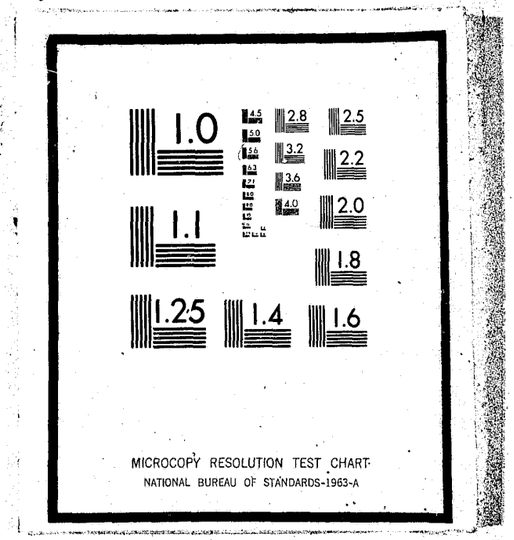

PREFACE

The content of this final report is the result of the joint efforts of the staff of Moshman Associates, Inc. and LEAA in examining the data-gathering activities and record-keeping techniques of LEAA-funded Drug Abuse Treatment and Rehabilitation Programs.

We are especially grateful for the guidance and assistance provided by Mr. James Johnston, the Contract Administrator, and Mr. Luke Galant, the Project Monitor, throughout the course of this study.

The LEAA Regional Administrators were most helpful as our contacts with the State Planning Agencies, and with project directors in scheduling appointments and insuring that our visits to the programs were productive. Their immediate responses to our requests were most appreciated when time was so short.

We also wish to express our thanks to the program directors and their staffs in providing us with the required information and in making it possible for us to observe daily program operations which supplied us with first-hand knowledge about programs' procedures and problems. Without their cooperation, it would not have been possible to learn about the many aspects of drug abuse treatment.

We are convinced that there is an urgent need for the establishment of a standard reporting system. We are confident that the materials we developed will enable the LEAA to implement a system as soon as possible.

Final Report
on
LEAA-Funded Drug Abuse
Treatment and Rehabilitation Programs

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Introduction

This report, specified as the final task in the study of LEAA-funded Drug Abuse Treatment and Rehabilitation programs, includes recommendations and conclusions based on experience gained during the implementation of Tasks I, II and III under Contract No. J-LEAA-046-72.

Task I involved the collection of data from 24 LEAA-funded Drug Abuse Treatment and Rehabilitation programs in 20 cities in the U.S. The LEAA supplied a list of data elements to be collected during our visit to each program. Actual data were collected for fiscal year 1972 and for the first quarter of fiscal year 1973. Program directors were asked to make estimates for the remaining three quarters of fiscal year 1973 and for fiscal year 1974. The data were compiled and analyzed and statistics were derived and displayed in bar graph form on Performance Measurement System Charts E-21, E-22 and E-23, provided by the LEAA.

Blank copies of forms on which patient information is recorded were also gathered from each program in order to ascertain what data are currently being kept in patient files. Visits to the actual clinic sites as well as administrative offices were made wherever possible. Although these visits were brief, they provided an opportunity to observe actual program operations. Program directors were generally very willing to provide available data and to answer questions concerning their programs.

Task II included the development of a standard reporting form for use by individual programs and a Manual to

aid program directors in collecting, compiling and reporting data to the LEAA. The form includes most of the same data elements originally requested by the LEAA. Changes were made, however, where the collection of original data elements proved to be impossible or where more useful data could be obtained by refinement of definitions. Mean client time in treatment, for example, was divided into new sub-categories which more realistically reflect the treatment modalities now in use.

Complete instructions for filling out the form are included in the Manual for program directors. Each data element is defined, the purpose for its collection is discussed, and procedures for reporting are provided.

Task III entailed the writing of a manual for LEAA Regional Administrators and LEAA Headquarters. Again, each data element is defined and the purpose for its collection is discussed. The manual will enable LEAA to assemble the data reported by the programs and derive and display program statistics. It will also provide insight to potential problems with the reporting system, so that LEAA can anticipate the demand for consultative assistance to the program.

Instructions are included for aggregating individual program data and for displaying the totals on Performance Measurement System Charts E-21, E-22 and E-23. Suggestions are also provided concerning the uses of the data, such as procedures for making comparisons among programs.

This final report includes recommendations and final comments based on the experience described above. Recommendations are presented first, a discussion of current problems in program record-keeping and a brief description

of the LEAA's overall treatment effort follow. Preceding the final comments is a discussion on future problems which the LEAA may encounter with regard to program data collection.

Recommendations

We urge that the following recommendations be implemented by the LEAA in order to expedite the formation of a standard data reporting system for Drug Abuse Treatment and Rehabilitation programs:

1. A standardized data reporting system for LEAA-funded Drug Abuse Treatment and Rehabilitation programs should be put into operation immediately. The reporting form to be used by all programs and two manuals, one for program directors and the other for LEAA Headquarters already provided LEAA under this contract, were developed as the bases for establishing such a system. The reporting form is designed to be flexible and should be revised in the future as the need arises.

2. LEAA should require that grantees return their reporting forms to their respective LEAA Regional Administrators within thirty days after the end of each fiscal quarter. The form should be filled out by each program as fully as possible. If a program encounters difficulty in reporting specific data elements or in making estimates for the future, the program director should discuss the problem with the responsible LEAA Regional Administrator.

3. A centralized source of financial information on LEAA Drug Abuse Treatment and Rehabilitation programs should be established. Records of funds allocated by the national office to the regional offices and obligated by the regional offices to the individual programs should be updated

regularly. Centralized information should include Treasury disbursements to projects so that authorized persons have access to comprehensive, current information in one central point.

4. LEAA should attempt to avoid duplication of data-gathering efforts made by other agencies. Data-gathering activities should be co-ordinated with SAODAP and other agencies so that all interested parties can share in the resulting bank of information.

5. When reviewing program data, it is essential that the structure and objectives of individual programs be considered. LEAA-funded Drug Abuse Treatment and Rehabilitation programs encompass a wide range of treatment philosophies and modalities in treating drug abusers. These non-statistical factors are important in measuring the success of a single program and in making comparisons among different programs.

6. Overall summaries of the quarterly statistical reports should be sent to all grantees. Many program directors were anxious to learn about the activities of other programs and to obtain feedback from other programs' staffs about new approaches to treating drug abusers. Therefore, in addition to supplying the summaries to programs, other methods of improving inter-program communication should be investigated.

7. LEAA Headquarters should provide consultative assistance to programs to set up, operate and maintain a data collection system. Data collection for administrative and research purposes is generally an area of expertise in which programs have little knowledge and less experience.

8. Following the first year of data collection, a review should be made of all aspects of the standard reporting system. At that time needed revisions should be made in the reporting form and in the manuals. Suggestions and comments from programs should be encouraged by LEAA Regional Administrators to provide input for such revisions to those who are responsible for enhancing the system.

Data-Gathering Experience

During the visits made to program sites, special effort was made to collect samples of the forms in use by programs to record data. These forms made it possible to determine which data elements are kept by each program. This knowledge was especially helpful in developing a reporting form and accompanying manuals, as well as in arriving at the recommendations. Efforts were made to learn which data elements would be most useful to program directors. Most program directors, however, preferred to discuss problems of record-keeping in more general terms.

Methods of record-keeping varied greatly from program to program. Through intensive in-take and screening interviews, basic demographic and medical information is collected on individual patients. Most programs administer a series of questions to the patient in order to determine the patient's history with regard to drug usage and other social difficulties.

Although a large body of information exists in individual patient files, little progress has been made in compiling and summarizing it systematically. There are several reasons, the most important of which is lack of staff time. Most programs are understaffed and believe

they simply cannot afford to allocate personnel time to compile statistics. Requests for data have been limited and sporadic, making the gathering of data a low priority for most programs. In many states, patient files are confidential, and therefore can be viewed only by medical personnel who do not have time to compile statistics.

A substantial amount of the program information requested was available, including such items as number of patients served, patient capacity, number of patients employed and number of staff. More complex data elements, such as average waiting time and mean client time in treatment, were not available and could not be calculated from the data on hand. Program directors were reluctant to make estimates for future periods in all areas for which data were requested. They generally felt that the uncertainty caused by short-term funding made any future estimates pure conjecture.

A standard reporting form, a manual for program directors and a manual for LEAA Headquarters have been prepared on the basis of our data-gathering experience for the purpose of establishing a standard reporting system. The reporting system is intended to provide a simplified means for making comparisons among programs. Better knowledge of their own operations and how individual programs compare with the totality of programs provide the incentive for programs to keep and compile more complete statistical information.

General Description of Treatment Programs

Fourteen of the twenty-four drug treatment grants are being used solely for the treatment of heroin addicts. Many programs admit only hard-core addicts, those who have been addicted for at least several years and have failed previously in at least one treatment program. Methadone is now commonly used in the treatment of heroin addicts. Most patients are being maintained on a steady, daily dosage of methadone, although a few are attempting to gradually withdraw from dependence. Most program directors feel that withdrawal should be the main objective of treatment, but that addicts need extensive psychological counseling to complete withdrawal. Few programs have an adequate counseling component and thus are maintaining their patients on methadone until counseling services can be increased. Two program directors believe that there are hard-core addicts who cannot be expected ever to lead a drug-free life. For these patients, indefinite methadone maintenance is the only answer at this time.

Most LEAA Drug Abuse Treatment and Rehabilitation grants are being used for the treatment of heroin addicts. Other LEAA grants are being used for a variety of purposes: two are used strictly for providing referral services, two for comprehensive programs which provide non-intensive care to all types of drug abusers, two are used to treat alcoholics as well as heroin addicts, three for counseling of juvenile drug abusers and one is used only to pay administrative salaries. The juvenile treatment programs are oriented toward treatment of soft drug users, with the goal of keeping them away from the hard-drug culture. The comprehensive programs do treat heroin addicts, but they are located in cities where heroin is not yet a major problem.

Most of the patients in comprehensive programs are abusers of other drugs, such as hallucinogens, amphetamines and barbiturates. Counseling is the most common form of treatment in these areas of drug abuse although medical check-ups are given to determine whether any side-effects of drug abuse, such as hepatitis or malnutrition, are present.

Universal agreement does not exist among program directors on what the ultimate goal of treatment should be. Some feel that any addict can be "cured" with the proper combination of psychological help and rehabilitative opportunities. Other program directors feel that there are addicts who actually thrive in the hard drug culture and find great satisfaction in "hustling" for heroin or for the money with which to buy it. Current treatment methods, they believe, simply will not work with these addicts.

So far, very few addicts have been successfully rehabilitated. Dropout rates are high and many patients are beginning to abuse methadone despite programs' efforts to prevent it. As the statistical report supplied as Task I under this contract indicates, there are virtually no hard data available on the time needed to treat a patient. The absence of such data makes program planning difficult and helps create confusion regarding program goals. Many programs seem to be maintaining a large number of patients on methadone, simply because no substitute method of treatment is available.

Most program directors feel that their greatest need at the present time is more resources in terms of money and manpower. Some feel that they are making progress in overcoming the problem of drug abuse, while others feel that they are falling behind as the problem continues to grow.

Anticipated Problems in Record-Keeping

This study dealt primarily with problems of data collection and record-keeping among LEAA-funded Drug Abuse Treatment and Rehabilitation programs and possible solutions to these problems. The reporting form and the manuals already supplied to LEAA are intended to provide an approach to centralized data collection and to give individual programs an incentive to gather and compile certain data elements. However, the use of a standard reporting system will not solve all the problems of record-keeping. Several of the major problems were approached in the recommendations and are discussed in more detail below.

Great difficulty was experienced in obtaining financial information at all levels: program, regional LEAA and National LEAA. Although the reporting form provides a mechanism for collecting financial data, LEAA should keep a central record of all obligations and outlays involving drug abuse treatment and rehabilitation funds. Regional LEAA offices should be required to make quarterly regional reports by grant to the national office detailing obligations and expenditures of all drug treatment funds. Reconciliation of regional reports with existing national records will help insure an accurate central source of financial information.

Program directors have been frustrated by multiple demands for data. Programs which receive funds from a variety of sources may need to report to Federal, State and local government agencies, as well as private organizations. Each funding source may request different sets of data, thus making the compilation of data for each report a cumbersome task. Because many programs are too understaffed to compile even a minimal amount of data, requests

for statistics are often simply ignored. LEAA should therefore make every effort to co-ordinate its data-gathering efforts with other Federal, State and local agencies that are involved with drug treatment programs.

Some programs delegate record-keeping responsibilities to non-professional employees, primarily counselors who are ex-drug abusers or young people who are familiar with drug problems. These employees, while very dedicated in their efforts to help drug abusers, often see little point in keeping up-to-date records. Although in-take and screening interviews provide basic data on new patients, information about the patients' progress after entering treatment is scarce. Program directors should encourage non-professional counselors to update records immediately following an encounter with the patient.

Most program directors were reluctant to estimate data for future time periods because most LEAA grants are one-time sources of funding. Those who made predictions indicated that they were based on future funding which had not been approved. The problem of making estimates may be alleviated, however, for those programs which receive the six to eight year grants now being given by the National Institute of Mental Health for drug abuse treatment.

Interviews with program directors as well as on-site clinic observations confirmed that understaffing is the major obstacle to adequate record-keeping. The situation is underscored by the fact that most programs are requesting more medical and rehabilitative personnel, rather than more administrative personnel. Although an ideal staff/client ratio for drug abuse treatment programs has not yet been determined, it is obvious that most programs are not able

to provide the care necessary to rehabilitate drug addicts. Program directors maintain that treatment should take priority over all other activities, including record-keeping. Until the problem of understaffing is resolved, deficiencies in programmatic data can be expected.

The basic conclusion of this study is that data collection procedures for LEAA-funded Drug Abuse Treatment and Rehabilitation programs are not well developed. The major reason is that the process of drug treatment itself is still in an experimental stage. Most LEAA-funded programs have been in existence for only one to three years and have experienced minimal success in rehabilitating drug abusers. Many program directors believe that the drug problem in their communities is growing faster than are efforts to solve it.

A variety of treatment methods are presently being used, but there exists little hard data on the relative effectiveness of these methods. It is therefore very difficult to decide what statistics are most useful in measuring program performance. One answer may be to collect a large number of data elements and, over time, eliminate those which do not prove useful. However, most programs cannot afford to allocate valuable staff time to filling out lengthy forms. Forms must be brief, even if it is necessary to sacrifice potentially useful data elements.

The reporting form provided under this contract will enable LEAA to implement a standardized data reporting system. Although the system should increase and improve the flow of data from the programs to LEAA, it is important that the LEAA not rely on the form alone. Program

directors must be encouraged to communicate with LEAA on the relevance of data elements. LEAA should be aware of changes in treatment methods, which will in turn create the necessity for new measurements of program performance. Because drug abuse treatment is a relatively new field, it is extremely important that the reporting form remain flexible and that LEAA be prepared to make changes when the need arises.

The great diversity found in LEAA-funded Drug Abuse Treatment and Rehabilitation programs will make the operation of a standard reporting system difficult. A positive aspect of this diversity, however, is that it provides great potential for comparison. Programs can be categorized by treatment modality, type of patients served, geographical location or a number of other factors, and their performances compared.

Although psychological and medical research can be expected to supply the major breakthroughs in the field of drug abuse treatment, reliable statistics provide an important basis for learning more about drug abusers and how to treat them. Data should be made available to those universities, public agencies and private organizations that wish to study drug treatment statistics in detail. The LEAA should institute a standard data reporting system not only to learn more about its own programs but also to contribute to the progress of drug abuse treatment generally.

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