# METHADONE MAINTENANCE (B)

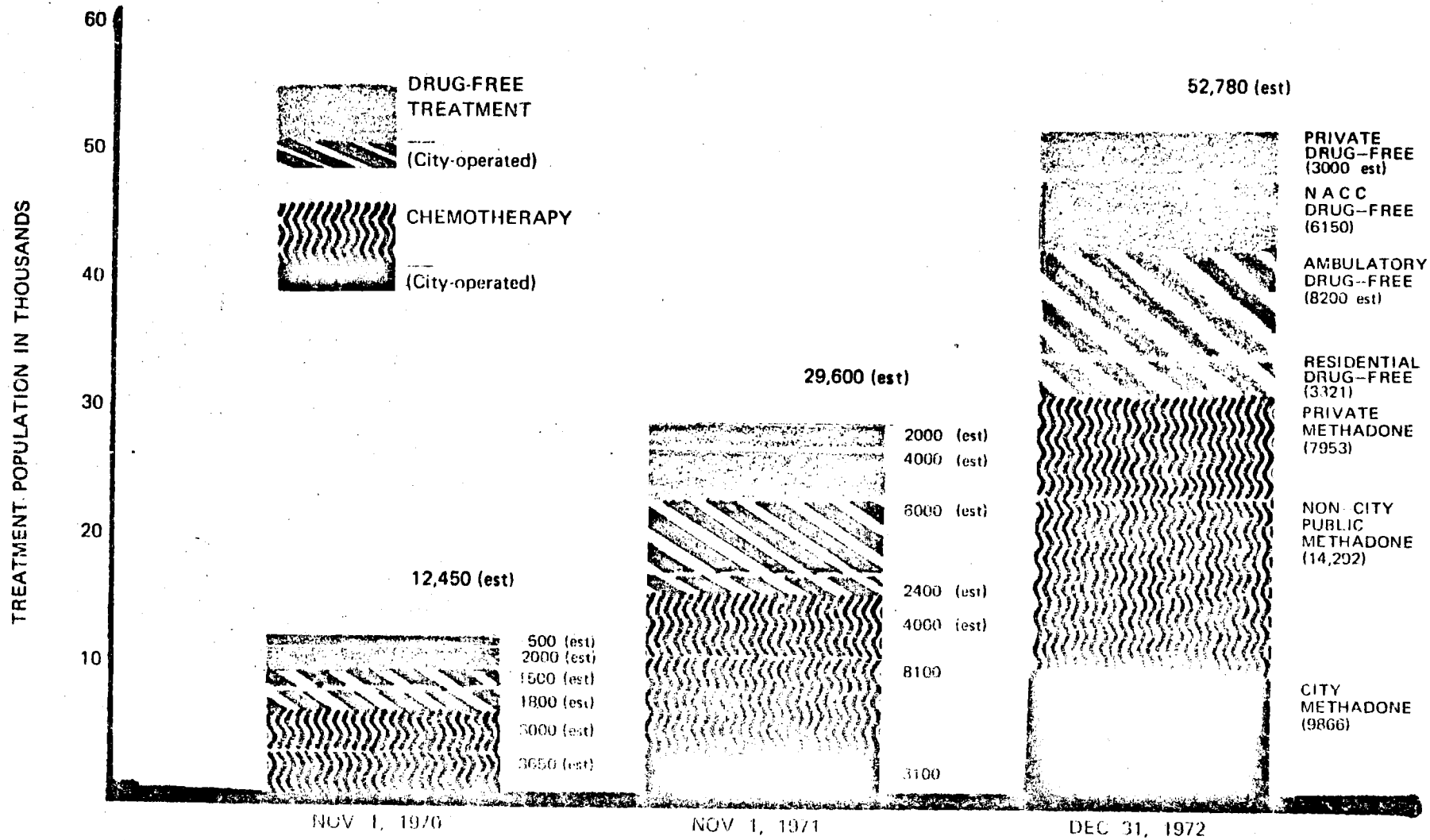
## THE ENTREPRENEUR'S VIEW

A portion of the text and several of the exhibits in this case originally appeared in 'Addiction Control in New York City (B)' 9-372-147, prepared by Mr. Robert E. Svensk under the direction of Dr. John R. Russell at Harvard University Graduate School of Business Administration, and distributed by the Intercollegiate Case Clearing House. This material appears by permission of the Harvard Graduate School of Business Administration.

This is a draft of a case prepared for use at the John Fitzgerald Kennedy School of Government, Harvard University, by Mark H. Moore and Mark Ziering.

Exhibit 1

**TREATMENT:**
**N Y C DRUG ABUSERS**
**1970 - 1972**



Also like the policy analyst, Chase noticed the enormous gap between the number of users on the street and the number currently in treatment. However, Chase had a somewhat different perspective on this problem. To the policy analyst, the idea of scale was relatively uninteresting--a simple matter of multiplication. To Chase, scale was a very important feature of the situation. Scale meant resource requirements, hospital recruitment, clinic sites to be found, the medical establishment to be mobilized. Scale was a major piece of the challenge.

> In the city of New York at that time, the best estimates were that there were somewhere between 100 and 125 thousand heroin addicts on the streets. And if you looked at the numbers in treatment, there were about, oh, I would say, maybe 5 thousand were in treatment. So you had this incredible gap. You had roughly anywhere between 100 or 125 thousand addicts who were not being treated. The thing to keep in mind is the adminstrative difficulty of filling this gap! When you say 5 thousand, that doesn't sound like a lot. Well, if you figure that maybe you can put 200 in each clinic (if you are lucky--most of them were smaller) you need an awful lot of clinics to hold even that number of people. There were probably 30 or 40 facilities needed around the city of New York just to take care of 5,000 people. And there were 100,000 to be treated.

The major difference in Chase's perspective and the perspective of the policy analyst was that Chase believed that he personally had both the capability and the responsibility to fill this gap. He headed the Health Services Administration (HSA) of the City of New York. It had a budget of $1.2 billion. It was a crime that the city was not doing more to deal with the heroin problem. Methadone maintenance was an inexpensive and simple response. It resembled programs he had set up before. He could make the program happen. The problem was simply to get moving.

B. Seizing the Initiative: What Happened

It seemed to the policy analyst that Chase faced a serious political problem in gaining responsibility for the program. He faced competition from at least three sources: Beth Israel, ARTC, and the Addiction Services Agency. Each of these agencies appeared to have a stronger claim to the mission of rapidly expanding methadone than H.S.A. How did Chase manage to seize the initiative?

Chase's first move was to write a memorandum to the Narcotics Control Council proposing to put 15,600 addicts in treatment in less than 1 year. The opening paragraphs of the memorandum appear below:

> PROPOSAL FOR A METHADONE MAINTENANCE TREATMENT PROGRAM FOR NEW YORK CITY
>
> The high incidence of narcotics addiction is one of the most critical problems facing New York City. Last Year, 900 persons, 224 of them teenagers--died as a direct result of heroin usage in New York City. Estimates of the number of heroin users in the city--which has 90% of the state's addicts, and, it is thought, one-half

However, from Chase's point of view, the outlandishness of his proposal was its most important characteristic. The proposal was designed to affect people's expectations in two important ways.

First, it was designed to get people thinking in terms of large programs--not experimental or pilot programs. Chase knew that one of the easiest compromises in governments is to set up small-scale pilot programs.

> The general response of bureaucracy to a problem is to take a piece of it and do something that they call a demonstration project. . . . It looks like you're working on lead poisoning or drug addiction and you can say, "See, we have got that program down there." Yeah, there are 40 addicts in it. That only leaves you 99,000.

Unless he made a conscious effort to keep the program from going down that track, it would end up as another ARTC-small and experimental. As Chase recalls:

> One of the big things at the start was asking "what is the universe?" I began arguing that we couldn't dicker around with programs for 80 and 100 people. We had 100 thousand addicts out in the street and we had to do something very substantial and breathtaking. We were going to do the <u>whole universe</u>.
>
> Well, suddenly that becomes a different problem. That kind of change in magnitude, from 8,000 to 120,000, is not simply a multiplication problem.
>
> So it was very important at the outset to say "We're not just gonna do a few, we're gonna do 120,000. They would say, "You mean, this summer we're gonna test 3,000 kids [for lead poisoning] a week, when we did 8,000 total all last year?" The answer: "Yup, that's what we are going to do."

Second, the memorandum was designed to create "momentum." The idea of momentum is central to Chase's management philosophy.

> I believe that when you do things, that speed is terribly important in government. If for nothing else, it builds momentum and allows you to get your program going. I'm not sure I'm making my point well enough, but what I mean is that in managing in the public sector, speed is more important than just speed. Speed has to do with momentum. And, in the public sector when you're trying to get something done in a place like New York City, everybody and everything seems lined up against you on the way to doing nothing. You get communities who say: "Don't do it;" you have a budget that says "Don't do it;" personnel says "Don't do it." The bureaucracy is weighted against you.

An entrepreneur who himself has "character and drive" can attract similar people, and furthermore can instill these qualities in those who already work for him. In effect, the supply of such people to Chase was larger and more immediately available than it would have been to others.

Second, Chase wanted not only proven managers but also some doctors who had managerial skills, or who could appreciate good management. This was the model that had been successful in implementing the Lead Poisoning program, and was a key element of Chase's overall strategy in managing the Health Services Administration. When asked about the process of choosing people to run programs in HSA, Chase made the following response:

> As far as I am concerned, the only people you really know for sure are gonna produce are people with whom you have worked with before, and people who have produced; that you saw it with your own eyes. I was prepared to believe that there were some good people in the Health Department. As a matter of fact, what I did very consciously at that point was to pick a doctor as the head of the [Lead Poisoning] program who had a very good reputation in the Health Department. You needed a medical type as the top guy for a couple of reasons. Number 1: there are usually some broad health issues in the design of the program. For example, at what level do you treat a kid? Should he be treated? Number 2: You had to talk to doctors, you had to recruit nurses, you had to talk to hospitals and to health centers. It was important to have somebody who could relate to them. Number 3: my particular position made it difficult for me to come in as a non-health person, a non-doctor, and start off the first program and do it all with managers. Politically, it would have been a dumb thing to do. So I had to have a medical guy. But what I did was to put in, as a number two, a guy that met that criteria that I just mentioned. Number 1: I <u>knew</u> he was good. He had worked for me a year and had done a damned good job. I knew he was a very tough guy and very effective. Number 2: I wanted a manager. I wanted a manager in that operation and it is something that I tended to do later on too--that was, to mix up the health professionals with managers. Because the kinds of things you need to do to start a program tend to be figuring out how to get 15 outreach workers into 7 blocks and making sure the cars are there and the tubes are there, and the needles are there and the nurses and everybody else are there. There are some people who do that much better than other people. And they tend not to be people with health training; or at least, not particularly those people. There are many who can do it, but there are disciplines other than health care that seem to produce those people in greater quantities.

It is important to understand that recruiting and committing such people is very expensive. Recruiting is expensive because it requires the manager's own time. Committing very talented and tough staff to one project is expensive because it means that their services are lost to other important programs. On the other hand, Chase is quick to point out that your best staff people are one of the few resources you can move quickly and easily. If you think a program is worth something, you ought to be willing to make that commitment.

Third and most important, the staff immediately set out to recruit the hospitals that would operate the individual clinics. In early April, every hospital in New York City was sent a letter asking it to sponsor a clinic. By the middle of June, the staff was negotiating contracts with the hospitals that had responded. The program was beginning to happen before Chase had either the authority or the money to operate it. This too was Chase's conscious decision. As Chase recalls:

> We leaned into that program pretty much . . . During May, we had lined up a number of hospitals--maybe a dozen. We had talked to them. We had somebody drafting a contract. . . I had to take a gamble.

Chase's early maneuvers produced a vital intermediate result: on May 29 Mayor Lindsay wrote a memorandum authorizing HSA to manage a large methadone program. The memorandum was worded to satisfy ASA's claim to a "coordinating role," but left little doubt who would actually manage the program.

TO: The Honorable Larry Bear
The Honorable Gordon Chase
The Honorable Mitchell Ginsberg
The Honorable Frederick O'R. Hayes

FROM: John V. Lindsay

SUBJECT: Administration of the New City Methadone Program

In order to preserve and strengthen ASA's role as the overall coordinating agency for narcotics, I have decided on the following arrangement for the development and administration of the City Methadone Program. This method will ensure the fastest possible implementation of the methadone program by utilizing HSA to run the single track model and ASA to implement its multi-modality program.

1. The Addiction Services Agency will formally apply for and receive the funds from the State for the programs being developed by HSA and ASA. The bulk of those funds or about seven million dollars will be assigned without reservation immediately to HSA, or to a fiscal intermediary designated by HSA. The balance or roughly two million dollars will be administered directly by ASA as part of its multi-modality program.

2. The proposal to the State will be made in ASA's name but the negotiations will be led by Gordon Chase, Administrator of HSA, and Mitchell Ginsberg, Administrator of HSA.

3. HSA will administer the program and funds for its share of the program. ASA and HSA will carry on extensive discussions of the appropriate policy and program issues. It is understood that this will be done in such a way as not to interfere with the HSA operation of the program.

4. The Mayor will review the program at the time the budget requests are submitted for review and decide at that time whether revisions in this arrangement are appropriate. Meanwhile every step will be taken to increase the strength and effectiveness of ASA.

Second, Newman was a responsible man. He understood that he was shouldering a responsibility for the future of methadone programs:

> My concern was partly that this program that I was responsible for would be an absolute failure. But a bigger concern was that, if this program were a tremendous failure, it could just destroy overnight methadone maintenance treatment in the entire country. Literally, from San Francisco to Maine and Florida, there would have been no more methadone maintenance treatment as we know it. . .had we tried to do something inappropriate and ended up with a failure . . . It was a hell of a responsibility.

Furthermore, Newman personally knew Dole and the others who were running the other programs. They knew he would run his program responsibly, especially since he had consulted with them often:

> I was really obligated to seek their advice, to get their opinion on how to do things. And as often as not, their opinion was contrary to what I wanted to do and . . . . did, and that just always made it difficult to avoid offending them . . . I didn't want to alienate the people who were running the same type of program that I was running.

Third, Newman was extremely careful to avoid competition with the other programs. He made it clear that he was not trying to take funds from them, and would seek City funds rather than endanger their funding from NACC. Moreover, before Newman began recruiting hospitals to participate in the program, he sent a complete list to the directors of the other programs and asked them to cross out hospitals which they were planning to recruit themselves. And he was always careful to praise the other programs:

> When somebody asked me, "what about Beth Israel," I said, "terrific program." "What about Fran Gearing?" I said, "Marvelous." "What about Bronx State?" "Oh, they run a terrific program."

Fourth, it seems likely that the directors of the Beth Israel program simply underestimated the ability of the City program to expand. Their own program had only 2,000 patients after six years, and there was reason to believe that the City program could not grow much faster. The city was going to train its staff at Beth Israel and follow Beth Israel's clinical procedures. Furthermore, the city program would be fettered by the city bureaucracy. Newman explains:

> Beth Israel initially wasn't uptight and wasn't defensive, I think, because they just never believed that we could do everything that we said we were going to do. And when we started talking about 2,000 patients at the end of the year, I think they just wrote that off and said . . . "he'll be lucky if he has 200 patients at the end of the year, and that's no threat."

Keeping sufficient pressure on the program managers also turned out not to be a problem. Since Chase had chosen aggressive people who cared deeply about implementing the program, there was relatively little need to create external incentives. Relatively modest incentives could be expected to unleash prodigious efforts.

However, Chase did not rely entirely on the internal motivation of his program managers. As soon as the program began, he "started counting." A detailed plan for implementing the program was developed. Specific individuals were identified as being responsible for specific actions. Deadlines were established for each activity. A procedure for regular reporting was created.

In addition, Chase reminded Newman of the urgency of their task with a gruesome statistic. Each month Chase would compare the names of the people on the waiting list for the City Methadone Program with the names of the people who were reported to have died from drug overdoses by the City Medical Examiner's Office. He would call Newman and tell him how many had died. For a man as deeply concerned about human lives as Robert Newman, these reports were agonizing.

E. Avoiding the Bureaucracy

Given the clear direction provided by the program plan, the detailed and timely reporting system, and the temperaments of his program managers, Chase could rely on an aggressive cutting edge. However, even the most durable cutting edge could be dulled if it was kept grinding against the bedrock of bureaucratic procedure necessary to establish a large, operating program. To avoid exhausting his management team in endless fights with the city bureaucracy, Chase made a crucial decision: He decided to run the program by contracting with city hospitals to provide the service rather than by operating the program directly under the supervision of the city.

To provide publicly financed services in New York City, three different institutional arrangements were possible. First, the city could provide the services directly through a city-operated agency. Second, it could contract with private institutions to provide the services. Third, it could create a "fiscal drop," a private institution which would legally be responsible for the program, but which would, in fact, be a front for the city agency that would actually manage the program.

From Chase's point of view, direct city provision had the enormous disadvantage that all administrative actions had to be cleared through the "overhead agencies" of the city government. Positions had to be created by the Bureau of the Budget and filled through Civil Service procedures; space had to be procured and approved by the Department of Real Estate; etc. These overhead agencies could bring a large program to a standstill simply by losing a few of the thousands of pieces of paper that had to be processed to commit city resources. If these agencies moved at all, they did so slowly: a recent review of the procedures of these overhead agencies revealed that 72 different processing steps were required to purchase a typewriter. Moreover, astride each processing step was a relatively low level bureaucrat whose only way of exercising power and making people notice him was to say "no." Theoretically, this mass of procedures made program managers "accountable" to the people of New York. However, from Chase's point of view, what the procedures really accomplished was to place major

F. Summary

Thus, Chase had seized the responsibility, recruited a project team, given specific policy direction, established a reporting system to keep the pressure on, and made several key decisions that would relieve his management team from restraints imposed by bureaucratic procedures or resource problems. It was time for him to play a less active role. Achieving the ambitious scale promised by Chase and working out operating details were left to Newman and his associates.

## III. Newman Implements a Large Scale Methadone Program

### A. Newman's Interests and Resources

When Mayor Lindsay authorized the Health Service Administration to operate a large scale methadone maintenance program, the Bureau of Methadone Maintenance was created within HSA. (See Exhibit 2). Dr. Robert Newman, appointed Director of the Bureau, did not formally report directly to Chase, but had access to Chase whenever he needed it. Newman's charter was to establish a methadone maintenance program. The precise shape that the program would take would depend largely on his interests, resources, and skills.

Newman's interests in the situation were somewhat different than Chase's. Chase's over-riding interest was to build a large program very quickly. Newman recalls:

> The one thing Chase would not tolerate, and I think rightfully so, was hesitancy to do something in terms of size without very good reasons for not doing it.

This pressure from Chase to go quickly was influential partly because Chase was Newman's superior, partly because Newman liked and admired Chase, and partly because Newman agreed with the objective. But there were external pressures as well. The grant from NACC which financed the program committed Newman to having a treatment capacity of 2,500 by February 1970, and 1,500 in patients in treatment by March 1970. The expectation created by Chase's initial memo also committed Newman to rapid expansion.

But Newman also felt pressured to adopt careful clinical procedures that were sure to slow the growth of the program. The directors of the existing methadone programs recommended that heroin users start treatment as hospital inpatients. However, inpatient treatment was very expensive, and would slow the rate of intake at a typical treatment unit to about three per week. The directors also recommended a three-month training period for the clinic staff. If Newman ignored these recommendations, he would risk his friendly relationships with these and other people in the New York medical establishment. He would also risk the success of his program and thus the nation-wide future of methadone maintenance.

He shared Chase's goal of making methadone treatment available to everybody who wanted it, but felt that Chase didn't appreciate fully the risk of failure:

> . . . Chase didn't have any real feel for the limiting factors in terms of maintaining the quality of care and . . . maintaining a uniform procedure, and perhaps didn't appreciate how vital that was. He felt the way most people feel even today: a methadone program is a methadone program as long as you give the

> patients their medication every day . . . He just didn't understand how you could run a bad methadone program.

Newman eventually did disregard many of the directors' recommendations but, at first, he was painfully aware of the experimental nature of methadone maintenance:

> I kept telling myself the pharmacological rationale for the success of methadone . . . I kept on reading over the evaluation reports and visiting the Beth Israel clinics and talking to methadone patients to reassure myself that this program really worked. Something about the whole business sounds magical. Somehow you just can't believe that you can really get these thousands of people and give them this methadone once a day and [have them] all stay in your program.
>
> I had a very similar experience when I built my first fish tank with this little clear plastic glue that they say will hold anything forever but looks like toothpaste. I started off big with fish tanks just as I was going to do with the methadone program. I built this four by two foot fish tank . . . Every morning, the first thing I would do was to run out and see whether or not the water was really still in that damned fish tank. And, really, it took a good month before I convinced myself that it really did work and the water really wasn't going to fall out.

Thus, all of the problems and tradeoffs noted by the policy analyst lay squarely on Newman's shoulders to resolve as best he could.

In seeking to develop and control the program, Newman had several significant resources. First, he had a small staff in the Bureau of Methadone Maintenance. He began with about 4 professionals and the authority to hire 9 more if he needed them. The tasks they would have to perform are detailed in Exhibit 3.

Second, he had very specific and detailed plans for both the development and operations of the methadone program. As previously noted, the Project Management Staff had developed a detailed plan setting out tasks, deadlines and organizational responsibilities. Elements of this plan are presented as exhibits 4 and 5. In addition, the staff had prepared a book of policies and procedures for methadone clinics that covered such issues as standard budgets, procedures for intake and procedures for dispersing methadone. The pace of the program's development and its style of operations would be guided by their plans.

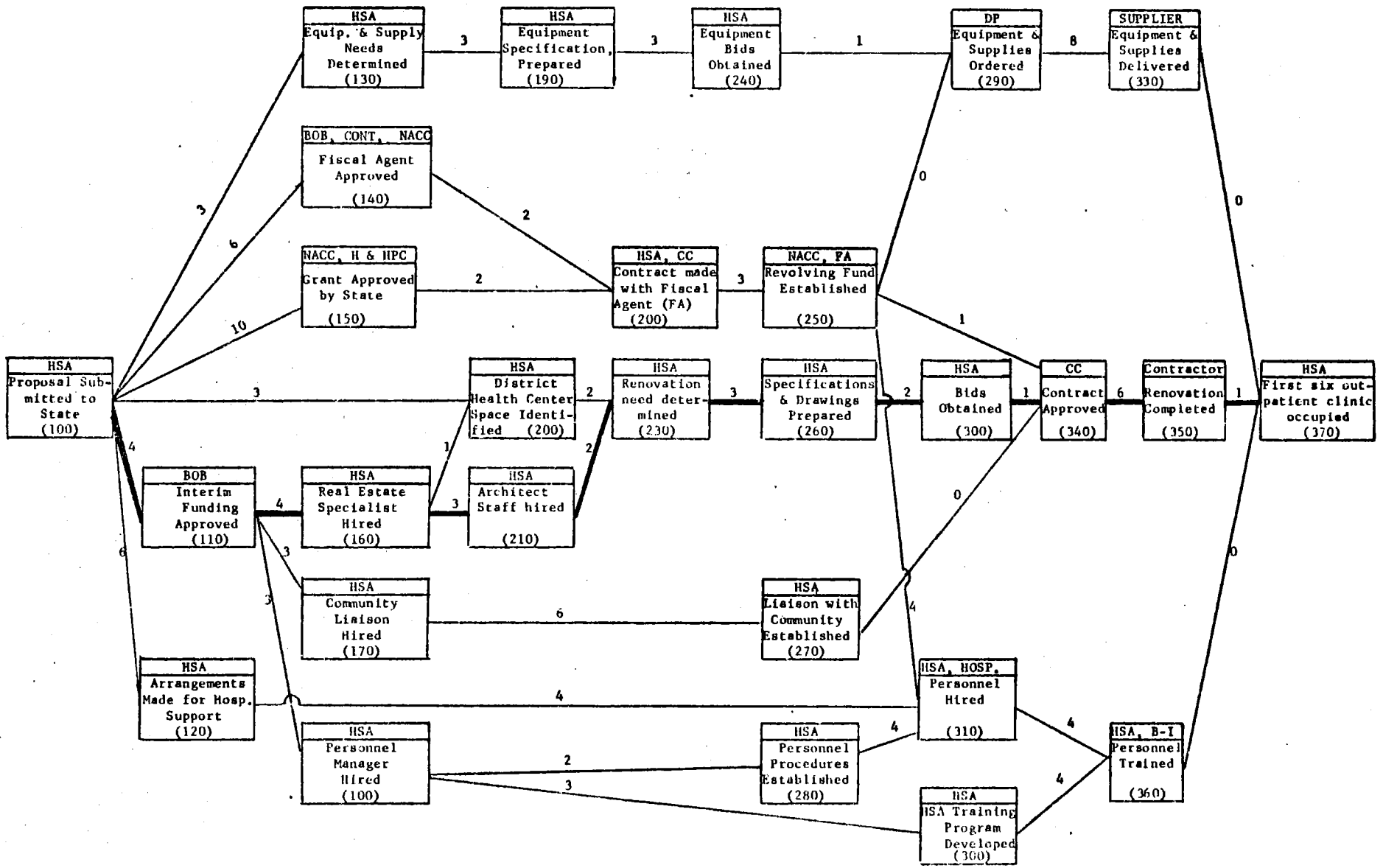
Third, Newman had strong personal relationships with people not only in the "methadone establishment" but also in the medical and public establishments of New York City. He could rely on these relationships for both information and work on behalf of the methadone program.

Fourth, Newman had the strong backing of Chase and the Mayor. While this did not protect him from occasional sniping from both ASA and some of the Mayor's assistants, Newman knew that in the end his decisions would be accepted.

# Exhibit 4

**Network Analysis for Opening of First Six Clinics**

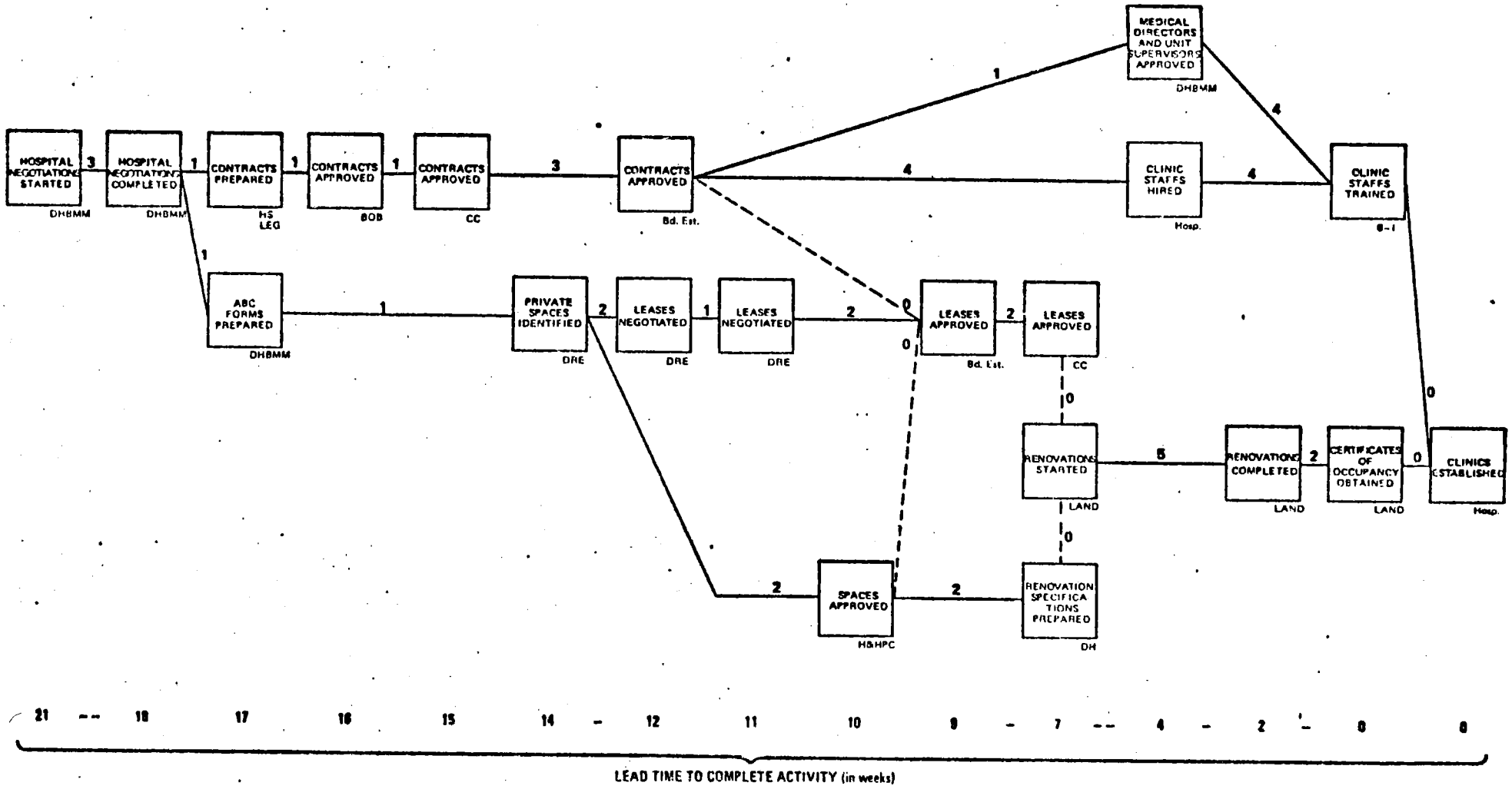
**Methadone Maintenance Treatment Program**




From Addiction Control in New York City, (see title page of this case).

Exhibit 5

## Standard Network for the Establishment of Clinic




From Addiction Control in New York City, (see title page of this case).

> . . . the next logical step was to run our own two-week training program . . We still do it that way.*

The plans to rely on the other methadone programs for patients were also thwarted. Newman recalls the following:

> They had a waiting list of their own of about 3,000 people. We started off on day 1 and didn't have any waiting list. We hadn't received any applications. We opened up 4 clinics and didn't have anybody to put in those clinics. Just getting from the established programs some of the names from the waiting list turned out to be impossible. We just couldn't get them to give us a list of 150 names. There was one problem or another. They just couldn't get themselves to do it.
>
> Fortunately, within hours after opening our own clinics, we had more applications than we could possibly handle. In fact, within 3-4 months our program alone had more applications on our waiting list than all of the other programs put together.

Newman's summary of the role of the other methadone programs is succinct.

> They didn't present a problem. On the other hand they didn't present all that much support . . . In terms of getting assistance from the established programs, what we did get was so inappropriate or so poor that we ended up doing everything ourselves.

It was fortunate for the pace of the program's development that the failures of the other methadone programs were not critical. In one case (patients), their potential contribution turned out to be unimportant. Patients voluntarily appeared in large numbers. In the other case (training), alternative methods that were not particularly costly were developed. In fact, the fact that HSA had to establish its own training program could be considered a benefit rather than a cost. Some of the institutional rigidities that had appeared in existing methadone programs might be avoided in the City program.

Newman's need to contract with hospitals for space, personnel, and administrative services was much more critical. Luckily for his program, Newman was fairly successful. Newman recalls his efforts:

> We just sent out a letter to every single voluntary hospital in the city [except for those that Beth Israel or Bronx State were planning to recruit] . . . one-page letters saying the city is initiating a methadone program [and] we have funding to cover all expenses pertaining to the program including rental of space, renovation of space, telephone, salaries, etc . . . For the first 20 clinics we really didn't have to do any pushing at all beyond that first letter. I would say that one out of every two hospitals that responded we did in fact end up writing a contract with.

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*From Addiction Control in New York City, (see title page of this case).

that detailed these official procedures. In practice, the central office directed the program as if the clinics were official city agencies, except that the clinic staff was hired by the hospitals. However, Newman himself recruited many of the doctors who served as clinic directors.

To insure that the clinics were operating on schedule and with the proper procedures, Newman's staff spent much time designing, implementing, and perfecting the program's information system. It had four important characteristics.

First, the inputs to the system were designed to be both easy for the clinics to submit, and necessary for their day-to-day operations.

> We set up the procedures in such a way that the clinics cannot function--they simply cannot treat patients--without going through the entire data system . . . They submit the data because that is the only way they can dispense methadone, the only way they can justify the expenditures for staff. In other words, it is a clinically oriented system.

Newman did not require the clinics to report reams of data, which might have been found useful by researchers, for fear of burying the clinics under a mound of paper.

Second, the system was very fast. Chase and Newman received weekly reports on the activities of the previous week. They could pinpoint the responsibility for failures and demand and monitor improvements with almost no time lag. Chase recalled:

> . . . We went over to ASA to see what the drug-free programs were like . . . They had a reporting system: a census once a month. The census lag was two months. So in July, I picked up a report from May . . . I said, "All right. That clinic's doing badly. Let's call them up on the phone . . . What's wrong? Why is your intake so low?" The answer was "oh well, that report is old. It is 3 months old, Now it's much better." By the time you got the next report you have got the same story again.
>
> [Under our system] I could pick up the phone on Tuesday and call up Bob and say, "Hey, Lower East Side clinic took in two people in the last two weeks. What the hell is going on? Call them up and do something about it. If you can't do it, let me know what I should do."

Third, the system produced accurate, discrete information about the clinical practices of the clinics. Records for individual patients listing the services they received were retrievable and could be aggregated on a variety of dimensions. Chase described the versatility of Newman's information system:

> Bob's system was so good that he could tell . . . who came in last week, why they came in, when they came in--all that kind of stuff. He could tell you who got how much methadone on what day: "So and so got 60 grams on Wednesday and he is going to get

[Excerpt from Addiction Control in New York City (B)*]

1. The Project Plan

The original project plan was submitted as part of HSA's proposal to NACC in July 1970. Major objectives of the project were the following:

-Establish a Bureau of Methadone Maintenance in the Department of Health with key staff hired by September 1970.

-Establish 20 out-patient clinics by February 1971, as follows:

| | | |
|---|---|---|
| Clinics | 1-2 | in October |
| " | 3-6 | in November |
| " | 7-9 | in December |
| " | 10-15 | in January |
| " | 16-20 | in February |

-Open an intake unit on Riker's Island by October 1970 for the purpose of counseling prisoners about the maintenance program and screening and processing applicants for admission.

-Establish one in-patient treatment unit by October 1970.

-Create a mobile intake unit to screen and process applicants by November 1970.

-Establish a fully operational urinalysis program by November 1970.

-Achieve a patient capacity of 2,500 by February 1971.

-Have 14,00 patients in treatment by March 31, 1971.

In addition, the Project Management Staff had developed a detailed project plan that specified all the specific actions that had to be taken by different agencies to achieve their larger objectives.

PMS found it userful to describe the MMP effort in two phases. The first covered the opening of clinics 1-6 and included the initial set up of BMM, itself (see Exhibit 4); the second was the iterative process that would be necessary to open each additional clinic after the start up effort was complete (see Exhibit 5). Setting up each clinic required completion of a number of key tasks:

-Negotiating a contract with the hospital.

-Obtaining contract approvals from the
(i) Bureau of the Budget
(ii) Board of Estimate
(iii) Corporation Counsel

-Identifying private space, if necessary.

-Obtaining lease approval.

-Renovating the space.

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*Source noted on Title Page.

Despite this progress, there had been slippages. All were slight and a variety of causes could be identified. Delays in ordering equipment and planning laboratory renovations were affecting the urinalysis program. Nothing at all had been done to start the inpatient clinic, largely because no one at BMM had had time, but also because Dr. Newman was no longer sure that one was needed. Because of the slowdown in the rate of contract negotiations, clinics five through eight would not be opened as originally scheduled. Finally, the first four clinics all had been affected by community sentiment. Delafield Hospital - which was sponsoring three of the first four units - decided, unilaterally, to set back the opening date from mid-October to October 31. This would coincide with the opening of a community-sponsored detoxification unit that the hospital was also going to operate. Delafield's administration feared adverse reaction if the city's clinics were opened first. The fourth clinic, at Jamaica Hospital, met with more specific hostility. As Raymond described it:

> The problem was that the hospital was trying to do some blockbusting out there and we got in the middle of it. They owned a building on a residential street that was partially occupied as a residence. They were going to move the clinic into the other half of that building without ever consulting the community at all; so the community heard about it and really raised hell at a very large meeting. Newman went out and spoke to them and agreed with the decision of the community that the clinic should not go there. The hospital found a very adequate two-story building right behind their hospital that they owned. It borders on the same street but the entrance is around the corner and now the community's perfectly happy.

PMS rescheduled major milestones as shown below:

| | Original Plan | Revised | Number of Weeks' Slippage |
|---|---|---|---|
| Central Staff Hired | October 2 | - | |
| Clinics 1-4 Opened | October 16 | October 30 | 0* |
| Inpatient Treatment Unit Opened | October 23 | December 4 | 6 |
| Riker's Island Intake Unit Operational | October 30 | - | 0 |
| Clinics 5-8 Opened | November 6 | November 27 | 3 |
| Central Intake Unit Operational | November 20 | - | 0 |
| Urinalysis Program Fully Operational | November 27 | December 11 | 2 |
| Clinics 9-14 Opened | January 15, 1971 | January 1, 1971 | -2 |
| Clinics 16-20 Opened | February 5, 1971 | - | 0 |

*Note: Although there was two weeks' slippage in the scheduled opening date, the number of clinics to open in October increased from two to four.

Exhibit 6

Clinic Locations

| | Scheduled Opening Month | Location | Space Requirements |
|---|---|---|---|
| GROUP I (1-4) | November | | |
| Jamaica (1) | | Queens | In hospital-owned space |
| Delafield (1-3) | | Manhattan | One in hospital, two in a city health center |
| GROUP II (5-8) | December | | |
| Lower East Side | | Manhattan | In city-owned space |
| Beekman-Downtown | | Manhattan | In hospital-located rental space |
| Elmhurst (1) | | Queens | In hospital |
| St. Mary's | | Brooklyn | In city-provided rental space |
| GROUP III (9-14) | January | | |
| Bronx Lebanon (1-2) | | Bronx | In city-provided rental space |
| Greenpoint | | Brooklyn | In hospital |
| Long Island College (1) | | Brooklyn | In city-provided rental space |
| Long Island Jewish (1) | | Queens | In hospital |
| Roosevelt | | Manhattan | In hospital-provided rental space |
| GROUP IV (15-17) | February | | |
| Jamaica (2) | | Queens | In hospital-owned space |
| Mary Immaculate | | Queens | In city-provided rental space |
| Peninsula General* | | Queens | Cancelled |
| Long Island College (2) | | Queens | In city-provided rental space |
| GROUP V (18-22) | March | | |
| Elmhurst (2) | | Queens | In city-health center |
| St. Mary's (Charles Drew) | | Brooklyn | In city-provided rental space |
| Long Island College (3)** | | Brooklyn | In hospital-provided rental space |
| Long Island Jewish (2)* | | Queens | In city-provided rental space |
| Richmond Memorial** | | Richmond | In hospital |

*Peninsula General cancelled its contract with the city in January and was replaced by a second clinic at Long Island Jewish.

**Added as clinics 21 and 22 when the in-patient unit was abandoned.

From Addiction Control in New York City, (see title page of this case).

## I. Two Years after the Analysis: The Output

The following editorial appeared in the New York Times on September 18, 1973:

### A DRUG SUCCESS

> Back in 1969, when drug abuse was an almost wholly unanswered problem in New York City, those addicted to heroin had to wait as long as six months to be interviewed for acceptance into a methadone treament program. After the interview, those accepted often had to wait another six months or more before actually gaining entrance into such a program--one that detoxified addicts and stabilized them on a maintenance dose of methadone. The goal was to kill the overpowering craving for heroin and thus enable addicts to resume employment and normal social life.
>
> During the inordinate wait for treament, addicts were forced to manage as best they could on the city's streets. Too often this meant resorting to crime to raise money for heroin. Addicts out on probation after the commission of one crime were frequently arrested again for the commission of another in a discouraging, revolving-door system of criminal justice.
>
> The city's Department of Probation stepped in at this point and established methadone clinics of its own. At the height of its activity, the department maintained five clinics with as many as 500 or more addict-parolees in treatment. Now, these clinics are being phased out. the one in Queens has already been closed down. The reason? The city's own methadone treatment program, under Dr. Robert Newman of the Health Services Administration, has so swiftly and so successfully expanded its capabilities that there no longer are waiting lists for admission into methadone treatment.
>
> Ther have been so many stumbling failures in the city's response to the drug menace that they have blurred its successes. This is one. Addicts seeking methadone treatment today, whether parolees or not, are fortunately able to obtain it without delay.

One year after the pessimistic appraisal by the policy analyst, New York City had a methadone program with over 700 people enrolled in the clinics. Two years later the program was still growing. Exhibit 1 shows the total number of patients in methadone treatment over the three-year period from March 1970 to March 1973. Moreover, the Beth Israel Program, stung by the unexpected competition from the City's program, had also grown. Consequently, in March 1973, there were 20,000 heroin users in methadone programs.

What had occurred to change the basic situation? Who moved to create the program at such a scale? How was the city bureaucracy made to move so quickly? These are the questions for this part of the case.

## II. Gordon Chase Makes Room for a Large City Methadone Program

### A. Chase's Interest in Methadone Maintenance

In November 1969, Lindsay appointed Gordon Chase to the position of Health Services Administrator. The appointment surprised the medical establishment of New York City. Chase was the first non-M.D. ever appointed to a high policy-making role in the health area. By nature, Chase was an aggressive manager. Given the importance of this job and the close public scrutiny that would be given to his performance, Chase's natural aggressiveness was enhanced. Within the first several months of his tenure, he had successfully implemented a program to screen children for lead poisoning. But he was eager for new programs and challenges.

Chase had no direct line responsibilities for the heroin problem. The responsibility primarily belonged to Larry Bear, the Commissioner of the Addiction Services Agency. However, Chase did sit on the Mayor's Narcotics Coordinating Council. Consequently, he was knowledgeable about the problem and had routine access to information about it. Moreover, Chase did have some influence over the City's vast medical establishment. In 1969, this establishment included 7 medical schools; 18 municipal hospitals; 60-70 voluntary hospitals; 25,000 physicians; and 2,500 psychiatrists. It seemed obvious that even if only a tiny fraction of this enormous capacity could be devoted to the heroin problem, there could be a large impact. Thus, Chase loomed on the periphery of the city's response to the heroin problem.

Chase's view of the heroin problem and methadone maintenance was similar to the view of the policy analyst's, but differed in some important respects. Like the policy analyst, Chase noticed the size of the heroin problem. As he recalls:

> The first thing that was terribly depressing was the fact that there were large numbers of people dying of overdoses eveyr month. The average overdose death rate in New York City was about 100 a month. Those are the ones that we knew about! There were probably an awful lot of people who never showed up in the Medical Examiner's office. The second thing was that all the crime rates were skyrocketing and particularly crimes that were considered to be addict-related like crimes against property: burglary, robbery, car theft. . . So that at that time drug addiction was starting to be considered as the number 1 problem in the city.

Also like the policy analyst, Chase was impressed by the ability of methadone to attract and retain heroin users in treatment, and by the apparent reduction in crime and increases in employment that resulted. He knew that the evidence on methadone's effectiveness was not absolutely compelling, but believed that the evidence was strong enough to justify action--particularly when there was so little else to use in coping with the heroin problem.

of all addicts in the nation--range from about 65,000 known addicts to a suspected figure of 100,000 - 200,000. Moreover, the percentage increase of new heroin users in the last few years has risen at a sharp and alarming rate: in 1968, the number of heroin users in Queens showed an 84% increase over 1967; the Bronx, 66%, Brooklyn, 45%, Richmond 40%, Manhattan, 29%.

At present, treatment and rehabilitation facilities for drug addiction control serve only a very small proportion of the population in need. Only twenty-five hundred patients are participating in methadone maintenance treatment programs throughout the city. (The waiting lists for entry into this program at each of the two major methadone maintenance centers in the city numbers over 2500). Several hundred other addicts are participating in various kinds of therapeutic communities in New York.

We believe that the critical proportions of the drug problem in New York City calls for a rapid expansion of facilities for the treatment of addicts. Methadone maintenance, which is currently regarded as a viable and successful treatment program for hard-core addicts, should be made available to the 20% of the addict population which we estimate will meet the program's treatment criteria. We thus propose a citywide methadone maintenance treatment program to service 15,600 addicts over a 12-month period.

The proposal was, and was intended to be, outrageous. Some quick, back-of-the-envelope calculations by the Project Management Staff showed that it was clearly impossible to place 15,000 people in treatment in less than a year. Chase himself hedged a little in sending the memorandum. He included the following remarks in a transmittal memorandum to Robert Morganthau, the deputy mayor:

Attached is a proposal for a methadone maintenance program which calls for putting about 15,600 addicts on methadone over a 12 month period--at a cost of about $13 million. A couple of caveats are in order:

-The paper has been produced on a crash basis and is not a well-honed product. This doesn't strike me as serious since we will have time to sharpen it (and the program) if and when it looks like we will be getting some money.

-The projection of 15,600 addicts in a 12-month period is plainly on the optimistic side--and may very well be downright unrealistic. However, this also doesn't strike me as particularly serious at this point (a) since it is probably well to set out sight high at the outset and (b) since--if we need it--we can always take more than 12 months to reach our 15,600 goal.

> I've always had a feeling that the most effective way to overcome it is to build up a critical mass of momentum, which has a lot to do with doing things quickly. As a matter of fact, if you look back at some of the assignments I have given, the kind of deadlines, you would say, Jesus, how would you expect to possibly get those things done in a week or four days? Well, part of it was this effort to get people moving quickly.

This concept of momentum and speed pops up in almost any discussion with a successful government entrepreneur, but the exact nature of "momentum" remains elusive. One can observe evidence of "momentum" such as the willingness of one's own staff to work long hours with great confidence and enthusiasm, the unexpected responsiveness of other units of government, and occasionally, in the almost invisible voluntary efforts of single individuals scattered within and without the government. However, what creates this momentum is unclear. Possible factors are the obvious determination of influential people to make the program occur, a generally shared sense that the program is an appropriate and significant response to a serious problem, a public announcement that mobilizes those who were ready to act, the strong desire to back a winner, and the acute fear of being the only one standing in the way. What is clear is that the expectations of thousands of people has something to do with creating or maintaining momentum. Chase's memo was directed at those expectations.

Chase's next move was to recruit and commit staff resources to design and implement the methadone program. Chase considered this move a critical step in initiating any programs. He devoted his own time to the recruitment and selection of these people. He had a fairly specific idea of the kind of people he needed.

First, he wanted people with "character and drive." What Chase meant by "character and drive" is suggested by the following quotes:

> Most people either do not know how or do not believe that they can get things done. You ought to see the look on people's faces when you say to them 'go open up a clinic'. The people I want were the people who have that look on their face but show up two weeks later with the clinic open.

> What I tell people who want work for me is the following: I want you to do this. I want you to do it very fast. I know it's hard. There are people all over town telling you it can't be done. You've got to get it done. If there are some areas you need me to bust open, let me know quickly. The name of the game is winning - not your ego and not my time. If you ask me to deal with problems which I think you should solve, I'll tell you so. It's not a failure to seek help.

> This one guy was just terrific. He was one of the most determined people I ever saw. The Bureau of Budget and City Hall just knew that he would never take no for an answer. He would camp out in their offices and keep calling. I try to instill a spirit of resistance in my staff. I tell them 'you don't take "no" from the Bureau of the Budget.'

By the end of April, Chase had assembled a staff to plan the development of the methadone program, and implement the first steps of the plan. The staff included the following people:

Dr. Robert Newman: A "fiery young doctor" committed to Public Health programs who had served as the District Health Officer in Harlem and on on the Lower East Side, and as the Director of the National Nutrition Survey in New York City;

Chip Raymond: A "proven troubleshooter" who had worked for Chase when Chase was the Deputy Administrator for the Human Resources Administration;

Alan Gibbs: An Assistant Administrator at HSA who would be responsible for managing relations with other city agencies; and

June Fields: A staff member of the Project Management staff who would be responsible for the detailed design of an implementation plan and the development of an information system which would allow continuous monitoring of the implementation effort.

It is important to understand that this was a "shadow staff." Chase had not yet been given the authority to expand the methadone maintenance program. Many of those on the staff were borrowed or stolen from other programs. Newman recalls:

> I had a full time job. I wasn't getting paid. I was just sort of doing this on the side from March until the beginning of July.

Thus, the only thing that was holding the effort together was each individual's commitment either to Chase or to the program. It is strong evidence of Chase's individual ability that he was able to exact a large amount of work from a staff which had nothing more than this moral commitment to him.

From March through July, the staff worked in three different areas. First, they began the detailed design of the program--how the security of the methadone could be guaranteed, how urinalyses could be performed at the necessary scale, how many staffers would be required in each clinic, how fast the clinics could be opened and when they would need money, etc. They then wrote policy papers describing the structure and procedures of the clinics, and developed a detailed work plan showing which agencies had to do what in what sequence for the clinics to open and operate effectively.

Second, the staff provided Chase the ammunition he needed in the continuing policy debate over the design and administration of the program. Chase's proposal in March provoked a stream of memos from ASA objecting to the plan and proposing alternatives. While statesmanlike, their memos emphasized the threat of diversion and the uncertain benefits of methadone treatment. They also argued that the city's overall heroin policy would be further "fragmented" if ASA were not in charge of the methadone program, and proposed that methadone programs be developed as a part of their "community-based" narcotics treatment system. In addition, there was detailed criticism of specific parts of the program. Chase and his staff responded meticulously to these objections. Their responses kept the debate open,

In less than 3 months Chase had committed New York City to a large methadone program and had wrested the responsibility away from all competitors.

C. Seizing the Initiative: Retrospect on Obstacles

The obvious question is what happened to all those obstacles that seemed insurmountable to the policy analyst. Chase got the program rolling with no money and against the likely opposition of Beth Israel and ASA.

1. Money

Chase was able to get his program rolling without funds for two reasons.

First, nothing that he did until the end of May cost money. His activities required only his time and the time of his staff. Although these resources probably had high opportunity costs, no one could charge Chase for these costs.

Second, Chase simply gambled that the money would be there when he needed it:

> If you are managing, you don't necessarily spend your time on what's traditionally a problem. You have to make a judgement. Now, we all tend to think that money has always got to be a problem. So, we've got to spend time on money. What I said to Newman (who took a long time before he believed me) was "Just don't worry about it. Don't think about it. You just get those facilities open. Fight with the communities. Spend your time going to the planning board."

Chase knew that NACC had lots of money and would probably fund the program. In any case, the city's narcotics problem was so severe, and the methadone program so cheap, that Chase "just knew" the City would have "no choice but to fund every facility you could open . . . You knew you were going to win it . . ."

2. Beth Israel

Beth Israel's program had been reluctant to support other methadone programs. The method was still controversial politically, and Dole and the others who ran the existing programs feared that an irresponsibly-run program might end in scandal. Dole had an interest in continuing to control methadone treatment in the City, at the very least because such a scandal could ruin the reputation of all methadone programs, including his own. Because he was the authority on Methadone maintenance treatment, he probably could have vetoed the City's program had he tried. Why didn't Dole stop the City program?

First, Newman planned to follow most of the policies of the Beth Israel program:

> I came into it with a very, very strong personal identification with one particular form of methadone maintenance treatment, namely the type of treatment program that Rockefeller University had pioneered and that Beth Israel and Bronx State had initiated. I was personally committed to running that type of a program and no other type of program.

Finally, it turned out that Dole favored the expansion of the City program, once he saw that its policy was responsible. His stakes were not in any particular program, but in the use of the treatment method. To the extent that the city was willing to take the heat for any failures, leaving Dole able to disavow the program, he was enthusiastic. His support for the program and for Newman helped to forestall criticism of the city program.

3. ASA

Why didn't ASA stop Chase? It had consistently opposed methadone maintenance. As the City's drug-treatment coordination agency, it had an obvious interest in taking charge of any methadone program the city was to set up. The answer is simply that ASA lacked the authority to turn Chase off. Probably, nothing less than an unambiguous order from the Mayor would have stopped him.

Why couldn't ASA convince the Mayor to order Chase to stop? First, the Mayor probably wanted expanded methadone treatment. Even if he didn't, the City Council certainly did, and it would have been embarassing to stop a program that had already started. Second, the Mayor had no reason to believe that A.S.A. would be able to run such a program. The agency had prepared no plan. Its claim that it should "coordinate" drug-treatment could be satisfied by a pro-forma arrangement. Third, Chase had a good track record. He had produced programs for the Mayor that had durable substantive and political value.

Only an implacable enemy of methadone maintenance or a zealot for tidy government structures would have given ASA the program. ASA's failure to stop Chase demonstrates the strength of the adage "you can't beat something with nothing", especially when some kind of action is clearly required.

4. Summary

Thus, by June 30, Chase had established his authority to run a city methadone program. What had appeared to be a tight battle ground turned out to be a vacuum. What had appeared to be ferocious and powerful opponents turned out to be pussy cats. Perhaps the key to this success was that Chase never waited to be granted the authority--he immediately started acting as though he had it.

D. Motivating the Program Managers

Once Chase had seized the responsibility for the program, the problem was to make sure that the program happened. Chase had to develop a coherent and detailed description of the program he wanted, keep the pressure on his program managers, and guarantee sufficient resources and authority for his managers to implement the program.

The program planning activity turned out not to be a difficult problem. The city progam could simply copy the procedures, staffing patterns, resource requirements, etc., of the Beth Israel program. While everyone understood that adjustments would be made, the research protocol Beth Israel has submitted to the Food and Drug Administration provided sufficient direction to establish the program. Moreover, much of this work was already done.

programs under the veto power of relatively obscure low-level bureaucrats who may or may not have been better able to judge the interests of the City than Chase. Thus, Chase saw little that was beneficial and much that would slow the development of the program in this first kind of institutional arrangement.

Contracting with private institutions could provide some relief from the overhead agencies. The contracts had to be approved by the Board of Estimate, and some actions and services were still required of the overhead agencies; but many of the severe restrictions on purchasing and hiring would be eliminated. How much control one lost over the program in order to obtain this increased freedom of action depended on characteristics of the program, the contracts, and the management. If the important parts of a program could not be described in sufficiently concrete terms to be placed in a contract, or if the contracts failed to specify the specific services that were being contracted for, or if nobody monitored the contracted work, then the city's control over the program would be weak. However, if one could describe the important aspects of a program in concrete terms, write these aspects into a contract, and monitor the contract closely, then one could surrender little control.

From Chase's point of view, this option was well suited for the planned methadone program. The procedures for high quality methadone maintenance treatment were easy to describe in concrete terms. Consequently, relatively detailed specifications for the program could be written into the contract. In addition, the people who would run the program (doctors and nurses) were fairly well accustomed to bureaucratic disciplines such as reporting on their activities. The data needed to monitor the work were easy to collect and report. Thus, Chase judged that he would be able to maintain tight control over the program through tight contracts and close monitoring.

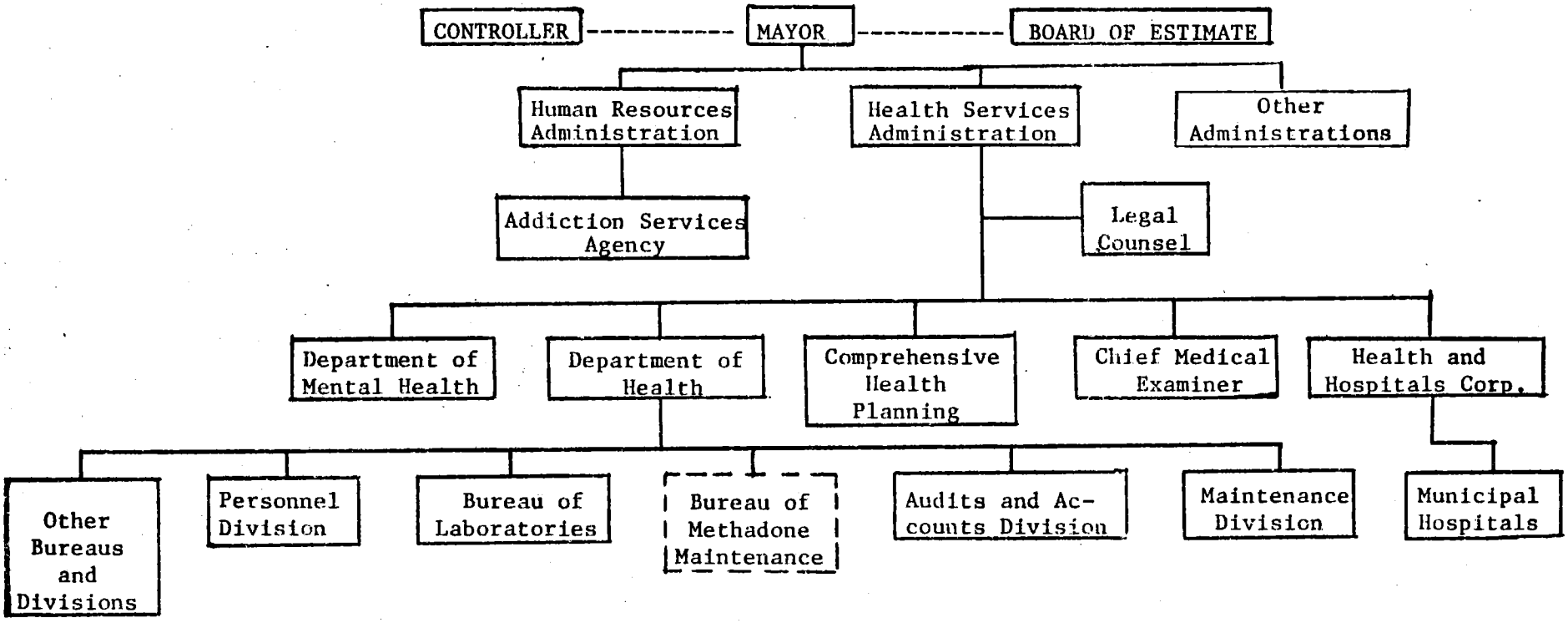
The contract system had one other very attractive feature: It would allow Chase to tap the enormous resources of the New York City medical establishment. From the beginning, Chase had been convinced that solutions to the city's heroin problem would have to depend on the medical establishment.

Chase initially planned to use the third option, the fiscal drop, which he liked to describe as a device for carving a piece of the government's operations out from under the direct control of the government overhead agencies. Two such drops then in operation in New York City were the Health and Hospitals Corporation, and the Off-Track Betting Corporation. Such corporations allow government money to be used with less detailed accountability than would be possible under the traditional government agencies, and therefore with maximum flexibility. Chase was strongly attracted to this flexibility. Indeed, he secured an agreement with the Institute for Public Administration to become the fiscal drop for the methadone program. However, at the time that plans were developing to create a fiscal drop, the Democratic City Comptroller, Abe Bean, criticized Lindsay for trying to run programs outside the city administration by hiring consultants.

Because a new fiscal drop would provide Lindsay's rival with additional political ammunition, Chase decided to establish the methadone program as a contract operation.

Exhibit 2

Organization Chart Showing Drug-Related Activities for the City of New York




from Addiction Control in New York City, (see title page of this case).

Exhibit 3

List of Task Responsibilities
for the Bureau of Methadone Maintenance

- Negotiating with hospitals and arranging for their participation
- Overseeing the establishment of clinics and monitoring clinic operations
- Approving clinic medical directors and unit supervisors
- Mounting an out-reach program to reach more of the addict population
- Creating a community liaison program to explain the use of methadone
- Assisting hospitals in recruitment
- Establishing and staffing two intake units
- Providing vocational support services and working with business and industry to develop jobs for patients
- Providing legal assistance to patients in the Program as required
- Arranging for training of clinic personnel by the Beth-Israel Medical Center
- Developing and supervising a City-orientation program
- Arranging for data processing and evaluation
- Developing adequate systems for record-keeping and reporting

From Addiction Control in New York City, (See title page of this case).

Exhibit 4 (continued)

## Key to Organizational Codes

| Organizational Code | Organization |
|---|---|
| B-I | Beth-Israel Medical Center |
| BDEST | Board of Estimate |
| BOB | Bureau of the Budget |
| CC | Corporation Counsel |
| CONT | Controller |
| DH | Department of Health |
| DHBMM | Department of Health Bureau of Methadone Maintenance Treatment |
| DP | Department of Purchase |
| DRE | Department of Real Estate |
| H&HPC | Health and Hospital Planning Council of Southern New York, Inc. |
| HHC | Health and Hospitals Corporation |
| HOSP | Hospitals |
| HSA | Health Services Administration |
| HSLEG | Health Services Administration Legal Counsel |
| LAB | Department of Health Bureau of Laboratories |
| LAND | Landlords |
| NACC | New York State Narcotic Addiction Control Commission |
| PERS | Department of Personnel |

From Addiction Control in New York City, (see title page of this case).

After considering his interests and resources, Newman devised a strategy that had three key components. First, he would rely on New York's medical establishment for many of the many of the basic resources required to operate the clinics themselves. Second, he devised an information system that allowed him to monitor the hospital's performance. Finally, he used his own staff to solve adminstrative and political bottlenecks that slowed the hospitals' performance. The details of Newman's efforts are explained below.

B. Using the Medical Establishment

The suggestion that existing institutions be used to implement a new program crops up almost as frequently as the suggestion that existing institutions be better coordinated. One might think that enormous resources could be magically released simply by waving a hand over existing institutions. In practice, it is often difficult to determine which specific problems can be attacked with what institutions. It is even more difficult to establish the relationships and commitments which are necessary to release the assistance that is potentially available.

In this case, Newman hoped that existing institutions would provide him with patients; clinic space; medical personnel trained in the procedures of methadone maintenance; and adminsitrative supervision of supplies, records, etc. Newman expected existing methadone programs to provide him with patients from their waiting lists and train staff for his clinics. He planned to rely on hospitals to provide space, to hire most of the clinic personnel, and to provide administrative back-up for the program. If at least, some of these burdens could not be shifted to these other institutions, Newman's tiny central staff could not hope to maintain the required pace of program development.

Newman's plan to send clinic staff to Beth Israel for training quickly fell apart, and he had to develop his own training program.

> . . . Beth Israel grossly underestimated our ability to open new units. They kept telling us no matter how many staff people we wanted trained, they would train them; and all of a sudden the day came that we said, "We have fifteen people we'd like trained. 'Where do you want them to go?' And Beth Israel said, 'Impossible! We might be able to handle maybe two or three.'
>
> So we arranged to have the first group spend a little time in the Beth Israel clinics, some time in the Bronx State clinics, and a lot of time in the central office talking to us about paper work, procedures, and what we wanted done and how we wanted them to do it.
>
> Then, within a couple of weeks after it turned out that Beth Israel was not going to be able to handle our training, we made an arrangement with Bronx State. They have a very well-organized, tightly controlled training program which is a two-week, intensive nine-to-five, five-days-a-week operation. We had a handful of people go through the Bronx State program but [its strict attendance requirements were unsuitable] for us because at the same time that we were training people, we also had them opening up units and starting to treat patients.

Others who worked in the program remember that the response to this first letter was disappointingly light. Newman continued his efforts; taking advantage of his personal relationships with people at the hospitals:

> A couple of places, I knew the people at the hospital. This made it a little bit easier because I followed up the letter two days later with a phone call, saying, "Listen, we've had some contact with you before in other programs, other capacities. What do you think? Are you interested or not? Let's discuss it."

Response was good, partly because Newman was offering them an easy way to solve one of their own problems.

> The hospitals were under a lot of pressure from the community to do something with regard to addiciton. They really didn't know what that something ought to be. We came along at the right time and said, "listen, you don't have to do any planning, you don't have to do any work, we will help you find the space, we will get community approval," and so on . . . We were willing to pay everything connected with the operation of the clinic except overhead, and the amazing thing was that for the two first contract years we had no overhead in any one of our contracts. From what I gather it's pretty unusual for hospitals to accept a contract without any overhead.

Thanks to the hospitals, Newman's staff had to find space for only six of the 25 clinics that he would try to open during the first year. The spaces that were found by his staff had to be approved through time-consuming city procedures. Obviously, the methadone program's expansion would have been greatly slowed had the hospitals not supplied the other 19 spaces.

Thus, Newman's efforts to enlist existing institutions were successful in the most important areas. He committed hospitals to provide space, personnel and administrative back-up. He was successful in enrolling the hospitals partly because he asked them. However, other factors explaining his success are his personal relationships with people in key positions in the hospitals, the community pressure on hospitals to do something about heroin addiction, and Newman's willingness to do much of the work for the hospitals. In effect, Newman solved a problem for the hospitals very inexpensively. He did not create a problem for them.

C. Maintaining Control and Accountability

Newman had met the need for rapid expansion by farming much of the work out to the hospitals. However, this expedient created a new problem. How could Newman guarantee the quality of the program when he was not running it directly? He decided to make the contracts very specific, and set up an information system to monitor compliance.

Thus, Newman's contract differed from those usually signed by government agencies. NACC and the Office of Economic Opportunity, for example, often funded projects, returning only to evaluate them after a year or so of operation. Newman's contracts bound the hospitals to follow precisely procedures and policies set out by the central office. The office eventually published a manual

> 60 grams on Friday or 120 grams for take-home." I could call him up and say, "Bob, how many people are getting 100 milligrams or more?" And he could tell me in no time flat.

Fourth, Newman's central office staff verified the information that the clinic sent in, as he explained:

> They would routinely go out on spot checks and just verify the information that we had received . . . We would go in there around 3 o'clock and say, "Okay, stop dispensing for 5 minutes. We want to see whether everything that you have reported up to now really adds up and that you have used the number of methadone tablets that you say you have," and so on.

Chase and Newman were careful to use the information from the system often so that it retained its value as an incentive. They not only criticized people whose tasks were not getting done, but praised those who were doing a good job. Thus, their subordinates knew that their work was being watched and appreciated.

D. Forcing the Pace

The mobilization of the medical establishment and the development of an effective information system were necessary strategic components of the program. However, mobilizing the medical community and developing the information system required the successful accomplishment of hundreds of daily tasks. Moreover, there were many other issues that had to be handled on a daily basis. The actual process of opening the clinics is described in a case produced by the Harvard Business School. The relevant portions of the case, with explanatory paragraphs added as necessary, appear below.

-Hiring clinic personnel

(i) Medical Directors
(ii) Unit Supervisors

-Training clinic personnel.

PMS' first project plan, issued in August, indicated several potential problem areas that might impede progress as scheduled; among them were community resistance, the availability of qualified personnel, and difficulties in locating space.

2. Opening the First Four Clinics

The early months of the program were extremely hectic. Chip Raymond, now Assistant to the Director for Administration, described the activities of the staff as follows:

> My role, essentially, was jack-of-all-trades. I got involved in pretty much every aspect of the program from setting up the pharmacy system to working on urinalysis, to being responsible for setting up the central office, negotiating contracts--a whole series of little petty things--being responsible for getting all the personnel through the Department of Personnel. Newman's basic responsibility was going out and selling the program, negotiating contracts, and recruiting doctors which was a very big problem, initially. Gibbs was pretty much involved in setting up the contract with NACC and negotiating all the contracts with the hospitals and handling everything with the different city agencies to get the contracts approved. June Fields (a staffer from PMS) helped us in just kind of overseeing the program and feeding out reports and kind of checking up on everybody to see where they were. She helped us get things through the Board of Estimate and the Bureau of the Budget and helped us set up the central office--pushing equipment through and things like that. Bruce Gantt worked on setting up the intake unit and was responsible for training.

Moreover, a procedure had developed for negotiating contracts with the hospitals. Newman and Raymond would visit hospitals and press hard for a commitment. Once a hospital agreed to operate a clinic, Newman and Raymond were joined by Alan Gibbs, an assistant administrator from HSA, who took charge of contract negotiations. The contracts set forth the hospital's responsibilities and specified a time schedule for opening the clinic and taking patients. The usual intake rate was 20 per month until 100 were in treatment. Also included in the contract was the date (one month before clinic opening) when the clinic's staff should be hired. The hospital could cancel the contract whenever it wanted to. Because Newman and Raymond were trying hard to convince as many hospitals as possible to locate their own clinic space, contract negotiations frequently took longer than anticipated.

By mid-September, when the first project status report was issued, these efforts had produced significant progress. Contracts had been negotiated with 7 hospitals for 11 outpatient clinics. Most personnel for the first two clinics had been recruited. In the central office a number of key positions had been filled, although neither a deputy director nor a coordinator of community relations had been found. PMS concluded that all 20 outpatient clinics would be open, as scheduled, by February 5, 1971.

In the weeks that followed, effort focused on negotiating contracts for the remaining nine clinics and on completing the steps necessary to open the first four unts. Raymond recalls that "we were [very] concerned about getting those first four open." By mid-October, contracts for all twenty units had been signed (see Exhibit 6). Private space, supplied by the city, would be required at only six locations instead of the ten to fourteen expected. Two of the first four clinics (Group I in Exhibit 6) would be located in hospital-owned space and two in city-operated health centers. Most clinic personnel for the four Group I units had been hired and were ready to begin training.

It was at this point that the agreements with existing methadone programs to provide patients and training broke down. This posed a threat to the quality of the program. Nevertheless, on November 4, BMM's central intake unit was opened and began inducting addicts (directly from the street) for treatment at Group I clinics; and on November 17 and 18, despite training delays, the Group I units began operation - four and a half weeks behind the schedule outlined in the PMS project plan.

3. Opening the Remaining Clinics

Besides the opening of the first four clinics, two other significant events took place in November: the Riker's Island intake unit was activated and plans for an inpatient unit were abandoned. NACC agreed to let funds earmarked for the inpatient clinic be used, instead, for two additional outpatient units, bringing the total to twenty-two. Despite these accomplishments, when the project group turned its attention to the remaining clinics, it was clear that further slippage had taken place. The status report issued on November 20 indicated that the hiring of key central staff was now seven weeks late. As before, the cause was failure to find either a deputy director for BMM or a community relations representative. The urinalysis program, too, had continued to slip since the last report. While the Bureau of Laboratories was successfully handling the current load of urinalyses, no renovation plans had been made or equipment orders placed preparatory to handling the much larger requirements that would have to be met in the future. The two agencies involved, HSA and the Department of Public Works had yet to agree on the amount of new capacity that would be needed. Finally, all clinics in Groups II through V were even further behind their initial schedules (see Exhibit 7).

By January 1971, contracts had been negotiated for the two new out-patient clinics; but the accomplishment of other major milestones had slipped further behind. Central staff hiring was now fifteen weeks delinquent; the urinalysis unit eleven weeks late; and clinics in Groups II through V further in arrears (see Exhibit 7). The reasons for slippage in central staff hiring and the urinalysis program remained unchanged. For the eighteen clinics (as had been the case with the first four clinics), continued delinquency was attributable to several causes, the most important being the availability of space, the pace at which hospitals were recruiting personnel, and continued community resistance.

Space Availability. For those clinics where private space was to be rented by the city, the Department of Real Estate was responsible for locating suitable quarters, negotiating leases, providing the Board of Estimate with information necessary to approve each lease, and carrying out all the other paper work that was

Exhibit 7

## Original and Revised Target Dates for Major Milestones

| | Original Completion Date | Revised 9/16 Completion Date | Revised 9/16 Weeks Slippage | Revised 11/20*** Completion Date | Revised 11/20*** Weeks Slippage | Revised 1/15 Completion Date | Revised 1/15 Weeks Slippage | Revised 3/26 Completion Date | Revised 3/26 Weeks Slippage |
|---|---|---|---|---|---|---|---|---|---|
| Key Central Staff Hired | 10/2 | - | 0 | None Set | 7 | 2/19 | 15 | 4/16 | 25 |
| Group I Clinics Open (1-4) | 10/16 | 10/30 | 2 | X** | 4 1/2 | X | X | X | X |
| Inpatient Treatment Unit Open | 10/23 | 12/4 | 6 | Abandoned | - | - | - | - | - |
| Riker's Island Intake Unit Operational | 10/30 | - | 0 | X | 2 1/2 | X | X | X | X |
| Group II Clinics Open (5-8) | 11/6 | 11/27 | 3 | 1/15 | 9 | 1/29 | 11 | X | 12 |
| Central Intake Unit Operational | 11/20 | - | 0 | X | -2 | X | X | X | X |
| Urinalysis Program Fully Operational | 11/27 | 12/11 | 2 | 2/12 | 11 | 2/11 | 11 | X | 11 |
| Group III Clinics Open (9-14) | 1/15 | 1/1 | -2 | 2/12 | 4 | 3/26 | 10 | 3/31 | 10 1/2 |
| Group IV Clinics Open (15-17) | 2/5 | 2/5 | 0 | 3/5 | 4 | 4/2 | 8 | 4/12 | 9 |
| Group V Clinics Open (18-20)* | 2/5 | 2/5 | 0 | 3/5 | 4 | 4/2 | 8 | 6/7 | 14 1/2 |

*Increased to 22 clinics total in November.

**X = Completed.

***Schedule revisions were made monthly by PMS. Only bi-monthly revisions are shown in the exhibit.

From Addiction Control in New York City, (see title page of this case).

required. PMS pointed out in its Project Plan that:

> The speed at which space for facilities is found and leases negotiated will most likely be the determining factor in setting the level of the program. The grant . . . provides for 20 clinics, but additional money has been reserved by the (NACC) and will be given to the City if the program progresses according to the planned time frame.

The Municipal Services Administration, of which the Department of Real Estate was a part, was described by a member of the Project Management Staff as "one of the most important and least efficient administrations in the city. The departments in MSA are old-line, paper-pushing agencies where only long-time bureaucrats, who know their way around every dusty desk, can get anything done. The complexity of the paper traveling through and the nature of the services performed give it great potential for losing something in the shuffle." The Department of Real Estate, under the direction of Ira Duchan, was an agency where verbal negotiations and personal contacts built up over long periods of time were believed to be the most important aspects of getting anything done. Duchan joined the DRE in 1946, worked his way up through the civil service ladder without ever leaving the department, and was appointed its commissioner by Mayor Lindsay.

In October, when the requirements for rented space were firmed up, Alan Gibbs sent a letter to Duchan requesting that DRE begin locating facilities for eight clinics. The letter indicated where the spaces should be, the physical properties called for, and included a schedule showing when the space would be needed to meet program deadlines. It also requested that someone in the department be assigned to the methadone project on a full-time basis, a method frequently used for large projects. The letter was followed by a meeting between June Fields and the Commissioner to discuss DRE's participation in the project. She described her experiences with DRE as follows:

> They were not very cooperative. We had to have a meeting with them and say, "Look, this is a Mayoral priority," before they would assign anyone. We did get someone assigned, but that person had a lot of other responsibilities, too, and he really didn't spend much time on the methadone program. We've never had the Mayor's office talk directly to the Commissioner [of Real Estate]; I arranged the meeting and I've talked to the Commissioner several times. There were also several letters that tried to say that we certainly appreciated the work they were doing but that it wasn't quite enough.
>
> An agency like that can throw a lot of monkey wrenches just by being unwilling to be hurried. It may not even be a question of whether or not they've found the space; there are other steps that they are responsible for like negotiating and preparing the lease, preparing a resolution for the Board of Estimate, carrying it to the Board, and defending it. So you have to really be on good terms with them. If the space has been negotiated on a Tuesday and you want to get it on the Wednesday Board of Estimate calendar, someone has to work very hard to get a resolution ready, and he's not going to do it if you're always dumping on him.

> They were asked in October to find eight spaces; ultimately, one space actually turned into a city lease. As a result, other agencies had to be deeply involved in looking for space. We suggested maybe forty to fifty different sites for the real estate department to look at, most of which were obviously unsuitable.[1] What we were doing in suggesting sites was trying to get the DRE people, who were professionals, to say how lousy Fields was at doing this and begin to do it themselves. But they didn't. This is not to say that they didn't work, but it was very haphazard and only done under pressure with someone else taking substantial parts of the initiative.
>
> It's hard for me to think of how it could have been done differently. The man who was the representative of Real Estate apparently understood that methadone was very high priority and talked about it as being high priority, but he had a lot of other things to do. A call from the Mayor's office might have helped but it may just be that DRE's whole sense of priorities is not budged by outsiders. If they're used to taking things as they come, and someone inserts something and says it's an "expedite," it may just jar them so much that they won't even talk about it.

The January 15 status report identified as the project's key problem the failure to find space for seven clinics. Already, the scheduled opening of three clinics had been delayed for lack of space. Several hospitals, at HSA's urging, agreed to open their units in temporary space but, without exception, these facilities would be inadequate in the long run and permanent space would still have to be found. In addition to looking for space herself, June Fields requested help from several community groups, and the DRE placed ads in the newspapers.

Recruiting. Each hospital was reponsible for recruiting and hiring all personnel for its clinic(s). Physicians, unit supervisors, and research assistants had to be approved by Dr. Newman. (Research assistants, all of whom were Phase III patients, were interviewed by a member of the central staff who was also a patient.) In fact, Dr. Newman rarely disapproved of anyone that a hospital said it wished to hire, and, throughout the project, he and Raymond made substantial efforts to help the hospitals recruit their staffs. They gathered resumes for various positions, placed ads in the newspapers, and Dr. Newman made frequent appearances before medical groups and societies. Still, very few hospitals met the contractually specified deadlines for staff hiring. In some instances, this occurred because the hospital refused to put anyone on its payroll until clinic facilities had been located. In others, the only cause seemed to be the absence of any sense of urgency regarding clinic opening dates.

June Fields attributed this problem to the large number of hospitals involved and the fact that each one had its own way of doing things. Even though the contracts were very specific, she believed that:

> The effort to get people to live up to the contract was relatively soft because lots of people thought the hospitals were doing the city a favor.

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[1] Fields began her own facilities search in January.

Commenting on the same topic, Dr. Newman said:

> The main problem we have is avoiding the hospitals' and unit staff's impression that we're just a funding agency; because on paper that's what it looks like. It looks as though we're like OEO; that we give a hospital a contract to run a methadone clinic and that at the end of six months or a year, we might come in and look around and see how they're doing and decide whether or not to refund them. That's exactly the opposite of what we really are.

By mid-January, all the staff for Group II clinics were hired, but accomplishment of this milestone had been delinquent, and their training consequently was seven weeks in arrears. Recruiting and hiring of Group III staff had also slipped a total of seven weeks.

Community Resistance. The desirability of community support for the city's MMP was something of which HSA had been keenly aware from the beginning. In late May 1970, Dr. James Haughton, First Deputy Administration at HSA, met with representatives of the Addiction Services Agency to discuss the problem. He reported to Chase:

> We had hoped that it might be possible to build upon the city's existing community groups involved in the addiction problem, but it quickly became apparent that since these groups were developed by ASA and committed to the Phoenix House rehabilitation approach, it would not be possible to involve them in the methadone program.
>
> The representative of ASA regretfully informed us that the staff of that agency are so committed to abstinence programs that they have instilled in their community groups an absolute and complete resistance to any kind of substitution program. He felt therefore that an attempt to use these groups would only increase the general community's resistance to the methadone program.

In June, HSA's proposal to NACC described the agency's plans for a public information and community participation program of its own as follows:

> To generate the broadest possible public understanding of the methadone maintenance treatment program, a major community-based public information effort, directed by the central unit, will be undertaken. Community education workshops and seminars will be established to provide citizens with information about the methadone program. Community relations representatives will work with community groups to involve them in this educational effort.

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> Mass media will also be utilized to extend the outreach of the program and inform the public as to its goals and procedures. The unit will also dispense general information regarding methadone programs, including criteria for admission and locations of facilities.

As the MMP program got under way, however, very little was done to meet the community relations aspects of these plans. Instead, it was left up to the hospitals to establish and maintain good rapport with area residents and to pave the way for the new clinics. Some expended considerable effort doing this - working either through the appropriate neighborhood health councils[3] or the hospitals' own community liaison apparatus. Some, on the other hand, simply disregarded community reaction altogether.

One example of a hospital that did not consult the community - Jamaica (Group I) - has already been described. Another was Bronx Lebanon, which had agreed to open two Group III clinics. Operating almost completely without help from the central office, the hospital located one space on its own premises and one in a building in the South Bronx already leased to the city for other purposes. (The Department of Health planned to take over the lease.) "Things were going along fine with this space, internally," said June Fields, "when suddenly there began to be a whole network of calls from South Bronx residents to Bob Newman and Chip Raymond, all dumping on the Department of Health." The reason for the opposition was not any objection to methadone. It was based, instead, on the pending opening, some two blocks away, of a methadone clinic sponsored by Bronx State Hospital. Bronx State had worked closely with various neighborhood groups for over six months and it was these same groups that resented the city's failure to consult them about its program. Their resentment was sufficient to force Bronx Lebanon to abandon the South Bronx unit and open both its clinics as a combined unit in the remaining space. This meant inadequate facilities for both clinics as well as the absence of a city-sponsored clinic in an area where one was badly needed. In contrast to Jamaica and Bronx Lebanon, Long Island College Hospital in South Brooklyn was highly sensitive to local feelings. According to June Fields:

> There are a lot of groups in the South Brooklyn area because it covers a lot of little communities--Red Hook, Brooklyn Heights, Cobble Hill, and others. When they first began with the methadone program, the hospital asked the ghetto medicine involvement committee to suggest locations for three clinics and the committee recommended one in Red Hook, one in Gowanus and one in Cobble Hill.
>
> We moved along on the first clinic [in Cobble Hill] in space that had been found by a member of the committee, but when it came time to open, there was a lot of controversy because it was right across the street from a Catholic elementary school.

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[3] Neighborhood health councils usually had representatives from local community development corporations, poverty programs, health and medical facilities, and so forth.

Chip Raymond elaborated:

> There was a tremendous meeting and Newman went out and spoke and pretty much quelled most of the fears about putting it in there. Their greatest concern was bringing addicts in from outside the community; but we had about ninety applications and seventy-five of them were from people living within five blocks of the clinic location. That killed most of the objections, but about two weeks later, someone threw a couple of ash cans through the clinic windows. That was a little disturbing and we had to have a couple more meetings about it.

Trouble also developed with the second Long Island College clinic planned for the Red Hook area. Again, June Fields commented:

> There were a lot of community contacts and continuing discussions with people like the doctors who headed the Red Hook Neighborhood Health Council. Chip talked to the Health Council and the Tenants' Association and I negotiated with a sort of neighborhood council that had representatives from a number of local agencies.
>
> The hospital wanted to open this clinic in the hospital itself, but the Neighborhood Health Council wanted it in the local health center. The Council won and then they thought that local people should be hired to staff it. They advertised locally but found out that most of the people who showed up were not acceptable for clinic jobs. So they had to get the resumes that the hospital had gathered and do the job over again. It all took time.

In Fields' view, the delays caused by these community troubles were hard to assess but she thought they ranged from a few weeks, in the case of Bronx Lebanon, to well over a month for the first Long Island College unit. Dr. Newman recalled the Long Island College problem as follows:

> The hospital made sure that they met and that we met with every single community group they could think of. So we had a tremendous amount of prior contact. We sought these groups out. After meeting with "eighteen" different community groups, three days before the clinic was to open there was another group that either was created specifically for this purpose or that came out of nowhere and said, "Listen, nobody asked us and we don't want it!"
>
> The complaints were always the same: "Do anything you want with these junkies, just don't do it in our neighborhood!"
>
> The need for community relations people is not as clearcut as you might think from reading the project plan. June wrote the plan and she felt that there was a tremendous need for community relations. I had mixed feelings about it, initially; during the first months of the program, I became even more ambivalent about it. First, you have to assume that it's possible to anticipate

community problems; second you have to assume that it's feasible for a community relations person to handle those problems; third, you have to be confident that your community man won't create problems where there wouldn't have been any. Whenever I go to a community meeting, I always ask myself if we could have avoided this with a community relations person or if that person could have replaced me at this meeting.

We're not telling the community that this is the solution to their drug problems, because it's not. It probably has virtually no impact on their drug problems. This is not a community-oriented program; methadone is a means of treating individual patients. So it has a clinical rather than a public health orientation, and as long as this is true, why should a community group any more than a professional group decide what's best for the patient.

[End of excerpt from 'Addiction Control in New York City (B)'].

E. Epilogue: Outputs and Outcomes

The influence of space availability, recruiting, and community resistance continued to be felt in the months that followed. On March 26, the PMS project status report showed that the urinalysis unit was operating at the capacity needed, but that clinics in Groups III through V were now 10 1/2. and 14 1/2 weeks behind schedule, respectively (see Exhibit 7). Community problems were affecting both the Mary Immaculate unit and the second clinic at Long Island Jewish.

Despite the problems, by June 1971, there were over 2,000 people treated in City Methadone Programs. Moreover, in March, now plans had been layed for another aggressive expansion of the methadone program. The objective laid out in that plan were largely met. There were nearly 6,000 people in the city's methadone programs by June 1971 and nearly 11,000 by June 1973.

The growth in the City's Methadone Program had also influenced the growth of Beth Israel's Methadone program. Chase recalls:

What was fascinating was the reaction of Beth Israel to our program. They always said "you're going too fast, you're doing it wrong." But they changed their way of doing things. Between 1964-1970 their program grew from 0 to about 2,000. In six years they took in about 300-400 patients per year. Once we started taking in 2,000 per year, they accelerated.

You have to understand Ray Trussel (head of Beth Israel). Ray is a real competitor. Ray liked having the biggest methadone program in the country. So, he started to go very fast himself. There was sort of a standing joke: whenever we'd say, "Hey, Ray, how many've you got?" He'd say: "How many you got?" . . .and we'd say "We've got 2,000." He'd say, "I only got 2,500" -- "we've got 3,000" he'd have 3,300 --always had more. Eventually we passed him! But in the next 3 years he went from something like 2,000 to today to 6,500. So, from a rate of about 300 a year he started taking in a couple of thousand a year. At any event he got to the point where there were no waiting lists.

The combined effect of these expansions was to put over 20,000 heroin users in treatment by January 1974.

Given these governmental outputs, what were the outcomes? What happened to the health of users, to dignity and autonomy of users, the spread of heroin use, and public expenditure with the problem? While the evidence is not extremely strong, the following propositions are offered with some confidence:

-From 1970-1973 the number of heroin users and others who died from methadone overdoses increased steadily. However, the combined total of heroin deaths and methadone deaths declined significantly.

-Both the incidence and prevalence of heroin use in New York City declined over the period from 1972-1974. Fewer people experimented with heroin use. More old users abandoned it. This was at least partly attributable to successful efforts to control the supply of heroin to East Coast Cities.

-While arrests for homicide, rape and aggravated assault increased in New York City in 1972 compared with 1970 and 1971, addict-related crime were down significantly in 1972: Robbery decreased 10%; burglary was down 16%; and larceny was down 76%. Moreover the fraction of people in New York City jails who were heroin users fell from 50% in 1970 to 25% in 1972.

-The retention rate in the methadone program for all patients is 76% after one year, and 65% after two years. These figures are based on the experience of all admissions since the Program began. Included, for instance, are over 1,000 patients whose treatment was initiated on a decommissioned Staten Island ferry boat - the worst possible physical setting for the development of a clinical relationship. It must also be emphasized that individual clinic size (some of the 44 facilities have a capacity for well over 500 patients) has not been a factor in either retention rate nor any other parameter of treatment effectiveness.

-The annual average cost for treatment was $1,300/patient.

All in all, not a bad result.