OEO Drug Treatment Programs

GERALD SPARER

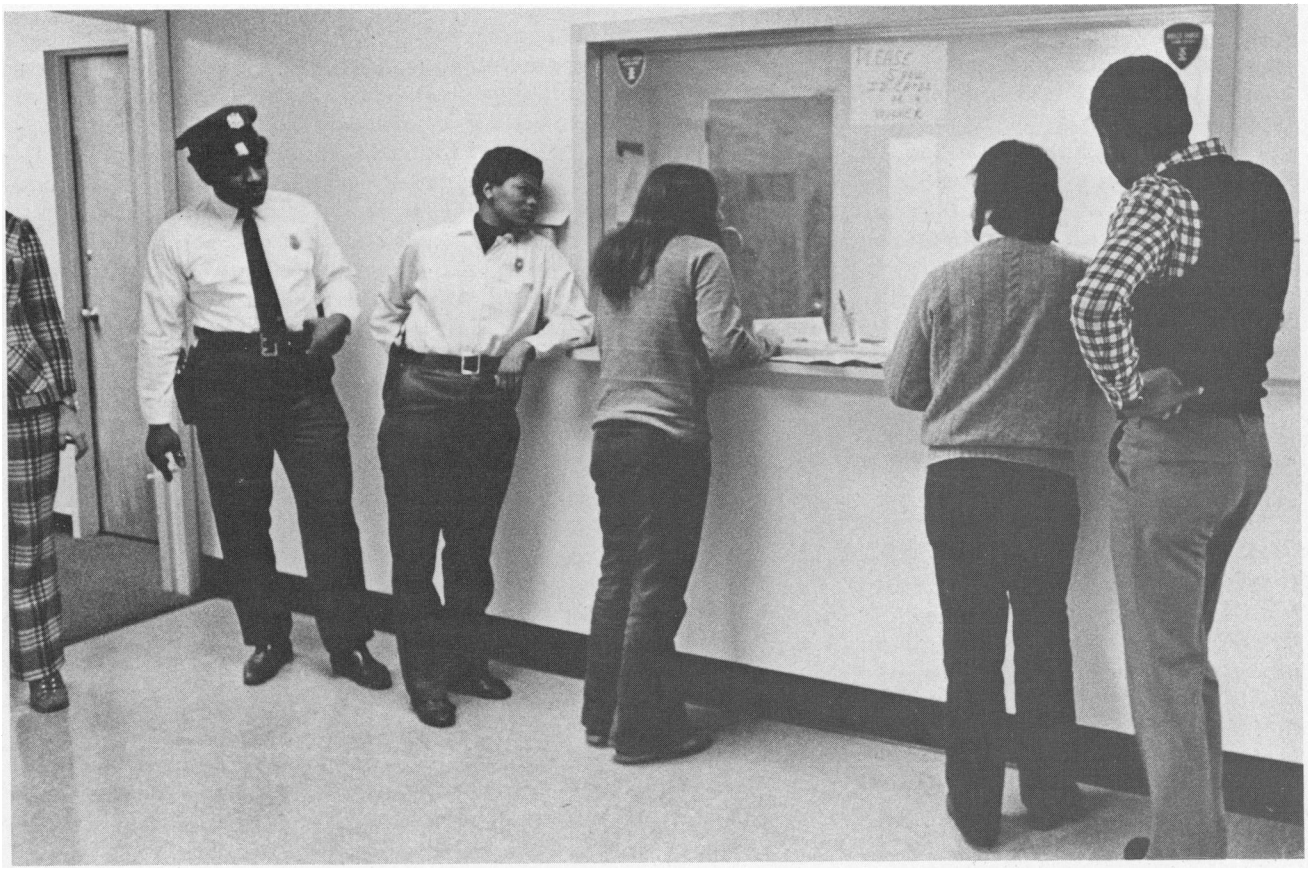
Are community-based, nonprofessional, drug-free programs effective?

A MAJOR NEW ACTIVITY in community-based drug addiction treatment programs was undertaken in the early years of the Office of Economic Opportunity health programs. The treatment programs were conceived of by the Congress and by OEO as a one-time investment to stem the growth and spread of drug addiction. The aim was to stimulate the initiation of local drug treatment activities in selected areas around the country.

Recognition of the scale, magnitude, and the antisocial effects of the drug epidemic in the country had encouraged the Federal Government to increase outlays from $45 million in 1969 to $132 million in 1971. The Federal budget for fiscal year 1973 revealed that of the $365 million being used for drug abuse programs, $230 million was for treatment and rehabilitation.

The OEO efforts were concentrated on community-based, drug-free methods until 1971, when the Special Action Office for Drug Abuse Prevention (SAODAP) encouraged OEO to support a large number of methadone maintenance programs. The OEO programs concentrated mostly on ambulatory treatment—only a few resident programs were included. They were rarely affiliated with hospitals, com-

West Philadelphia Community Health Consortium Drug Abuse Rehabilitation staff members portray methadone recipients



munity mental health centers, academic institutions, or other traditional providers of health or mental health services.

A study of all 20 OEO-assisted drug abuse treatment programs in New York City was initiated in 1971 and completed by June 1972. The study was performed under a contract for the Office of Economic Opportunity by System Sciences, Inc. *(1)*. My report is concerned with the implications of the study findings for similar projects, as well as the effectiveness of such projects for providing a variety of services to drug addicts.

For this analysis, effectiveness is examined within the following dimensions: *(a)* project administration, management, and costs, *(b)* client management processes—intake, treatment, socialization, and followup, and *(c)* internal staff capacities to treat.

The study objectives and methodologies were specifically concentrated on the internal project operations, as assessed from observation and discussion with staff and current clients. No attempt was made to examine the relationships between the project and other referral agencies from the perspective of these outside agencies, nor was any attempt made to interview client graduates. Thus, the analysis precludes a major outcome variable for assessing program performance; that is, outcome of the intervention in terms of such indicators as reduction in illegal drug use, reduction in criminal behavior, and increase in socialization, including employment and living arrangements.

I recognize that a serious question could be raised concerning whether judgments about program viability can be made in the absence of such impact data. Unfortunately, the bridge between program processes and program outcome has not yet been clearly enough established for the health field and much less so for mental health and social support services. Process analyses used here are basically measures of program performance consistent either with program operational objectives, good management practices and principles, or generally accepted treatment practices for the field. The process-review methodology used here is comparable to the medical care peer-process reviews. Such reviews, in the absence of rigorous clinical trials, permit professionals to analyze processes of delivery services to determine if they are being performed in accordance with commonly accepted practice.

□ *Mr. Sparer is acting director, Division of Health Services Evaluation, National Center for Health Services Research of DHEW's Health Resources Administration. He was formerly director of the Division of Planning and Evaluation of the Office of Health Affairs, Office of Economic Opportunity. This paper is adapted from a presentation at the annual meeting of the American Public Health Association in San Francisco, November 1973. Tearsheet requests to Gerald Sparer, National Center for Health Services Research, HRA, Room 15A-27, 5600 Fishers Lane, Rockville, Md. 20852.*

The assessment of program viability that uses a process analysis assumes that there is some relationship between the process and the outcome. There is always the possibility that no such relationship exists or that the traditional indicators of process performance are not the crucial indicators that relate to client outcome. One could hypothesize, for example, that it may not matter what happened inside the treatment programs. A more important variable may be that clients are for the first time committed to and relating to an existing social institution. They have sought and accepted the help of that institution. The actual processes of that institution may not matter so much if the institution creates an environment that provides a relatively continuous and comfortable relationship for the client. It remains for a more sophisticated and intensive program process analysis related to outcome to test the variations of such hypotheses.

Program Characteristics

Most of the programs were initiated in 1968 and 1969, a few as late as 1972, but several pre-dated the OEO funding. Annual program expenditures ranged from approximately $20,000 to more than $200,000, with most between $40,000 and $80,000. The largest number of clients reported in any one program was 112 and the smallest was 14; 25 to 30 clients was typical.

Most of the programs ranged in staff size from 3 to about 17; 5 to 7 was typical. The client-staff ratio ranged from 1 1/2 to 1 to 19 to 1, varying with the nature of the projects. The projects included *(a)* 2 youth centers providing preventive and education programs, *(b)* 5 ambulatory induction centers, primarily concerned with getting the addicts off the street and serving as a holding station for referral to treatment programs, *(c)* 7 ambulatory treatment centers, *(d)* 2 residential induction centers, *(e)* 1 residential treatment center, and *(f)* 4 vocational education and rehabilitation centers.

Although the program objectives and related characteristics varied, there was a surprising similarity in range of costs per client year. The residential centers cost between $3,500 to $3,800, the ambulatory treatment centers approximately $1,500 to $3,000, the induction centers $1,000 to $2,000, and the youth centers about $1,500 a year.

Client Characteristics

The characteristics of the clients of the projects were predictable. The youth center preventive programs tended to attract clients under 18. For the rest, the clients were more likely to be between 18 and 29, about one-third female, and 90 percent black or Hispanic.

Of the illegal drug users, the largest number had started using drugs about 5 years previously. For those under 25, the drug commonly was marijuana. For those over 25, the first illegal drug used was likely to have been an opiate. About 26 percent of the clients admitted using illegal methadone.

Only about 15 percent of the clients had ever been declared to be juvenile delinquents, and only about 10 percent had ever been committed to an institution for juveniles.

Of the 80 percent (284) that had been arrested previously, about half (156) were between the ages of 15 and 20. Of those with an arrest record (289), about one-third (126) had been arrested four or more times. Of approximately 400 drug users, more than half reported using more than three drugs.

Program Management

An assessment of overall program management is based on three factors: supervision and management, staff motivation, and client records. These are rated on a 3-ranked scale as poor, fair, and good. Poor is unacceptable performance, unacceptable records. Fair means that some minimal standards of performance are met, but technical or administrative improvement would be desirable. Good indicates that the project is performing satisfactorily, meeting generally accepted standards, and that no assistance is needed to improve in that regard.

It can be assumed that in every program there may be an almost complete lack of any followup capacity or information. When a client drops out of the program, he may at best be scored as a positive drop or a negative drop. This means only that as far as the project records or the recollection of staff are concerned, the client dropped out and gave either a good or a bad reason. The good reason very often was either, "I'm returning to school," "I don't need the assistance any more, and I'm o.k." or "I have a job." Bad reasons were based on a judgment of the staff member that the client had reverted to drugs or had been arrested.

Thus, in a major client-management objective—outcome of treatment—each project scored uniformly low. Staff members did not know what happened to their clients after they dropped out.

Client records at the youth centers ranged from poor to fair. The ambulatory induction centers were generally good and provided minimal descriptive data. In the ambulatory treatment programs, four of the six projects reviewed had good records. Three of these were the Daytop programs, which had carefully controlled and structured processes. Two programs had unacceptable recordkeeping practices. Residential induction and treatment programs were uniformly good, but vocational education and rehabilitation programs were uniformly poor. Thus, in terms of those programs primarily oriented toward client treatment, recordkeeping was acceptable.

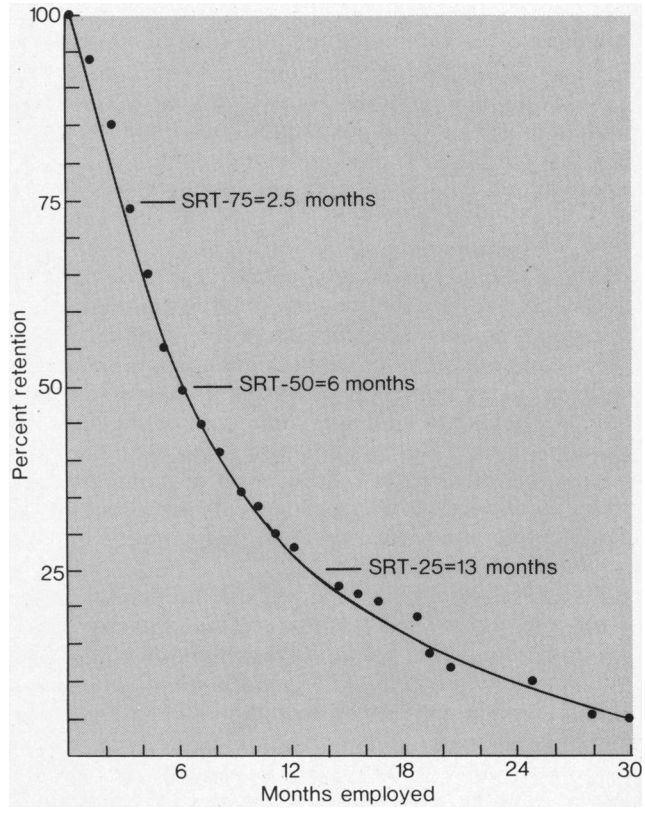
Staff morale is an important component of treatment programs. Perhaps one of the strongest features of the community-based treatment programs was that staff commitment to addict treatment was almost uniformly high. This commitment was strong despite high turnover rates and internal frictions.

Management supervision relates to the ability of the project director and key project staff to delegate responsibility effectively, to organize, make assignments, and control operations. Eight of the programs reviewed had poor supervision. In four of these poorly supervised programs, morale was rated high, perhaps indicating a great potential for and commitment to client services.

An analysis of the turnover rates from the staff questionnaire revealed a serious problem with retention of staff. For a sample of 86 providers of therapeutic services from 19 programs, a 6-month turnover rate of 50 percent was recorded, and only 25 percent of the staff remained for a year or more, as shown in the chart. No clerical, secretarial, or other support personnel are included in the chart. The reasons for this high turnover rate included internal frictions, delayed appropriations, low salaries, staff frustrations with their capacities to deal with the problems, and more opportunities offered in other programs. The negative implications of this high turnover rate are obvious in the kind of treatment intervention that relies heavily on staff-client interactions over a sustained period of time.

Staff characteristics were not particularly unusual. Sixty-five percent of the staff were male, 85 percent

Staff retention time (SRT)



Note: Sample includes 86 providers of therapeutic services from 19 programs. No clerical, secretarial, or other support personnel are included.
Source: reference 1.

were black or Hispanic, and 80 percent were under age 35. Fifty-seven percent of the professional staff were ex-addicts. If the two projects whose policies precluded ex-addicts on their staffs are excluded, then 72 percent of the treatment staff were ex-addicts. About 56 percent of the staff had completed high school or had earned a graduate equivalent degree. Of these, 28 percent had attended college and 16 percent were college graduates.

The following assumptions were made for the study:

1. The projects applied to public agencies for funds to provide an array of services to a defined group of clients with a specific problem.
2. In defining this array of services, program administrators have committed themselves to various modes of intervention and to a defined set of services.
3. They have all undertaken commitments to manage the program appropriately.
4. Each program has established operational goals that include providing needed treatments to clients, including individual and group counseling, job assessment and referral, legal and health services referrals, and detoxification.

The study was conducted in four major phases:

1. Interviews with the director or assistant director of each program by small groups of study teams who were collecting general background data on the agency.
2. Three-day intensive observation of project staff by each of the study teams.
3. A short-form client questionnaire administered to 100 percent of the active clients and a long form administered to a sample. Some 618 short questionnaires were administered and 458 long forms were completed.
4. In-depth interviews were completed with the 98 staff members in the 20 programs, and 70 percent of the entire client-provider staff was interviewed.

Staff Skills

When a client comes to a health care provider—a physician, a dentist, a psychiatrist, a physical therapist—he has identified a problem and has assumed that the provider is able to offer some assistance in either curing or ameliorating that problem. In health care, a client has at least some confidence that his provider can offer some useful treatment. The traditional providers are licensed to practice. So, too, when an addict comes to a drug treatment program, he expects that the program will help him; but the providers are not licensed.

To assess whether a program can be helpful to the client, the study tried to measure the capacity of the staff to meet clients' needs. These needs were classified into 4 major categories and 11 subject areas. The major categories were counseling, referral, crisis intervention, and detoxification.

The subject skill areas against which each provider was evaluated were group counseling, individual counseling, vocational educational counseling, family counseling, health service referral, social service referral, job training and placement referral, educational training and placement referral, legal referral, crisis intervention, and detoxification.

Ninety-four staff members were evaluated in terms of each of the preceding skills. Each provider was ranked on the basis of his skills as excellent, good, fair, or poor. These ratings were defined as follows:

Excellent: The subject is fully conversant with the current state of the art, capable of effectively and appropriately applying the skill in question, and is actively pursuing available means of expanding his or her capabilities in the area.

Good: The subject's knowledge and performance are acceptable in that outcomes of skill application are presumed to be positive, but has little conceptual base or significant deficiencies, or both, in factual knowledge of the area in question; motivation for improvement is strong and would benefit greatly from relatively little training.

Fair: The subject's knowledge and performance are unacceptable, but potential for upgrading of skill through appropriate training is high because of strong personal resources and motivation. His performance is not harmful to the clients he treats.

Poor: The subject's knowledge and performance are totally unacceptable, and there is no potential for upgrading through training; should be removed from treatment environment because of actual or potential negative effect on individual clients or treatment process, or both.

The excellent and good ratings indicate some potential for positive impact on the client. A fair rating shows that the subject's knowledge and performance are unacceptable, but that his performance is not harmful. A poor rating indicates that knowledge and performance are unacceptable and might be destructive.

There is a serious question as to whether a fair rating—the equivalent of a placebo—is acceptable. The question may be moot, but if a client comes to a program for assistance that is to be provided by a staff person, who, no matter how well intentioned, lacks the skills or ability to provide it, one could judge that the client is being harmed. Even a fair rating would then be unacceptable. From the standpoint of potential for positive interaction, the rating of fair suggests that, were staff skills raised, the potential might be realized.

A review of the ratings for all 11 subject areas revealed that 35 percent of the staff members were fair and 20 percent poor. Depending upon one's view of placebo value, one could say either that 20 percent of the services provided were harmful, or that 55 percent did no good. This choice pervades the remaining analysis.

In group counseling skills, 56 percent were either fair or poor. Individual counseling was the most positive skill, with 66 percent of the ratings either excellent or good. Ratings on vocational education showed 61 percent fair or poor; family counseling, 59 percent fair or poor; health service referral skills, 49 percent fair or poor; social services referral skills, 60 percent fair or

poor; job training and placement referral, 65 percent fair or poor; education, training, and placement referral, 73 percent fair or poor; legal referral skills, 64 percent fair or poor; crisis intervention management, 55 percent fair or poor; and detoxification referral, 64 percent excellent or good.

Composite Staff Skills Assessment

The analysis of skills by aggregating each of the 11 skills across all of the 94 staff members interviewed provided an overall assessment of staff capacity. The analysis of staff skills by project provided an assessment of project capacity.

For purposes of this analysis, the skills were regrouped into the four major categories: counseling, referral, crisis intervention, and detoxification referral. The scoring scale 1 through 4, poor through excellent, was used to rate each of the factors. Two potential cutoff lines for analysis of project viability were established; that is, a scoring of 2.5 was used to indicate that the project was performing in at least a minimally acceptable manner and had a positive capacity. A cutoff at 2.0 could indicate those projects with at least a potential for acceptable performance, depending on additional staff skills and training, but would indicate that the services were neither harmful nor positive.

When the 20 projects were examined by these dimensions, only 9 projects showed a composite average score of 2.5 or higher. Seven additional projects could be added if the cutoff of 2.0 were used. Concerning each of the major skill areas, only 7 projects had positive (+2.5) counseling and referral skills, while 10 projects had positive (+2.5) crisis intervention and detoxification referral capacity.

This scoring scale suggests that projects were more likely to provide positive crisis intervention and had a higher level of skill in detoxification referral. This finding implies that when the client was in serious trouble and had an acute need for assistance many of the projects might have provided that assistance. Conversely, the assistance the client needed on a more routine basis—long-term counseling, referral, placement, and so on—was still significantly deficient.

Of the 20 programs examined, client treatment was the major focus of 10. The remaining 10 were either preventive induction or rehabilitation type projects. An examination of the 10 treatment centers—the ambulatory treatment centers and the residential induction and treatment centers—showed a pattern consistent with the pattern for all the projects examined; that is, 5 of the 10 projects scored above 2.5. Three of the 10 fell below 2.0 and must thus be rated as detrimental to client care.

Implications

The implications of this analysis tend to confirm other indicators of project performance and, therefore, viability. That is, only 50 percent of the projects seemed to be providing client services at a high enough technical level to permit a judgment that they were likely to have a positive impact on the problems treated. Additional reflection on the implications may be gained from answers on the client questionnaire. Clients were asked for their judgments on the most helpful program services and the value of program services. Almost uniformly, the clients indicated that individual counseling and group counseling were most helpful.

Thus, one could conclude that clients were generally satisfied. They had come to a program for some treatment. They looked to the counselor for it, and what he provided was believed to be helpful. However, in many of the services provided outside of personal counseling, which were thought to be important to the more complete rehabilitation and socialization of the addict, the counselors were rated as deficient by their peers.

Conclusions

In general, the following factors emerged from the analysis of the OEO drug treatment programs:

- They served as a useful place in the community for addicts to seek assistance.
- The kind of counseling assistance the addict receives is perceived by him to be helpful.
- On a one-to-one basis, many of the counselors have both the commitment and the ability to relate to the client and keep him interested. At least the counselors can get the attention and respect of the clients.
- Counselors generally are not sufficiently skilled for following through on the rehabilitation processes; that is, referral to other agencies for education and vocational rehabilitation, for assessing the skills and needs of the client, and for providing more active social intervention.
- The counselors are receptive to receiving additional training in order to provide such intervention.
- Unfortunately, the high turnover of counselors caused by administrative and managerial problems, as well as perhaps their own frustrations in dealing with difficult problems of treating addicts, may be the most crucial factor in the question of the viability of the programs. An intensive training program aimed at upgrading of skills is urgently needed. A commensurate upgrading of income may do much to lessen the high turnover rate of the provider staff.
- Costs are acceptable.
- Client recordkeeping is acceptable, but outcome data are uniformly deficient.
- Some upgrading in management is needed—too many programs are deficient.

Only about 50 percent of the community-based programs are currently effective. With suitable upgrading of management and technical skills, most can provide acceptable services. Some are harmful and should not be continued.

Reference

(1) System Sciences, Inc.: Comparative analysis of twenty New York City "drug free" drug abuse treatment programs. Bethesda, Md., November 1972.