the spring of 1972. This was transferred to another facility for a short try-out and returned to CMI in late October for another month's demonstration to test its utility in actual operations rather than its reliability. The on-site urine testing and rapid results proved to be very helpful to counselors as a tool for verificaion of the patients' drug use history. A decision to purchase supplies for the machine and negotiate a leasing arrangement has been made and is in process. The CMI staff have also been learning to operate the equipment and will take complete control after January 1, 1973.

As noted in the report of the Clearinghouse for National Identification (Component #2B), approximately 2,435 footprints have been taken at CMI. Whereas this initially involved certain CMI staff time, since the number taken each day has diminshed from approximately 30 to around 11 it has not been necessary to utilize CMI staff.

NTA signed a new computer contract in November which affected CMI in several ways. It eliminated the need for an embossed patient ID card and thereby substantially reduced both the time and cost factors of the photo-cards. Patients no longer have to come through CMI for a center code change on the card if they transfer between clinics. This alone has allowed CMI to close at 6:00 p.m. instead of 7:00 p.m. with no deletion of services. The computer contract additionally provides CMI with pre-printed and carboned intake

interview forms. Once the medical histories and physical exam forms are also printed, the exhausting process of mimeographing and hand-collating forms can cease.

All Medical Technician Assistants have completed off-site training in NTA clinic procedures. Two counselors have received 48 hours of instruction in counseling techniques, community resources and use of supervision in a new DHR-sponsored course. The Acting Administrator has completed 40 hours of class work in Personnel Management Practices and two clerks have attended 24 hours of training in office skills and procedures. All CMI staff will receive equivalent training time in their field during the next quarter. There is still a weekly staff meeting for internal communication and training.

The new DHR maintenance contract for "clinical" cleaning began October 1 and has finally solved that problem in the building. Staff at last have a tolerable working environment that is conducive to a smooth and professional operation.

B. Program Problems

Staff morale, continues to be low because the operation has such a small current patient load and there is a general ceiling on promotions and apparent career opportunities. The absorbtion of the unit under District funding will stabilize jobs, but new ways to utilize the staff must be explored.

C. Financial Summary

See Form LEAA OLEP -157 (not attached).

D. Management Commentary

As previously reported, the intake of patients began decreasing toward the end of the grant. Explanations for this trend are not confirmed but apparently include an improvement in the local heroin epidemic resulting from a decreased supply of heroin and poorer quality of the drug; a more sophisticated street knowledge about the effects of different drugs with a consequent shunning of heroin; and continued community controversy about the value and effectiveness of methadone treatment.

This decrease in numbers of patients seeking treatment has provided CMI with time to develop and refine some of its original plans and procedures. During October, the original patients who has been in continuous treatment for a full year were identified and recalled for a follow-up physical examination and social evaluation. This procedure is continuing on a monthly basis. Also, other NTA patients who had never previously been examined at CMI because their entry date was earlier than October 1971, were identified at the clinics and referred for medical evaluation. The processing of these patients, originally projected in the grant, had been postponed during the months when intake swamped facility resources. Cooperation by clinics and

patients in returning for these annual physicals has been sketchy, but is improving with the backing and assistance of the Bureau of Treatment Services.

All of the staff at CMI have concentrated this quarter on implementing the new terminal digit filing system for both the patients' charts and the x-ray films. The conversion has been completed. Records from NTA clinics on all patients who have dropped out now revert to CMI files for inclusion in the chart for the new clinic if the patient is readmitted to treatment. The radiologist has caught up with the backlog of old films to be read so that the complete file system now operates smoothly with a control clerk to monitor any check-out of charts by other than CMI counselors.

Component # 5: Phase I Methadone Maintenance Clinic
59 M Street, N.W.

On September 30, 1971, this clinic operating at 59 M Street, N.E. was transferred from HUD-MODEL Cities funding to LEAA funding. The clinic is designed to provide initial outpatient medical counseling and services to 300 patients who have either selected methadone maintenance as their treatment modality or who are investigating that option with the expertise provide by the clinic. Small caseloads, personalized services, provision for training and/or employment, as well as other critical and immediate problem solving services are provided. Funding for the continuation of this clinic has been provided from other sources as of January 1, 1973.

A. Activities and Accomplishments

The clinic operates a six week program on the average with time adjustments as warranted. Each new patient must attend an orientation session, scheduled three times a week, which deals with the structure of the program, medical knowledge about addiction and maintenance as a treatment modality. During the program, patients report daily to receive medication, must be seen by counselors at least twice a week, and give at least two urine specimens per week. Should a patient fail to appear at the clinic for 48 hours, his counselor attempts to contact the patient by telephone or by personal visit. Satisfactory adjustment to Phase I is consideration for transfer to a Phase II-III Methadone Stabilization Clinic. During the period October 1, 1971 through December 18, 1972, 841 patients had been stabilized and transferred to a Phase II-III Clinic.

When a new patient arrives from Central Medical Intake, he is seen by a member of the medical staff, informed about the program, interviewed, the extent of his habit is estimated, a dose of methadone is given and an orientation date is set. During the orientation, the Administrator deals with the structure (hours, rules, urine testing, etc.) of the program, a Social Service Assistant, who is a senior patient himself, explains the treatment from his point of view, and the entire staff structure is explained. For the next six weeks, the patient will report daily, will give at least two urine specimens per week and is expected to see several members of the staff briefly each day to discuss his progress. The entire group of patients meets every Thursday to "rap" with the staff. At this time, patients not responding to treatment are encountered and patients are encouraged to encounter the staff with any of their expectations which have not yet been met.

Treatment team meetings are held once a week, where each counselor reports on his caseload. These meetings are used to keep all staff abreast of all patient progress, to outline treatment and attempt to deal with specific problems, and as a means by which staff performance is evaluated.

A pilot project for pre-packaged methadone was begun at this clinic on May 4, 1972. In June of 1972, all NTA operated, and NTA contract clinics began using pre-packaged methadone. Patients involved in treatment responded well to this new method of dispensing medication. The clinic also participated in a special project for the Special Action Office for Drug Abuse Prevention (SAODAP). This project involved the completion of a series of test forms by patients. The SAODAP is considering asking all drug programs in the country to use these test forms. This clinic found the project to be very beneficial in eliciting precise data from patients when interviewed, especially when this data is converted to computer print-outs that are readily accessible to staff for review.

An EMIT system (on-site urine testing machine) was installed at the Phase I Methadone Maintenance Clinic in July 1972. The immediacy of urine test results obtained by the use of this machine has been highly favorable; test results have been very effective when used in conjunction with counseling. One of the drawbacks experienced in this clinic was the patient traffic problem encountered in testing approximately 450 patients, with urine specimens given two times per week, Monday and Friday. Testing for opiates and methampehtamines takes approximately six minutes. While the patients were awaiting for urine test results the clinic area was congested with people. In addition, the clinic did not have sufficient staff to assist with a pilot program of this magnitude. The administrative evaluation of the EMIT system is that, if installed in a smaller populatec clinic with adequate personnel, it would be an asset to the program.

Another innovative pilot project was initiated at the Phase I Clinic during the grant period. The clinic was selected for the NTA-Social Rehabilitative Administrative (SRA) joint pilot project to study the advantages of providing comprehensive counseling and social services to the families of NTA patients as well as to the patients themselves. A control group of ten patients was selected to participate voluntarily in the project. Counselors report that there have been many favorable comments from members of the control group regarding the services being delivered.

B. Program Problems

Although all of the positions had been filled at one time, there have been problems in obtaining personnel to fill existing vacancies in the following positions: Clinic Administrator, Clerk-Typist, Community Coordinator, and Secretary. The Community Coordinator and Secretary positions are currently being filled. Recruitment is still underway for the Clerk-Typist position.

Further clinic renovations are needed. These renovations include:

1) installation of a permanent heating and air-conditioning system;
2) installation of glass doors at the entrance to the building;
3) installation of doors for the restrooms (male and female); and
4) installation of a hand basin for the Medical Unit.

C. Statistics

Patient census: Qrt. ending:	12/31/71	3/31/72	6/30/	9/30	12/31
Abstinence	0	1	0	0	1
Maintenance	333	337	476	402	177
Detoxification	0	4	12	7	5
Hold	0	0	0	0	0
Total Reportable Patients	333	342	488	409	183

D. Financial Statement

See Form LEAA-OLEP --- 157 (Not attached).

E. Management Commentary

The objective of this component of the grant was to establish a facility to provided initial services for NTA patients who elected methadone maintenance as a treatment modality. The facility was to have a capacity of 300 patients.

The clinic operated well during the entire period of the grant. One of the reasons for this is that the clinic was able to handle many possible problems because of its existence prior to LEAA funding; problems developing from start-up had already been handled. The smooth operation of the clinic is the reason it was chosen to participate in the special and pilot projects mentioned in Section A.

MODCAP was the only NTA Phase I Methadone Maintenance Clinic for most of the grant period; consequently, its patient population increased steadily to a high of 488 reportable patients as of June 30, 1972. During the fifth quarter, there were operational changes made in terms of modality at a number of clinic, i.e. CEASED Clinic (funded by Grant 71-DF-925 (S-1) became multi-modality. As a result of such changes, other clinics began handling Phase I maintenance patients taking pressure off of MODCAP.

During the sixth quarter, the treatment modality of MODCAP was changed to a Phase II, III Stabilization Clinic. NTA also made a policy decision that after October, 1972, clinic capacities would be reduced to 250 patients. At the end of the grant, MODCAP had fallen below 300 reportable patients for the first time during the period of the grant. It has been decided to transfer patients to MODCAP from the 44 G Street Clinic (funded by Grant 71-DF-925 (S-1)) to even out the patient load and bring MODCAP upto a 250 patient capacity.

Component #6: Phase I-II Detoxification-Abstenence Clinic
901 First Street N.W.

A. Activities and Accomplishments

This clinic opened on October 4, 1971, at 941 North Capitol Street, to a small number of patients. The opening was about one week off schedule in terms of becoming operational. The delay in opening the clinic and the delay in handling full intake resulted from reticence on the part of the community to locate another clinic in the same area wherein the NTA Administrative Office, Central Medical Intake and two other clinics were already located. This obstacle was overcome by house-to-house informational visits, flyers, etc., culminating in a series of three community meetings; one at New Jersey and K Streets, the second at Sibley Plaza, and the final meeting at the Community Facility Center #1, 941 North Capitol Street, N.E., on September 30, 1971. After this last meeting, a majority of the citizens voted in favor of the establishment of the clinic. Model Cities and People Involvement Corporation Board approval was given on August 12, 1971.

The facility was relocated on August 1, 1972, from 941 North Capitol Street, N.E. to temporary quarters in a new multi-service community center located at 901 First Street, N.W., three blocks north of the previous site. This was made necessary primarily because the original building had been scheduled for immediate demolition preparatory to the construction of a new office building, and secondly because of the inadequacy of the old facility. As a result of the move to the present temporary quarters, many of the problems such as poor maintenance and lack of adequate space for counseling, cited in earlier progress reports submitted during the grant period, were eliminated. The temporary quarters at 901 first Street, were originally obtained for a period of 90 days. This lease was subsequently extended until June, 1973.

After participating in a one day Central Medical Intake (CMI) program, those patients whose treatment plans call for a detoxification-abstinence program are transferred to a Phase I-II Detoxification Abstinence clinic. The facility funded by this grant is operated from 9:00 A.M. to 9:00 P.M. five days each week, plus limited weekend and holiday hours.

Phase I patients, in addition to undergoing drug withdrawal on an outpatient basis, receive intensive counseling designed to help them cope with their addiction, employment, family and other problems and to get them involved in other appropriate health, vocational and social services which are available in the community. Personalized services and small Counselor caseloads are stressed.

All patients are required to participate in NTA's urine surveillance program.

Phase II patients are those who have been fully detoxified and who exhibit an acceptable degree of stability in coping with their immediate problems and in utilizing appropriate community services. Counseling for this group is reduced from intensive to moderate. Counseling at this stage focuses on the development or improvement of employment capabilities and other long range activities such as monitoring for drug use through urine surveillance.

Clinic personnel received training at MODCAP (Component #5) in all aspects of intake, methadone distribution, counseling and procedures between the third week of August and the first week of October. Thereafter, training was continued informally through the mechanism of two weekly meetings; the Treatment Team Meeting to discuss problem patients and the Sensitivity Meeting to discuss clinical problems. The in-service training program was further intensified during the last quarter. Added to the program was a Staff Group Techniques class monitored and directed by a student from Indiana University who is preparing his thesis for the Doctorate of Philosphy Degree. This activity has proven to be extremely informative and stimulating. The other training programs, previously mentioned, have been in progress during the entire program year. Expecially helpful to the staff is the Staff Development and Training Sessions held each Friday from 10:30 a.m.to 12 noon. NTA authorities as well as professional staff from area hospitals and educational institutions are used as supplemental speakers at these training sessions. A few counselors also were selected to attend various workships from time to time to improve their counseling techniques.

The Detox-Abstinence clinic's patient population grew very fast. The clinic was to have an anticipated caseload of 250 patients. As of December 27, 1971, the reportable patient load, by treatment categories, was as follows:

Abstinence	55
Methadone Maintenance	2
Methadone Detoxification	202
Hold	51
Total Reportable Patients	310

The Vocationl Rehabilitation Specialist assisted the patient in his progress toward stable employment. He also advised the staff regarding special problems encountered in contacts with patients and employers. He was responsible for identifying skill inventories and job potential abilities of the patients.

As of the first reporting quarter, December 31, 1971, thirty-five patients were employed, eight were in training programs, two were in school and employed.

During the final quarter of the grant period the Vocational Rehabilitation Specialist was able to place patients in positions both in government and in the private sector. However,it should be noted that many employers were not interested in giving ex-addicts a chance to demonstrate their ability to function on jobs. Many employers asked questions such as "why should I hire ex-addicts when I can get enough personnel with no drug history?" The standard staff response to this is that referrals are made only after a period of careful observation to determine motivation. In addition, the Vocational Rehabilitation Specialist tried to persuade employers to view ex-addicts as individuals who are perfectly capable of being an asset to a business rather than a liability.

The Community Coordinator has been involved in educating the patient population to the various community resources and social services available. A program was developed in which social workers and counselors learned to coordinate various agencies' services for all NTA patients and their families; referrals were made to a variety of agencies to expedite the delivery of social services such as: child-care; food stamps; medical and dental clinics; and other community health services.

During the first quarter of operation, the clinic staff developed a social and recreational program for their patients. It was felt that the success of the Detox-Abstinence clinic would be enhanced by its ability to provide worthwhile leisure time activities for abstinence patients as an additional incentive for remaining in the program. In November, the staff nurse began a weekly "good grooming" course which was received with enthusiasm by patients. A sewing course was developed and given during the second quarter. A basketball team and a cheerleading group were also started.

B. Program Problems

The clinic staff is concerned over the limited security measures now in effect to safe-guard methadone at the center. The methadone is kept in a safe, but the daily supply is left in an open area and is readily accessible to anyone desiring to remove it from the clinic.

The medical unit is in need of an emergency first aid kit to be able to deal with crisis situations.

Emergency medication is dispensed to all patients reporting in from Central Medical Intake and from the Criminal Justice

System. In order to ensure that this operation functions smoothly, there is a need for better cooperation from all persons involved. This is also true of the five (5) day clinics who have requested that their patients be medicated at the Detoxification-Abstinence clinic on weekends.

The lighting is poor at the present location; in fact it is not operating at times. However, it is expected that this problem, as well as the crowded conditions which require more than one counselor and patient to occupy a room at the same time (this destroys the desired counselor-patient relationship) will be resolved when the clinic moves into permanent quarters.

C. Statistics:

Patient Census: Qtrs. ending:	12/31/71	3/31/72	6/30	9/30	12/31
Abstinence	55	26	18	42	25
Maintenance	2	3	2	2	44
Detoxification	202	283	291	183	165
Hold	51	0	0	0	0
Total Reportable Patients	310	312	311	227	234

D. Financial Statement

See Form LEAA OLEP - 157 (not attached).

E. Management Commentary

The objective of this component of the grant was to provide counseling services for NTA patients who selected an abstinence oriented treatment program. The clinic capacity was to be 250 patients. After the clinic opened in October, 1971, the patient population grew rapidly and was over-capacity by December, 1971. The facility at 941 North Capitol Street was not capable of handling such a large population. Overcrowding severely hampered the quality of services being provided to the patients. The opening of additional clinics providing a detoxification - abstinence treatment modality and the move to a new facility at 901 First Street, N.W. greatly improved the quality of services and had a beneficial affect on both patient and staff morale.

Because of the reduction in intake and subsequent efforts during the quarter to equalize patient distribution, this clinic was changed from an exclusive detoxification - abstinence clinic to a multi-modality clinic. Increased concentration on counseling has been initiated.

During this quarter, two clinics were designated for treatment of out-of town patients. The clinic at 901 First Street was selected to treat any out-of-town patients who were to receive less than 80 mgs of methadone.

Component #7: FEATS

A. Activities and Accomplishments

Community relations have been of significant importance to the program. The problem of community acceptance in Service Area 3 was one of the major problems throughout the operation of the program. Community opposition resulted in the agency losing a number of proposed treatment sites. The prime objection was raised against a large treatment center appearing in any one neighborhood.

Because of continued community opposition, the treatment approach was decentralized in mid - 1971 to three smaller clinics strategically located to serve the surrounding neighborhood. Therapeutic Community and a smaller clinic approach was received more favorably votes were received from various community organizations. This was further evidence by the fact assistance was offered by civic groups in locating and acquiring clinical sites.

At the beginning of the FEATS program, the counseling and treatment facilities were housed in a trailer located in Service Area 3 while the Administrative Support operated out of 122 C Street, N.W. Upon acquiring the facility at 5210 Just Street, it was decided that the total program would operate out of this location until additional space could be located.

The therapeutic community concept was delayed pending acquisition of additional space for three clinical facilities previously proposed. During the later part of 1971 NTA began negotiating for National Capitol Housing Administration space in Kenilworth Courts. The community through its' council and civic organization gave its approval with the stipulation that only residents of Mayfair, Parkside, Paradise, East Gardens and Kenilworth Court would be patients. The clinic with a patient capacity of 250 opened during April, 1972. This clinic is a multi-modality, seven day clinic and is located at 4508 Quarles Street.

The site was renovated to incorporate all the facilities necessary to render adequate treatment in an environment that would be conducive to good working conditions and therapeutic treatment. Initially, there were problems with community complaints, break-ins, and vandalism, but, as a result

successfull community relations, the program now maintains a very cohesive working relationship. An additional parking area was installed to eliminate any neighborhood parking problems and hi-intensity lamps were installed outside the facility for the safety of both patients and staff. An additional clinic site has been acquired at 6029 Dix Street, N.E. The site was negotiated with the sanction of the Far Northeast Advisory Board. After the completion of the renovation, the clinic will be a seven day multi-modality treatment facility with a patient capacity of approximately 450 patients. There will be sufficient space for classroom activities, planned recreation and group meetings. renovations for this facility are presently being negotiated. It is hopeful that the renovations could be completed within 45 to 60 days.

Renovations of the Just Street facility is nearing completion. The exterior painting and landscaping has been completed. The culinary equipment for the kitchen has been delivered and installation is currently in process.

Total conversion to a Therapeutic Community, the treatment modality for which this site was originally acquired, cannot be completed until the outpatient clinic operation has completely moved to the Dix Street facility. The final conversion will consist of minor repairs and painting and should be completed within two weeks after the outpatient clinic at Dix Street is fully operational.

The two FEATS outpatient clinics are currently identifying potential clients for the Therapeutic Community. Once the Therapeutic Community becomes operational, it is anticipated that clients will be recruited in blocks of 8 until the total occupancy of 32 has been attained. Due to the shortage of staff in the Just Street outpatient clinic, key staff the Therapeutic Community are presently performing clinical duties. The agency is currently recruiting outpatient clinic staff who will replace Therapeutic Community staff once the clinic relocates.

Throughout the program, the staff have been involved in in-house training in the dynamics of interviewing, counseling, group therapy and referrals. Staff who are without high school diplomas have been involved in Department of Human Resources sponsored GED programs. Some of the clients hired into trainee positions have been promoted into full-staff positions.

There is a social rehabilitation component operating to help stimulate patients to become active in useful activities outside of the clinical functions. Patients at the Just Street facility have organized a Patient Advisory Board to assist in solving the types of problems that develop during rehabilitation and to bring about a more amicable relationship between staff and patients.

B. Program Problems

Throughout the grant period, one of the major problems, aside from facility acquisition, was the time involved in the completion of contractual work and the quality of the finished product.

The Just Street facility was acquired approximately 20 months ago and the basic renovation work was still in process at the termination of the grant. For example, the landscaping was not completed and the plumbing and wiring has to be replaced because of the inadequacy of the original installation.

C. Financial Statement

See Form LEAA OLEP - 157 (not attached).

D. Management Commentary

The clinic at 4508 Quarles Street seems to have been able to resolve most of its problems and is operating smoothly. The community, which showed initial hostility, has fully accepted this clinic.

The Just Street clinic has serious morale problems because of the frequency of changes in the Administrator. A new Administrator was detailed to this clinic around the first of December. He has initiated a number of steps to improve staff morale and delivery of services. However, there still is antagonism among some of the staff, particularly in the medical unit.

Because of the difficulty in acquiring facilities, a decision has been made to operate the program with two outpatient clinics (Quarles Street and Dix Street) and one Therapeutic Community (Just Street). The Therapeutic Community will not become operational until all outpatient clinic functions have been relocated to Dix Street.

Because of community relations problems in Service Area 3, it is planned that NTA's CREPS (Community Relations, Educations and Prevention) team and the DHR Community Relations Team will work with the community to enlist their cooperation and support.

Component #8: Current Program Add-on

A. Activities and Accomplishments

The Vocational Services Coordinator position was filled at the end of November, 1971. The three Job Development Specialist positions were filled during the grant with the last position being filled at the end of October, 1972. Only one of the supplemental Vocational Counselor positions was filled.

After the arrival of the Vocational Services Coordinator, numerous meetings and discussions were held with other resource agencies in order to coordinate activities and to help design a city-wide system of vocational services to addict patients.

The DHR Vocational Rehabilitation Administration (VRA) [redacted] vided support and training facilities to NTA. The VRA [redacted] o availed the time of 4 1/2 counselors to work with NTA [redacted] ients. Meetings were held during the grant period to [redacted] cuss and finalize procedures for NTA referrals. Approximately [redacted] 0 to 25% of the vocational counselors' caseloads were referred [redacted] o VRA for training and placement. Positive Action, a self-motivated learning laboratory funded by VRA, also began accepting NTA patients.

During the second quarter, discussions were initiated with the U. S. Employment Services (U.S.E.S.) centering around NTA's utilization of the U.S.E.S. Job Bank and the the receipt of the U.S.E.S. daily printout of available jobs. Vocational Counselors attended courses given by the U.S.E.S. on utilizing the Job Bank and daily print-outs. A Job Bank, increasing employment potential, is now located in the centralized vocational rehabilitation offices.

The Civil Service Commisssion worked on guidelines for the hiring of ex-addicts during the fifth quarter of the grant. So far, 22 ex-addicts have been placed in Federal Government jobs. Although this is not a large number, it has been a breakthrough.

A concentrated effort to develop block jobs, usually consisting of on-the-job training or training/employment, was undertaken during the grant period. For example, Xerox Corporation provided 45 training jobs; the Urban League provided drafting jobs; on-the-job training in construction and handling heavy duty machinery was provided by Metro, Project Build and Module Housing; and Federal Community College offered training/employment in closed-circuit television. Negotiations were undertaken with the C & P Telephone Company to place NTA's most advanced patients in job slots. Northern Systems handled selection, referrals, and job-related education for Atlantic Masonry Company which promised to train 25 NTA patients in brick-masonry.

Meetings were held with the Board of Trade and National Business Alliances for the purpose of job placement. A number of private employers, e.g. Colbert Construction Company, Kensington Nursing Home, Corcoran Art Gallery, De Young Shoes, Woodner Hotel, etc., accepted NTA patients as employees.

A Council of Employed NTA Patients was developed during the fourth quarter. This group met regularly to discuss employment problems. This mechanism was enthusiastically received; some clinics also utilized this technique and found it valuable.

During the fifth quarter of the grant, the vocational rehabilitation effort was centralized and space was provided at 1400 Q Street, N. W. The Vocational Counselors were still assigned to specific clinics; however, part of their time (the afternoon) was spent in the clinic and part (the morning) in the central office. The Vocational Services Coordinator was made responsible for screening all applicants for jobs in the vocational rehabilitation area. Along with the Clinic Administrators, he was also to be responsible for evaluating the performance of all vocational rehabilitation staff. This centralization improved the coordination between the staff. The new facility also provided adequate space for in-depth counseling.

B. Program Problems

The major problem during the grant period for this component was staff vacancies. Vacancies in the Job Development Specialist positions (the last position filled in October 1972) hindered the development of block jobs. At the end of the grant, 10 Vocational Counselor positions (from a variety of funding sources) were still vacant. Some clinics has no vocational rehabilitation personnel. This staffing situation adversely affected the number of job referrals which could be processed and the follow-up necessary for successful placement.

The centralization discussed previously alleviated this situation somewhat. Clinics without sufficient vocational rehabilitation support were provided part-time services of counselors assigned to other clinics. Centralization allowed NTA to maximize vocational rehabilitation services to all clinics.

C. Financial Statement

See Form LEAA OLEP - 157 (not attached).

D. Management Commentary

The objective of this component was to expand the vocational rehabilitation effort in order to provide the level of vocational counseling, screening, referral and follow-up deemed necessary for rehabilitaton. Personnel vacancies have hampered successful completion of this objective. However, the vocational rehabilitation staff has made major efforts in developing job training opportunities for NTA patients and in trying to institute the milieu necessary for increased employment of ex-addicts. For example, after working with GAO for over one year, five NTA patients have finally been employed. Numerous private firms and governmental agencies (both Federal and District) have agreed to employ NTA patients. Block jobs and expanded training opportunities have also been developed.

The job development effort by the Vocational Counselors increased significantly during the grant period. Although the primary responsibility of the Job Development Specialist is in the area of job development, Vocational Counselors have a secondary responsibility in this area. These two specialist positions working in tandem have resulted in increased employment and training placements.

Gathering of statistical information on the vocational effort had been haphazard. This area improved greatly after the hiring of the Vocational Services Coordinator; centralized reporting has also enabled NTA to maintain better information on the success of its vocational rehabilitation effort. In addition, the vocational rehabilitation staff started working with the NTA Research Division during the last quarter of the grant on a project to test the effect of jobs with upward mobility on favorable progress.

From the best information available statistics from January 1, 1971, through November 30, 1972, are as follows: 1005 patients were placed on jobs; 188 patients were placed in training situations; and 191 patients returned to school or were placed in GED programs.

From July 1972 through November 1972, additional information is available: 411 patients were referred for job interviews; and 347 follow-up visits and 304 job contacts were made by the vocational rehabilitation staff.

SUMMARY
LEAA Grant 71-DF-925
Selected Addiction Program Development
and Expansion, (Part I)

1. Administration - Only the Training Specialist position remained unfilled during the total period of the grant The decision to centralize training in DHR was made during the final quarter of the grant.

2A. Central Information System - During the first quarter the Central Information System identified several stages of analysis necessary to the development of a systems mode for CIS; modifications were made to the current system to make it more responsive and a new computer contract was let to implement the design of a new NTA system; this design included methadone accountability.

2B. Clearinghouse for National Identification - SAODAP recommended that this project be continued for a second six months to complete four tasks. NTA requested that it be allowed to reprogram $27,848 of the money alloted to the Evaluation Component of Grant 71-DF-925 (S-1) to be used for continuation of this project.

3. Drugmobile - The Drugmobile has been well received by the community; it receives more requests than it can handle. The Drugmobile program will be continued by means of District funds.

4. Central Medical Intake - CMI has met all the objectives initially set forth in the grant and has become an integral part of the NTA system. Toward the end of the grant, intake decreased substantially; this allowed CMI to do follow-up physical examinations and handle patients who entered treatment prior to October 1971 and had never had an examination.

5. Phase I Methadone Clinic - MODCAP has now been converted to a Phase II Methadone Clinic. The Clinic is also below capacity. Patients will be transferred from the 44 G Street Clinic, funded by Grant 71-DF-925 (S-1), to help equalize the patient distribution.

6. Phase I - II Detoxification-Abstinence Clinic - The lease for this clinic's temporary facility has been extended to June 30, 1973; the move to a permanent site will not occur until after that time. This clinic will now be classified as multi-modality and will offer treatment to methadone stabilization patients as well as detox-abstinence patients.

7. FEATS - FEATS will now consist of two outpatient clinic (Quarles Street and Dix Street) and one Therapeutic Community (Just Street). The Therapeutic Community will become operational after the outpatient program relocates completely to Dix Street, which should occur within 45 - 60 days.

8. Current Program Add-on - The vocational rehabilitation staff has made major efforts in developing job training for NTA patients. Statistical reporting improved significantly during the grant period.

END