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# AN EVALUATION OF FIVE DRUG TREATMENT AND REHABILITATION PROJECTS

A Cluster Evaluation for
the Office of
Criminal Justice Planning
State of California



System Sciences
INCORPORATED

August 26, 1974

REVIEW OF CLUSTER EVALUATION
NARCOTICS EDUCATION AND
PREVENTION PROJECTS

Following is my review of System Sciences, Incorporated's (now known as Center for Planning and Research) Final Report for the Cluster Evaluation of Narcotics Treatment and Rehabilitation Projects:

A. Background

The cluster evaluation is an attempt to measure the effectiveness of five projects offering a range of modalities of drug treatment upon client drug rehabilitation. The following projects were included in the cluster:

1. Sacramento County Methadone Maintenance Program

The Sacramento County Mental Health Department operates two outpatient clinics dispensing methadone to heroin addicts and providing counseling services. (Counseling services are entirely voluntary rather than required.) Each clinic has the capacity to treat 150 clients.

2. Aquarian Effort (Sacramento)*

A diverse community-based project including a six-bed detoxification unit; a crisis line counseling service; outpatient individual and group counseling service; a free medical clinic; a free legal clinic; and a drug abuse education program conducted in conjunction with local schools. The project has two facilities.

3. Walden House (San Francisco)

Walden House, Incorporated operates a voluntary residential treatment program (therapeutic community) with aftercare services for drug abusers in the Haight-Ashbury and Pacific Heights districts of San Francisco. The program has two major facilities: one house in Haight-Ashbury for youths (capacity of 32); and one house in Pacific Heights for adults (capacity of 32). A storefront aftercare facility provides outpatient counseling for clients who are re-entering society and for ex-clients and others with drug problems. A satellite apartment provides living quarters for residents in the process of re-entry.

* It should be noted that the Methadone Program and the Aquarian Effort are the primary drug treatment resources in Sacramento County. Residential therapeutic communities and other drug-free modalities are not available in Sacramento. Thus there are few resources for continuous client follow-up.



4. The Open Door Drug Clinic (West San Gabriel Valley, Los Angeles)

A community-based outpatient clinic located in Alhambra and serving youth of the West San Gabriel Valley. Primary services offered to its middle-class high school clients include individual counseling; group therapy; family therapy; a hot line offering emergency service and referral service; counseling and drug education in high schools; community information and outreach in the form of public lectures and other media; and assistance in coordination of community drug abuse treatment and rehabilitation policy. Although high priority is given to individual counseling, the clinic offers a variety of therapeutic approaches to the problem of drug abuse.

5. Camarillo Resocialization Program for Drug Abusers

This project, located at Camarillo State Hospital is best characterized by a closely inter-related treatment and research program. The treatment program consists of four units: a) a detoxification unit; b) a long-term classical therapeutic community, called "the family"; c) a shortened version of the therapeutic community, called "the Awakening"; and d) an adolescent unit which serves as a short-term therapeutic community. A significant service of the Resocialization Program is its Social Service Aide component which provides temporary jobs (nine months) as research assistants for graduates of the project.

B. Evaluation Outcome Measures

The cluster evaluation focused on measurement of the following objectives common to the cluster projects:

1. reduction in criminal justice system involvement among clients
2. rehabilitation to a drug-free lifestyle*
3. increase improvement in employment/education
4. improvement in social relationships.

Data for a sample of clients from each project was collected and analyzed. Standardized data elements were utilized to facilitate inter-project comparison. In addition, the evaluation conducted a number of structured interviews with project staff and other relevant individuals. Interviews focused upon assessment of the following factors: a) project goals; b) treatment philosophy; c) therapeutic approach; d) project organization; e) description of ideal client types; f) project history, including funding; g) distribution of staff time among project activities; and h) staff training and experience. Standardized cost-benefit measures were also developed to provide an additional framework for interpretation of project results.

* All projects with the exception of Camarillo accept some reduction in client drug use as a positive accomplishment. As a therapeutic community, Camarillo requires drug abstinence as a measure of success.

In summary, the evaluation focused on collection and assessment of information related to the following three major factors:

1. Demand - refers to the numbers and types of drug abusers that are appropriate to a treatment modality and those that are not receiving adequate treatment.

2. Impact - refers to end results achieved by the project in terms of crime reduction, improving the criminal justice system, or improving other aspects of community life.

3. Performance - refers to the treatment facility's services evaluated in terms of efficiency, quality and adequacy of services.

Of particular interest are the definitions of treatment modalities, clinic environments and client status and schedule provided by the evaluation team on pages 19-20 of the report. These definitions are extremely useful for facilitation of cross project comparison. Similarly, the report includes an extremely helpful and insightful discussion of methods for developing an index or scale of a client's drug problem and using this scale to identify the most appropriate treatment modality for an individual client (see pp. 24-27 of the report).

C. Evaluation Results

1. Criminal Justice Impact - was measured primarily in terms of the decrease in arrests of clients after start of treatment. Data was taken from rap sheets, probation and parole files and project records. Arrests after treatment were measured against prior arrests. All modalities for which data were available, except Camarillo's short term unit*, showed significant reductions in arrest rates (results ranged from 53% reduction for Walden House clients to 91.5% for Camarillo's "family" unit. Perhaps more important is the finding that the percentage of clients who had no arrests after treatment ranged from 41% in Sacramento's Methadone Program to 86% in Camarillo's "family" program. In addition, 86% of Camarillo's "family" program clients were drug-free for one year or more after their entrance into the program.

2. Improvement in Employment

The percentage of Sacramento Methadone clients employed doubled during the treatment period. Similarly, 86.5% of Camarillo's graduate clients were employed. Employment opportunities for clients of the other projects did not improve significantly, primarily because the projects placed little emphasis on job training and placement.

* Arrest rates for Camarillo short-term unit were affected by high frequency of arrest of a few individuals.

3. Cost-Benefit Analysis

Cost benefit measures were developed to consider the result of expenditures by measuring the dollar cost necessary to achieve a given unit increase in benefits (e.g., dollars per arrest free client). In summary, these measures provide the information needed to describe the utility of some of the major services provided by each project. In this evaluation costs were measured in terms of costs for decreased arrest and decreased drug use. As might be expected, therapeutic communities, such as the Camarillo "family" program cost more than other treatment modalities to produce drug-free graduates. However, the therapeutic communities produce a significantly higher proportion of clients who remain drug-free.

D. Conclusions of the Evaluation

1. All modalities achieved success with substantial proportions of their clientele in terms of re-arrest. That is, substantial portions of each project's clients remained arrest-free over the period of observation following initiation of treatment (a period ranging from 3-24 months).

2. The Camarillo Resocialization Program achieved the best results in terms of drug-free and arrest-free clients. However, the therapeutic community involves a duration and intensity of treatment that is suitable for only a small percentage of the drug user community.

3. Graduates of drug treatment programs achieve better success after treatment when provided with steady employment.

4. Eighty percent of the clients using methadone in the Sacramento Methadone Program remained arrest free while in treatment.

5. Walden House, a modified therapeutic community, achieved the same success rate as the Camarillo Short-Term Program: 58% of the clients remained arrest free during treatment.

6. The Open Door Drug Clinic had excellent results with its clients (i.e., white middle class): 82% of a probation/parole sample of clients remained arrest free during the observation period.

7. As might be expected, only an estimated 20% of the Aquarian Effort's clients would show a decrease in frequency of arrest. (This project does not require that clients give up all drug use.)

## Comments on the Evaluation

This evaluation report is possibly the finest evaluation product ever submitted to OCJP. It is difficult to summarize all of the useful evaluation materials contained in the report; however, the report contains the elements of an effective model evaluation design for narcotics treatment projects - a design that could be even more effectively implemented over a longer study period than the months provided for this cluster evaluation. The effective use of standardized data elements once again demonstrates to me the viability of the cluster evaluation and program evaluation concept.

A quality evaluation must always include a clear statement of the report's limitations. To its credit, System Sciences, Inc. does clearly specify the weaknesses of its data. They indicate that caution should be exercised in comparing projects due to the varied techniques used by the projects in collecting data and the varied client population treated by each project. A more accurate assessment can be made by viewing the data as a whole, rather than examining specific data elements.

Secondly, the arrest data varied from project to project and for individuals within the same project in terms of the time period covered (3 to 23 months). Since recidivism rates vary over time, the implications are obvious in terms of reduced comparability of the projects.

Also, for some projects, the arrest data covers a period of only a few months and therefore can give no indication of medium or long-range recidivism rates.

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Final Report

# AN EVALUATION OF FIVE DRUG TREATMENT AND REHABILITATION PROJECTS

A Cluster Evaluation for the Office of Criminal Justice Planning State of California

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# EXECUTIVE SUMMARY

## AN EVALUATION OF FIVE DRUG TREATMENT AND REHABILITATION PROJECTS

This study is part of the comprehensive effort of the Office of Criminal Justice Planning to evaluate the impact of local action projects receiving OCJP grants. The report presents the evaluation of five drug treatment and rehabilitation projects in the State of California, and develops suggested evaluation strategy for future State use. The five projects were:

Sacramento County Methadone Maintenance Program
The Aquarian Effort, Inc.
Camarillo Resocialization Program for Drug Abusers
The Open Door Drug Clinic
Walden House, Inc.

The five projects cover a range of modalities of drug treatment. Sacramento County Methadone Maintenance Program is an outpatient clinic dispensing methadone to heroin addicts. The Aquarian Effort is a diverse treatment project in Sacramento including a detoxification unit, a crisis line counseling service, individual and group counseling service (outpatient), a free medical clinic, a free legal clinic, and a drug abuse education program for schools. The Camarillo Resocialization Program for Drug Abusers includes extensive treatment and research programs that are closely interdependent. The treatment program includes: detoxification, a classical therapeutic community, a shortened version of a therapeutic community, and an adolescent unit. The Open Door project is an outpatient counseling clinic that serves the youth of West San Gabriel Valley in Los Angeles County. Walden House, Inc. operates a voluntary residential treatment program in San Francisco with aftercare for drug abusers.

To study these diverse programs, a methodology was used that enabled the study team to: (1) understand each project well enough to identify the major features that contributed to success or failure; (2) understand and verify the findings of the evaluation components of each project; and (3) where possible, extend findings to provide a more complete picture of project impact. The needed information for this study was obtained by

reviewing project reports and grant applications, making on-site visits to each project, conducting statistical sampling of client records of projects, and making contacts with other local agencies that have interacted with each project. The examination of the self-evaluation efforts of each project included an analysis of the validity of the data and appropriateness and validity of methodology, and an appraisal of the conclusions based on the evaluation efforts.

In addition to the evaluation of the individual projects, an examination of the projects as a cluster was made in order to answer important management and evaluation questions, such as: What projects are most effective under what circumstances? Do the projects span the range of characteristics needed in a statewide program? Do the projects provide suitable models for developing similar modalities in other locations? What kind of support from communities has proved necessary for project success? What types of cost-benefit comparisons are valid and invalid? Do the levels of efficiency observed in the projects provide a basis for setting standards? What kind of approach to evaluation would be effective for the kind of project typified by the cluster? What types of guidelines can be established to aid in the selection of new projects?

The statement of impact-oriented objectives and the measurement of progress toward these objectives is a basic input to grant management. All five projects stated, for the most part, the same core objectives: (1) reduction in CJS involvement, (2) rehabilitation to a drug free life, (3) increase in employment and education, (4) improved social relationships. The major difference in objectives as stated was that all programs (with the exception of Camarillo) would accept some reduction in the severity of drug use as a positive accomplishment, while Camarillo (in the tradition of the classical therapeutic community) requires drug abstinence as a measure of success.

The measurement of progress toward objectives varies widely in quality and completeness among the five projects. Some projects (Sacramento Methadone, Camarillo family) collect arrest, employment, and other data on every client. On the other hand, Aquarian does not collect any impact data on individual clients. Yet, all of the programs are substantially in compliance with the terms of their grants. This circumstance points to the desirability of strengthening the grant process to assure that

standardized and adequate impact measurement approaches are specified prior to the initiation of the project.

A key question is whether the various projects are suited to providing service to the varied types of drug users that need treatment in each locality. Each modality of treatment appears to be best directed at a selected group within the drug use community. Open Door Clinic tends to be for the younger user, generally white middle class (Hispanic and non-Hispanic). Most clients have a light drug habit without a confirmed criminal life style. The Aquarian Effort provides service to almost every type of drug user, partly because of the lack of alternate facilities in the Sacramento area. Walden House tends to serve clients with substantial drug use habits and considerable histories of criminal justice involvement. Sacramento Methadone Clinic provides service primarily to clients with long histories of heroin addiction. Camarillo family and short term programs provide services to heavier users (primarily heroin), generally with extensive criminal justice involvement. The adolescent program provides services to young users and non-users considered to be incorrigibles.

In terms of impact on these client types, the projects have had varying degrees of success. With respect to criminal justice involvement, substantial fractions of the clientele remained arrest free over the period of observation subsequent to initiation of treatment (i.e., a period varying from 3 to 24 months). Best results in the projects were observed for the Camarillo family program where 86% of the probation group remained arrest free. However, because of the duration and intensity of treatment in this type of therapeutic community, this form of treatment can be successfully applied to only a small fraction of the drug user community. Results were also aided by the fact that jobs are generally provided for family graduates at Camarillo for approximately a nine month period subsequent to treatment. The Camarillo short term program showed significant results but was less successful in maintaining arrest free results. Fifty-seven percent of the short term group were arrest free. The result is at least in part due to the fact that graduates of this program generally re-enter directly into the outside environment without efforts on the part of the program to secure them employment.

Sacramento Methadone was quite successful with clinic patients, with an estimated 80% remaining arrest free while in treatment. The client was less successful with the probation/parole group: 41% remained arrest free, although 78% showed a decreased frequency of arrest. Walden House (a modified form of therapeutic community) reduced involvement at about the same rate as the Camarillo short term unit. Fifty-eight percent of Walden clients remained arrest free, and 74% showed a decrease in frequency of arrest. Open Door had excellent results with its type of clients; 82% of a probation/parole sample remained arrest free during the observation period. The lack of appropriate data from Aquarian Effort made it necessary for the evaluation team to make an indirect estimate of CJS impact for this project. On the basis of type and duration of treatment, it was estimated that about 20% of the Aquarian clients receiving counseling services at the Crisis Line Center would show a decrease in frequency of arrest. Diminished use of drugs was usually correlated with the reduction in arrests. Table A summarizes the arrest and drug use data.

Table A

SUMMARY OF CRIMINAL JUSTICE AND DRUG ABUSE IMPACT

| | Open Door (Probation/Parole) | Open Door (Clinic) | Aquarian Crisis Line | Camarillo Family (Probation) | Camarillo Short Term (Probation) | Walden Resident (Probation/Parole) | Sacramento Methadone (Probation/Parole | Sacramento Methadone (Clinic) |
|---|---|---|---|---|---|---|---|---|
| Decrease in arrest rate (%) | 59.5 | -- | -- | 91.5 | -- | 53 | 57.5 | 73* |
| % Clients improved (arrest) | 87 | -- | 20 | 100 | 90 | 74 | 78 | -- |
| % Clients arrest free | 82 | 50-70* | -- | 86 | 57 | 58 | 41 | 80* |
| % Improved (drug) (after 1 year or more) | -- | -- | -- | 86* | -- | 18* | -- | 67* |
| % Clients drug free | -- | 16* | -- | 86* | -- | 18* | -- | 91* |

* Results for clinic population obtained from project reports.

The utility of a project as part of a total state program can be measured to some extent by considering the costs incurred in achieving a given unit of benefit. There are a variety of such cost-benefit measures that can be applied to drug abuse treatment projects. Selected values of various measures are given in Table B for the five projects.

Table B

SELECTED VALUES OF COST-BENEFIT MEASURES

| | Open Door | Aquarian Crisis Line | Camarillo Family | Camarillo Short Term | Walden House Adult Residential | Sacramento Methadone |
|---|---|---|---|---|---|---|
| $/client year | $3,400 | $5,290 | $8,123 | $6,991 | $4,116 | $1,744 |
| $/attendance day | 13.00 | 14.50 | 22.00 | 19.20 | 11.68 | 4.98 |
| $/improved client (arrest) | 305 | 286 | 5,100 | 890 | 1,006 | 2,235 |
| $/arrest free client | 324 | --- | 5,920 | 1,415 | 1,291 | 4,252 |
| $/improved client (drug) in treatment | 429 | --- | 8,123 | 6,991 | 4,116 | 1,915 |

Costs per client year are generally within range of those observed in other studies. Since the objective of governmental efforts is to assist all types of drug abusers, comparisons on performance among projects is best restricted to those that provide service for similar types of clients. Open Door and Aquarian both include counseling service of light users on an outpatient basis. Costs per client year at Aquarian are somewhat higher primarily because of the large number of unregistered drop-ins that are not included in the calculations. Costs per improved client are approximately the same. The values for the therapeutic communities (Camarillo family and short term, and Walden residential units) can be compared. The Camarillo programs exhibit higher costs per client year than Walden. This is due in part to the hospital setting of Camarillo, and in the case of the family unit, to the longer treatment cycle. The family unit, like most such therapeutic communities, has a higher rate of success among

those that complete treatment than other modalities. Costs per arrest free or drug free client are apt to be higher in a classical therapeutic community (family unit) than for the modified programs (Camarillo short term and Walden residence units). However, the graduates of the classical therapeutic communities generally exhibit special qualities of leadership and knowledge that make them particularly valuable as counselors and organizers in many aspects of drug treatment and rehabilitation.

The type of project information that is relevant will depend upon the evaluation strategy adopted by the state as part of grant management. Regardless of the final arrangements, proper evaluation will require certain basic information related to three major factors: demand, impact, and performance. Demand refers to the numbers and types of drug abusers that are appropriate to a treatment modality and that are not receiving adequate treatment. Impact refers to change induced in conditions outside the project. That is, it refers to end results achieved by the project with respect to reducing crime, improving the criminal justice system, or improving other aspects of community life. Performance refers to the treatment facility's services evaluated in terms of efficiency, quality, and other factors that measure project services adequacy.

There are several relevant sources of information for evaluation. Periodic status reports from the projects are useful but there is a tendency in most information systems to depend too heavily upon them. Such reports are often an efficient way of obtaining data on client attributes, staff attributes, project activity, funding, and management policy changes. These reports are often less useful as a primary source of information on project impact.

Special evaluation studies conducted by the project, regional board, or the state agency can provide an in-depth understanding of impact of services, as well as added insight into current demand and performance. These studies can include on-site observation, client interviews, follow-up tracking of control samples, and use of baseline data. These studies require the existence of a qualified staff, generally beyond the capabilities of the project staff itself. While 5 of the projects were doing useful monitoring and assessment, only one project could be said to be doing evaluative research (Camarillo). In order to provide for improvement, it is recommended that the State include,

in the grant application, instructions for a specific requirement to review and approve the evaluation plan and the qualifications of the evaluators.

Reports and observations of federal, state, and local agencies are important sources of information for estimating demand and for estimating other characteristics such as community relationships, referral policies, local support, etc. State baseline data should be standardized to allow comparisons to be made directly with project reported results. Local sources of information should be used more frequently by the State in obtaining an appraisal of operations and problems in the grant projects.

The evaluation strategy should make use of the various evaluation approaches to meet state planning needs at minimum cost. It is recommended that the periodic project reports be used to provide information needed for grant compliance. These reports should include indicators of project activity and impact needed to "signal" important changes in the operation that might be a prelude to significant changes of performance (e.g., staff turnover, client population decline, etc.). Evaluators at the state level could examine the reported indicators for notable changes. When an indicator was judged to be out of the acceptable range and could not be explained, a standardized inquiry form would be sent to the project to determine the reason for the change and (if the change were negative) what steps were being taken to correct the underlying problem.

On-site evaluation would be required for a selected group of projects on a continuing basis, to build up the needed understanding of treatment process and to provide the criteria used by state and regional evaluators in judging the acceptance of periodic reports from projects. Such on-site visits would also be called for when there was an unexplainable persistence of unsatisfactory results from a project.

## PREFACE

This study is part of the comprehensive effort of the Office of Criminal Justice Planning to evaluate the impact of local action projects receiving OCJP grants. The report presents the evaluation of five drug treatment and evaluation projects in the State of California, and develops suggested evaluation strategy for future State use. The five projects were:

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Acknowledgement is given to the staff of the Office of Criminal Justice Planning for their assistance. Francine Berkowitz, who acted as project monitor, provided valuable insights into the evaluation requirements of the Agency.

Valuable assistance was also provided by the staffs of the five projects and their consultants. Their assistance made it possible for the evaluation team to gain a rapid understanding of project activities and to obtain client related data for analysis. Other agencies assisting in the evaluation included:

Los Angeles County Superior Court
San Francisco County Superior Court
Los Angeles Regional Criminal Justice Planning Board
Ventura Region Criminal Justice Planning Board
Bureau of Criminal Statistics, California State Department of Justice
Sacramento and San Francisco Area Offices, Parole Division, California Department of Corrections

San Mateo Probation Department (Juvenile and Adult)
Los Angeles County Probation Department (Juvenile, Adult, and Research Office)
Ventura County Probation Department (Adult)
Sacramento County Probation Department (Adult)
San Francisco Probation Department (Juvenile and Adult).

This evaluation was carried out by the West Coast office of System Sciences, Inc. Principal contributors were:

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Valuable critical advice was received from several consultants during the course of the study. Particularly important inputs were received from Dr. Stephen M. Pittel, Director, Berkeley Center for Drug Studies, Berkeley, California; Dr. John Newmeyer, Epidemiologist, Haight-Ashbury Free Medical Clinic, San Francisco, California; and Dr. Edward J. Sondik, Assistant Professor, Department of Engineering & Economic Systems and Department of Communication, Stanford University, California.

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# I. INTRODUCTION

## A. Objectives of Study

The objective of the Office of Criminal Justice Planning (OCJP) is a deliberate, constructive social change and in particular, a reduction in the level of criminal activity. To accomplish this objective, OCJP must seek a rational, effective allocation of its limited financial resources amidst an overabundance of requests for funds on the part of local government. The Agency therefore requires an objective basis for assessing the impact of funding local action projects on the communities serviced, and a basis for assessing the likely impact of proposed projects for future funding. This need calls for the evaluation of the OCJP funded local action projects toward accomplishment of their impact-oriented objectives.

While evaluation activities are being carried out by these projects, a requirement exists to make independent evaluations of the impact of the individual projects, and of groups (or clusters) of projects with similar or coordinated objectives. In addition, there is a need to examine the quality of each project's evaluation component and to make recommendations concerning the most effective evaluation strategies for each project within the cluster and for the cluster as a whole. The particular cluster to which this effort has been directed is composed of five drug treatment and rehabilitation projects:

- Sacramento County Methadone Maintenance Program
- The Aquarian Effort, Inc.
- Camarillo Resocialization Program for Drug Abusers
- The Open Door Drug Clinic, Inc.
- Walden House, Inc.

B. Background

The five projects cover a spectrum of treatment approaches and reach a wide range of client types. Each project has areas of considerable success and areas of self-admitted failure. This history of success and failure is typical of the drug treatment field where projects are always in a state of change caused by the many critical events occurring both in and around the project.

A snapshot view of a project at one period of time is not necessarily a complete picture of the project at some other period. Change is brought about by many conditions: changes in funding levels, impact of new regulations, failures of treatment or conflicts in philosophy, emerging community needs and attitudes, and so on. Thus, if a proper interpretation is to be made of the observed impact, consideration must also be given to the project's performance in terms of its own intrinsic characteristics and the conditions found in the surrounding environment.

A number of characteristics of drug treatment projects have been identified in previous work as being important to interpreting performance. These characteristics, which are being examined in this study, include: project treatment philosophy; characteristics of treatment modalities; attributes of clients who succeed or fail; staff capabilities and training; project objectives and criteria for success; in-house evaluation and feedback; and management capabilities.

Characteristics of the surrounding environment that should be examined include: characteristics of the addict population; relationships of the project with supporting agencies; regulations imposed on operations; funding, and funding variations; total community capabilities for drug

abuse treatment, rehabilitation, education, and prevention; and the attitudes of the community at large toward these projects.

Each project funded by OCJP is required to report its achievements of impact-oriented objectives. The approaches used to meet this requirement, among the five projects and in the field at large, vary in many respects. There are variations in: statement of objectives; criteria for measurement; data elements and data capture techniques; methodology for making judgments from the data; terminology; and format and quality of presentation. There are also wide variations in the quality and comprehensiveness of the evaluation efforts. These variations are due to such factors as differing views of the value of evaluation, difficulties in capturing data, variation in capabilities of evaluation groups, variation in funding of evaluations, and differing requirements written into grant request awards.

The OCJP must be able to absorb the information in these project evaluations and understand their implications in order to determine whether projects should be refunded or replicated in other jurisdictions. This task is made more difficult by the diverse content and format of the project evaluations. While some diversity in reports may be justified by the research orientation of the projects, standardization of reported information is desirable wherever possible. For this purpose, this current study is examining the project evaluation efforts so as to identify common objectives, criteria for measurement, and common data elements that would form the basis for an improved and coordinated evaluation approach. While the five projects will provide many of the necessary common elements, they will not provide all. Consequently, this current study will suggest modifications to provide a more complete basis for an improved evaluation approach.

C. Overview of Methodology

A responsible evaluation of projects in such a complex and rapidly changing field as drug treatment and rehabilitation requires that all important facets of each project be examined from several points of view. The methodology used in this study attempts to meet these requirements by gathering information from several sources and evaluating this information in the light of previous experience in the field of drug treatment. The basic purpose of the methodology was to help the evaluation team (1) understand the project well enough to identify the major features contributing to success or failure; (2) understand and verify the findings of the evaluation components of each project; and (3) where possible, extend these findings to provide a more complete picture of the project's impact.

The necessary wide variety of information was obtained by reviewing project reports and grant applications, making on-site visits to each project, and contacting various types of local and state agencies that interact with drug abuse projects. Review of the grant applications allowed the examination of the impact-oriented objectives and proposed criteria for measurement of progress toward these objectives. Review of subsequent quarterly progress reports and special evaluation reports provided an initial insight into the degree to which the projects had been able to apply these criteria successfully. These reports also provided much of the data on activity levels of service provided by each project, and in some instances, preliminary data on impact.

The on-site visit of the evaluation team provided an opportunity to observe the project in operation; determine the adequacy of the facilities; interview members of management, evaluation, and provider staff; and make use of project and client records. On-site visits were

conducted by an evaluation team consisting of a psychiatrist, an ex-addict paraprofessional, and a systems analyst experienced in community health and mental health activities. Interviews conducted by this team made use of modified versions of structured interview instruments that had been field tested in previous evaluation studies in New York.* A director's interview was conducted initially to establish the basic features of the program as seen by management. Topics discussed included: description of ideal client types; program goals; treatment philosophy; therapeutic approach; program organization; funding; and major problems of the project past, present, and future. Interviews of all available provider staff supplied important information on training, experience, and distribution of staff time among project activities, and gave an indication of adequacy of each provider to deliver service to clients.

Project and client records furnished much of the information needed to describe client attributes (e.g., demographics, drug use history, education, employment, etc.). These sources also made possible the validation of project report estimates on level of utilization and provider activity. Because of client confidentiality problems, gaining access to client records is a difficult, delicate, and time consuming operation. After extensive coordination effort with the projects, we were able to obtain access to client records in all five treatment projects, subject to some restrictions on personnel used, type of clients studied, and information abstracted.

Contacts with the criminal justice system resulted in access being

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* Comparative Analysis of Twenty New York City "Drug Free" Drug Abuse Treatment Programs, System Sciences, Inc., Bethesda, Maryland (November 1972).

given to probation and parole records in counties being served by the drug treatment projects. Sample groups of project clients known to probation and parole were then tracked through the records of these agencies. This effort permitted a determination of the changes in criminal justice records of the samples before and after initiation of treatment in the treatment projects. The local criminal justice representatives were also interviewed to obtain insights into their views of the usefulness and potential of the treatment projects in terms of referrals of criminal justice cases, and in terms of reduced crime in the communities served.

The examination of the self-evaluation efforts of each project included an analysis of validity of data and appropriateness and validity of methodology, and an appraisal of the conclusions based on the evaluation efforts. Key problems examined included the reliability of data from client questionnaires; lack of baseline data and control groups; use of specific statistical tests with samples of varying size and quality; validity of statistical inference and subjective classification; and substantiation of conclusions by client data. Consideration was also given to the use made of evaluation results -- for example, whether results are used only for reporting to OCJP and other agencies or are used for some additional purpose such as feedback into the in-house training and management, or the production of research reports that increase knowledge of drug abuse problems.

The information obtained by the evaluation team was reduced and tabulated to provide qualitative and quantitative descriptions of client attributes, treatment modalities, and staff and management characteristics; and to provide estimates of efficiency of service delivery,

and impact on the criminal justice system. As a basis for evaluation, resulting tabulations were compared with similar results within the cluster and similar modalities in the treatment community at large. The process of data reduction and comparison generated a number of significant observations on adequacy of treatment and opportunities for improvement of service and evaluation. It also provided considerable insight into the possible value of various measures of performance and impact. For instance, arrest rate data before and after treatment must be used with great care since with a small sample (such as is likely to be obtained in an individual project), the deviation of a few persons in the direction of increased crime can mask the improvement of the majority. This and other insights and observations were then used to develop (1) recommendations as to the useful and feasible evaluation designs for individual projects, and (2) an evaluation strategy for the cluster as a whole.

D. Basic Definitions

The completeness of definitions is often a good measure of the state of knowledge and organization in a technical field. The great diversity and the frequent inconsistency of terminology in the drug abuse and treatment area illustrate the basic lack of knowledge and the inadequately organized knowledge prevalent in this technical field. In spite of these problems, any report must attempt to select and use terminology that is understandable to the readers and is currently in use. The terms used throughout this report are drawn from recent Federal and California State sources as well as from descriptions of procedures used in California State activities. Important terms are defined in the text as they appear.

A caution is in order in the use of terms that are drawn from better organized fields of knowledge. These terms are helpful and usually appropriate; however, they bring with them overtones of knowledge and precision which they do not contain in the new and rapidly changing field. An example is the use of the term "encounter" drawn from community medicine where it has been defined to mean "a face-to-face meeting of provider and patient for the purpose of delivering a specific service." When applied to a specific area of medical specialty such as diagnostic X-ray, it takes on a fairly well understood meaning as to the unit of service delivered. But when a term such as "encounter" or "unit of service" is applied to drug treatment and rehabilitation, it could represent a wide range of types, quality, and length of service. Thus, when comparisons are made of encounters or cost per encounter between disparate treatment facilities, much more understanding of the basic underlying factors is needed before the validity of the comparison can be established.

E. Organization of this Report

This report is organized into three parts. Part I supplies the framework of purpose, scope, and other general information allowing the reader to obtain an overall view of the subject matter in the other two parts. Part II presents a summary of the principal characteristics of each of the five projects. Comparisons are made of project characteristics, evaluation components, performance, and impact. Definitions suitable for describing project activities are introduced, and recommendations are given for a State evaluation strategy. Part III is the most comprehensive portion of the report, presenting, for each of the five projects, descriptions and evaluations of service provided,

impact-oriented objectives and measurement criteria, client and staff attributes, quality of project evaluation efforts, and project impact, efficiency, and potential.

F. Summary Description of Treatment Projects

1. Sacramento County Methadone Maintenance Program

This is an outpatient clinic dispensing methadone to heroin addicts. Clients generally have a history of heavy use of heroin and considerable criminal justice involvement. Clients' ages range from 18 to 60, with an average age of over 30 years. White clients (Hispanic and non-Hispanic) predominate, with a proportionate representation of black clients. The clinic is part of the Sacramento County Mental Health Department. Other services include individual counseling and job counseling. About 30-40% of the clients receive individual counseling from program staff or from a nearby Sacramento County mental hygiene clinic.

2. The Aquarian Effort

This is a diverse treatment project in Sacramento, offering services to a variety of clients and transient people. The project includes a detoxification unit, a crisis line counseling service, individual and group counseling (outpatient), a free medical clinic, a free legal clinic, and a drug abuse education program for schools. The outpatient counseling service associated with the crisis line facility deals principally with young white (non-Hispanic) clients, with a small representation of Hispanic white and black clients. Both light and heavy drug users are represented in the client population. The detoxification unit and its supporting counseling provide service for heavier drug users, often with long criminal records; racial backgrounds are

evenly distributed among white (non-Hispanic) and minority groups. The drug education program offers lectures and counseling in high schools in conjunction with the Sacramento Unified School District.

3. Camarillo Resocialization Program for Drug Abusers

This program is located at Camarillo State Hospital, Camarillo, California. It is a unique program where extensive treatment and research programs are closely interdependent. The treatment program consists of four units: detoxification, a classical therapeutic community ("the family"), a shortened version of a therapeutic community ("short term program"), and an adolescent unit. The therapeutic community units are run largely by the experienced clients using encounter therapy, individual work assignments, and other modes of treatment in a highly disciplined environment. Clients of the adult units are young with a well-proportioned distribution among white and black clients. In the therapeutic communities, more than 55% of the clients were using heroin regularly prior to treatment there and have substantial histories of drug abuse and criminal justice involvement. The adolescent unit is structured along the lines of the adult therapeutic communities but is less highly disciplined. Client ages range from 15 to 18. Most clients use drugs other than heroin. All clients entering the various units are referred by county mental health agencies, principally Los Angeles and Ventura Counties.

4. Open Door Drug Clinic

This is an outpatient clinic serving the youth of West San Gabriel Valley in Los Angeles County. Treatment is geared toward primarily middle class white (Hispanic and non-Hispanic) high school

students and other young adults. Most clients are only light drug users or are non-users with personal problems. The primary services offered are individual counseling; group therapy; family therapy; emergency services via a hot line telephone service; community information and outreach; counseling and drug education in local high schools; and coordination in the community drug abuse treatment and rehabilitation activities.

5. Walden House, Inc.

This organization operates a voluntary residential treatment program in San Francisco with aftercare for drug abusers. The program contains a youth facility, an adult facility, and an outpatient facility which also contains living quarters for residents in the process of reentry. The program has moved steadily away from the classical therapeutic community model for drug treatment. Counseling and other treatment are delivered by the staff in a less highly disciplined atmosphere than that associated with a therapeutic community. The treatment schedule is also shorter (about 3 months is considered desirable for completing the residential phase of treatment). The clients are principally young non-Hispanic whites and blacks with a small representation of other minorities. The adult facility contains a substantial fraction of heroin users with a long history of drug use and criminal justice involvement. The youth facility generally contains lighter users and non-users. The majority of clients are referred to Walden by criminal justice and other community agencies.

# II. CLUSTER EVALUATION

## A. Purpose of Cluster Evaluation

In addition to the evaluation of the individual projects (Part III), it is desirable to consider the lessons to be learned from evaluation of the projects reviewed as a cluster. The individual projects (with the exception of The Aquarian Effort and the Sacramento Methadone Maintenance Program) are distributed widely throughout the state and do not interact. Thus, in a physical sense, there is little to be added to the description of services and other characteristics of the individual projects. However, in the sense of knowledge useful in state management decisions, there is much to be gained from a comparative examination of the projects.

The examination of the cluster will provide information useful in answering important management and evaluation questions, such as: What projects are most effective under what circumstances? Do the projects span the range of characteristics needed in a statewide program?* Do the projects provide suitable models for developing similar modalities in other locations? What kind of support from communities has proved necessary for project success? What types of cost-benefit comparisons are valid and invalid? Do the levels of efficiency observed in the projects provide a basis for setting standards? What kind of approach to evaluation would be effective for the kind of project typified by the cluster? What types of guidelines can be established to aid in the selection of new projects?

In the following pages, these types of questions will be addressed.

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* A program is defined by OCJP as a primary segment of a functional criminal justice category, consisting of all projects that have common or closely related objectives.

A comparison will be made of project characteristics including objectives, treatment methods, staff and client attributes, etc. Project self evaluations will be compared and considered in terms of current OCJP classifications, as well as designs and data types collected. Comparisons of achievement will be made in terms of criminal justice involvement, reduction in drug use, and other criteria. The potential of the projects will be considered so as to identify major features that influence possible future expansion or replication of the projects. The sum of the information will be applied to the question of the proper overall evaluation strategy for the State of California.

B. Common Objectives

While each project states its objectives in a different way, there is a commonality among basic objectives. Table 1 indicates objectives (either stated or implied) that form the basis of project operations. All of the programs direct efforts toward reducing criminal justice involvement of their clients; reducing or eliminating drug use; improving job prospects and education; and generally improving social relationships of clients and graduates. With the exception of Camarillo, all of the projects would accept a reduction in drug use by a client as a measure of success, even though all are ultimately aiming at complete abstinence. The Camarillo family program would not accept anything short of abstinence as a success.

The supporting objectives more clearly differentiate among the various projects. The Aquarian Effort, for instance, has shown a remarkable ability to create community awareness and to elicit financial and other support from the community. The program also devotes considerable effort to prevention/education activities and to development of former users into useful workers in this field. Open Door, also an ambulatory program, has

Table 1

OBJECTIVES STATED OR IMPLIED

| OBJECTIVES | Sacramento Methadone | Aquarian Effort | Camarillo | Open Door | Walden House |
|---|---|---|---|---|---|
| Reduction of CJS involvement | • | • | • | • | • |
| Reduction in drug use | • | • | | • | • |
| Rehabilitation to drug free life | • | • | • | • | • |
| Increase employment/education | • | • | • | • | • |
| Improved social relationships | • | • | • | • | • |
| Create community awareness and support | | • | | • | |
| Assist development of drug treatment modalities | | | • | | • |
| Coordinate drug free program and associated agencies | | | | • | |
| Redirect users into drug abuse work | | • | • | | |
| Prevention/education | | • | | • | |
| Research in drug abuse | • | | • | | • |

similar interests in prevention/education and development of community awareness and support. Camarillo is oriented toward a more basic role of (1) developing understanding of psychosocial and physiological factors important in drug treatment, and (2) providing the required expertise to other groups attempting to develop new drug treatment projects or programs. Sacramento Methadone and Walden House have an emphasis on accomplishing the core objectives. Walden House, with the assistance of local government, has been able to grow internally and thereby assist in meeting the community needs.

The commonality of core objectives suggests that common criteria and common evaluation techniques can be devised for this cluster. However, criteria for improvement in client performance are not now the same among the projects. Some degree of standardization can be developed but there are real differences in what each project can do to help clients, and some of the important differences should be recognized by the state's evaluation strategy. If all types of clients are to be given consideration, it must be recognized that some types of clients simply will not enter into some of the more "effective" programs. For instance, many who might benefit from a disciplined residential program will accept treatment only from a free-form ambulatory drug counseling center. Thus, while the objective is to achieve permanent drug free life, improvements short of that objective must be recognized if certain types of projects are to be accepted.

Another problem in setting criteria is concerned with rather general goals such as "improved social relationships." Although most therapists believe that this type of objective is very important for full recovery of the client, the means of measuring improvement are generally inadequate. In this study effort, the proposal has been made that satisfactory measurement of social relationships requires the application of "goal-oriented"

approaches in which goals are set for each client and success is recorded when these specific goals are reached.* However, in order for measurements from different centers to be comparable, it will be necessary to achieve some degree of standardization on the types of goals that are to be considered as significant improvement.

C. Comparison of Services Provided

SSI has examined the completeness of representation of the treatment modalities and other environmental factors represented by the cluster projects. Definitions and categories for describing projects were taken from definitions in Federal and California State sources and other documents describing systems used by California state agencies.** As expected, the definitions from the various sources differ in wording and emphasis. However, many of the same basic distinctions are made, so that in most instances, these source materials can be used to provide a consistent set of categories covering the spectrum of treatment and environmental possibilities. (See Table 2.) A summary of definitions used is given below. These definitions are meant to be suggestive of the treatment environment. For more complete technical definitions, the referenced sources may be consulted.+

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* "Evaluation," A Forum for Human Service Decision-Makers, Special Monograph No. 1, 1973, Program Evaluation Project, Minneapolis Medical Research Foundation, Inc., Minneapolis, Minnesota.

**S.M. Pittel and R. Hofer, "A Systematic Approach to Drug Abuse Treatment Referral," Journal of Psychedelic Drugs, 1974 (in press).
"Client Oriented Data Acquisition Process: National Management Handbook," National Institute on Drug Abuse, Rockville, Md., October 1973.
P.L. Birchard, "The Voluntary Selection of Drug Treatment Programs Project: A Final Report," Department of the California Youth Authority, May 1, 1973.

+ Above sources, and "Drug Use in America: Problem in Perspective," Second Report of the National Commission on Marihuana and Drug Abuse, March 1973 (U.S. Government Printing Office, Washington, D.C.).

Table 2

COMPARISON OF FEATURES OF PROJECTS IN CLUSTER

| CATEGORIES | Sacramento Methadone | Aquarian Crisis Line Counseling | Aquarian Detox | Camarillo Family | Camarillo Short Term | Camarillo Detoxification | Camarillo Graduate (Recent) | Open Door | Walden House T.C. (Adult & Youth) | Walden House Outpatient | Walden House Satellite Apt. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Client Relationships** | | | | | | | | | | | |
| Casual drop-in | | ● | | | | | | ● | | | |
| Inpatient | | | | | | ● | | | | | |
| Residential | | | ● | ● | ● | | ● | | ● | | ● |
| Outpatient | ● | ● | | | | | | ● | | ● | |
| Jail | ● | | | | | | | | | | |
| **Clinic Environment** | | | | | | | | | | | |
| Medical ward | | | | | | ● | | | | | |
| Psychiatric ward | | | | | | | | | | | |
| Live in/work in (non-hospital residence) | | | ● | | | | | | ● | | |
| Live in/work in (non-hospital correctional institution | | | | | | | | | | | |
| Live in/work in (hospital residence) | | | | ● | ● | | | | | | |
| Live in/work out | | | | | | | ● | | | | ● |
| Day care center | | | | | | | | | | | |
| Live out/work out | ● | ● | | | | | | ● | | ● | |

Table 2
(Continued)

| CATEGORIES | Sacramento Methadone | Aquarian Crisis Line Counseling | Aquarian Detox | Camarillo Family | Camarillo Short Term | Camarillo Detox | Camarillo Graduate (Recently) | Open Door | Walden House T.C. (Adult & Youth) | Walden House Outpatient | Walden House Satellite Apt. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatment Approach | | | | | | | | | | | |
| Information/education | | ● | | ● | | | | ● | | | |
| Community activity | | | | | | | | | | | |
| Alternatives orientations | | | | | | | | | | | |
| Individual counseling (brief) | ● | ● | ● | ● | ● | ● | | ● | | ● | |
| Psychotherapy (brief) | * | | | | | | | ● | | ● | |
| Family therapy | | ● | | | | | | ● | ** | | |
| Psychotherapy (long) | * | | | | | | | ● | | | |
| Group therapy (traditional) | | | | | | | | | | | |
| Encounter group (light) | | ● | ● | | | | | ● | ● | ● | |
| Encounter group (heavy) | | | | ● | ● | | | | ● | | |
| Religious group | | | | | | | | | | | |
| Therapeutic community (light) | | | | | | | | | ● | | |
| Therapeutic community (heavy) | | | | ● | ● | | | | | | |
| Slow methadone withdrawal | ● | | | | | | | | | | |
| Methadone maintenance | ● | | | | | | | | | | |
| Other chemotherapy (antagonists) | | | | | | | | | | | |
| Detoxification | | | ● | | | ● | | | | | |
| Hospital care (long) | | | | | | | | | | | |
| Reentry | | | | | | | ● | | | | ● |

* = by referral only
** = youth only

1. Definitions of Primary Descriptive Headings

The primary descriptive headings are client relationships, clinic environment, and treatment approach. "Client relationships" refers to the client's schedule and status for treatment at the project. For instance, the client might drop in irregularly for treatment, or might be a resident of a facility, etc. "Clinic environment" refers to the treatment environment of clients, such as medical ward (hospital, nonhospital residence, etc.). "Treatment approach" refers to the treatment modalities or techniques that are used in the project, such as detoxification, maintenance, etc.

2. Definitions of Categories

Although many of the categories under the primary descriptive headings are self-explanatory, some need further explanation. For these, the following definitions are given.

Client Relationships

- o Casual drop-in: a client without a specific schedule of treatment, and with no intent to continue treatment.
- o Inpatient: a patient who is hospitalized.

Client Environment

- o Live in(out)/work in(out)...: the term "work" refers to the regimen established for clients rather than what some clients might actually do.
- o Day care center: a condition where clients regularly reside outside the center, but have regularly supervised work functions and responsibilities inside the center.

Treatment Approach

- o Information/education: any organized effort, through schools or the media or in the treatment facility, directed primarily toward drug abuse prevention.
- o Community activity: any supportive, organized activity such as sports programs, field trips, etc.

- o Individual counseling (brief): short individual counseling sessions that are directed toward a supportive result -- e.g., motivating the client to undertake rehabilitation, increasing the client's self-awareness, counseling the client for employment, etc.

- o Psychotherapy (long): traditional techniques provided by a professional psychotherapist.

- o Family therapy: any counseling or supportive activities involving the client and his family.

- o Encounter group (light): the use of the feelings and attitudes generated by a small group as nonthreatening supportive therapy (e.g., Gestalt, transactional analysis, Esalen, etc.).*

- o Encounter group (heavy): the use of group generated feelings in an aggressive manner to explore and attack beliefs of group members, as a means of changing or reinforcing these beliefs.* An example is the Synanon game.

- o Religious group: the use of any individual or group counseling techniques that have explicit religious aspects or religious overtones.

- o Therapeutic community (heavy): therapy in a classical client-run residence with strict discipline and well-structured phases of treatment, using counseling techniques and work regimens.

- o Therapeutic community (light): a less disciplined, less structured residential program run by clients or by non-client staff.

- o Detoxification: detoxification that takes place in not more than 21 days.

- o Slow methadone withdrawal: a process of withdrawal over a period of more than 21 days by gradual reduction in dosage levels.

Examination of Table 2 indicates that all specified forms of client relationships are to be found in the cluster. With respect to clinic environment, types not represented in the cluster are: medical ward, psychia-

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* M.A. Lieberman, et al., "Encounter Groups: First Facts," Basic Books, Inc., New York, N.Y., 1973.

tric ward, and nonhospital correctional institution. Modalitites of (drug) treatment not found in the cluster are: group therapy (traditional), day care center, religious group, hospital care (long), and other chemotherapy. From the California survey of drug treatment projects, the major deficiencies in terms of the cluster would probably be the absence of a religious group and a nonhospital correctional institution.

D. Comparison of Clients Served

Since each modality is likely to be more effective for some clients than for others, methods are needed for identifying significant gaps in the treatment spectrum in a community. To develop such methods, it is necessary to define drug user types in terms useful to the decision maker, and to relate these types to specific treatment modalities.

Drug use types have been identified in terms of demographics, drug use, criminal justice involvement, and economic, social, attitudinal, and motivational factors. The National Commission on Marihuana and Drug Abuse* has defined five levels of drug abuse habit: (1) experimental drug use, (2) social or recreational drug use, (3) circumstantial and situational drug use, (4) intensified drug use, and (5) compulsive drug use.

- Experimental Drug Use

  This is a short term nonpatterned trial of one or more drugs at variable intensity but with a maximum frequency of 10 times per drug. Use is primarily motivated by curiosity or the desire to experience new feelings or mood states. This use most often occurs in company with some drug experimenting social group.

- Social-Recreational Drug Use

  This use also occurs in a social setting. Unlike experimental use, this use tends to be more patterned and more variable in terms of frequency, intensity, and duration. The most distinguishing characteristic is that it is a voluntary act.

* "Drug Use in America," op.cit.

- Circumstantial-Situational Drug Use

  This is distinguished by a pattern where use is motivated by the need for a drug effect that will help the user cope with a specific, sometimes recurrent, personal or job problem.

- Intensified Drug Use

  This use is a long term patterned use of drugs at least once daily, and is motivated by the need to achieve relief from a persistent problem or to maintain a certain self-prescribed level of performance. A distinguishing characteristic is regular drug use, which escalates to a pattern of dependence.

- Compulsive Drug Use

  This pattern is intensified use carried even further, producing physiological or psychological dependence of such magnitude that the individual cannot at will discontinue use without experiencing physiological discomfort or psychological disruption. It is characterized by reduced individual and social functioning.

While these definitions describe the possible degrees of drug involvement, they are not sufficient for surveying the needs of the potential client population. Efforts to develop referral systems have resulted in the identification of specific factors useful for planning purposes. Recent work by Savitz et al. has identified important client attributes for referral to methadone maintenance programs and therapeutic communities.* Based on decisions of an intake unit, drug user attributes (in order of importance) were:

| Referral to Methadone Unit | Referral to Therapeutic Community |
|---|---|
| 1. Length of addiction | 1. Previous treatment |
| 2. Amount of addiction | 2. Attitudes |
| 3. Previous treatment | 3. Family relations |
| 4. Attitudes | 4. Employment |
| | 5. Length of addiction |
| | 6. Rapport |

* L.G. Savitz, et al., "Referral Decision-Making in a Multi-Modality System," p. 158 in "1973 Proceedings, Vol. One," 5th National Conference on Methadone Treatment, March 17-19, 1973 (National Association for the Prevention of Addiction to Narcotics, New York, N.Y., 1973).

A recently developed referral system by Pittel and Hofer* has defined two categories of attributes that relate to client needs and client ability to benefit from treatment: (1) drug problem factors -- attributes relating to the seriousness of the drug problem, and (2) resource factors -- attributes measuring the strength of the client's internal and external resources. The drug problem factors include:

- Types of drugs
- Frequency of drug use
- Number of withdrawals
- Route of administration
- Cost of drug habit
- Longest abstinence period
- Combinations of drugs

Factors measuring resources of the client include:

- Peer relationships
- Residential stability
- Education
- Family relationships
- Motivation and commitment to treatment goals
- Social group participation
- Occupation
- Duration of drug involvement
- Involvement

In the Pittel and Hofer scheme, each set of factors is combined to permit an approximate measurement, on a continuous scale, of the client's drug problem (drug index) and the client's resources (prognostic index). For operational and planning purposes, it is probably justified to consider an index in terms of low, medium, and high values. The low values on the drug index would generally include the experimental users and a major portion of the social-recreational users and circumstantial-situational users. Medium values of the

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* S.M. Pittel and R. Hofer, "A Systematic Approach to Drug Abuse Treatment Referral," Journal of Psychedelic Drugs, 1974 (in Press).

drug index would include relatively light users with an escalating pattern of use. The high category would include the intensified and compulsive drug users, including the "hard core" types with long histories of drug and criminal involvement.

Client resources can be similarly graded into categories of low, medium, and high. Examples of a client with low resources would be a client living with someone else who is using drugs; or a client who is surrounded by peers using drugs. In addition, this type of client is often poorly educated and poorly motivated to change the situation. Another type of client with low resources would be an individual living in an unstable home environment without employment, education, and supportive friends. An example of a drug user with high resources would be one who was well-motivated; had functioned well in society prior to drug involvement; had a stable home situation; and could move into a positive environment after treatment. This type of client may have been using drugs under extreme conditions (e.g., Vietnam veteran).

Identification of the proper treatment modality for any individual is a job for a trained worker. However, the general concept is that clients whose internal and external resources are greater than the seriousness of the drug problem would be best treated in "light," usually ambulatory, therapy. Clients with low resources compared to the seriousness of the drug problem would be better served by the highly structured environment of a residential program, or by methadone maintenance.

A tabular representation of levels of client drug habit and client resources provides a convenient format for describing what portions

of the client population are best suited for each of the five treatment projects in the evaluation cluster. This representation is given in Table 3.

While the cluster projects do not cover all modalities of treatment, Table 3 indicates that they do provide a basis for offering treatment to the range of client types, at least with respect to levels of drug habit and client resources.

For clients with a heavy drug problem, the traditional therapeutic community program (Camarillo family, short term, and adolescent) would often be an appropriate choice. The lighter family programs (Walden) would also be appropriate where client resources were medium to high. Methadone maintenance programs (Sacramento Methadone) would be appropriate for many with low to medium internal and external resources, especially if they could not accept the structured environment of the residential families. The "high-high" case might also include intensive psychotherapy on an outpatient basis. This modality was not included in the cluster.

For the light users, the ambulatory, brief counseling modalities such as Aquarian, Open Door, and Walden outpatient clinics would be the preferable choices. The "low-low" case might also include an early user with a poor family situation. This particular type of case might be appropriate for a "day care center." For users judged to have a "medium" habit, choice of modality is likely to rest more on individual attitudinal factors than on generalized client attributes. For these clients, a wide range of modalities might be appropriate, ranging from the family programs to the ambulatory, light counseling programs.

Client demographics also can help to determine types and numbers of clients applicable to, or compatible with, the various treatment modalities in the project cluster. For example, age or age group (15-19, 20-24, over 35, etc.) would be an indicator of both the types of clients and numbers of clients, and the younger ages' tendency toward experimental, social-recreational, and circumstantial-situational use rather than intensified or compulsive use. Race/ethnic background can be an influential factor, especially regarding minority groups and their representation in given treatment modalities. The sex of the client can also be a consideration of treatment modality.

Table 3

MATCHING CLIENTS WITH PROJECTS ON THE BASIS OF DRUG HABIT AND RESOURCES

Client Resources

| Client Drug Habit | Low | Medium | High |
|---|---|---|---|
| Low (Light) | AC<br>OD<br>WO | AC<br>OD<br>WO | AC<br>OD |
| Medium | W<br>CF | AC<br>OD<br>WO<br>W | AC<br>OD<br>WO |
| High (Heavy) | SM<br>CF | W<br>CF<br>SM | CF<br>W |

AC - Aquarian crisis counseling
OD - Open Door counseling
WO - Walden outpatient clinic
W - Walden therapeutic community
SM - Sacramento Methadone
CF - Camarillo family, short term and adolescent programs.

Table 4 presents a summary of race and age of clients for the various treatment modalities in the cluster. More complete demographic information is given in the individual project reports (Section III). This information, together with the observations of the on-site evaluation team, provides the basis for a normative description of project clients.

The Open Door Clinic tends to be for the young user, generally white middle class (Hispanic and non-Hispanic). Clients might be described as experimental and social-recreational users, as well as non-users. Generally, they still have ties with family, school, and employment. Many have been arrested and placed on probation; however, most have not developed confirmed criminal life styles. Approximately one-half of the clients are female, which is a relatively high proportion for drug treatment projects.

The Aquarian Effort provides service to almost every type of drug user, partly because the Sacramento area lacks sufficient treatment modalities. Aquarian crisis counseling deals primarily with young non-Hispanic white clients. This racial distribution is not representative of the problem. Although most of these clients are young, middle class types with school and family ties, a significant number have more serious drug and criminal justice involvement. The Aquarian detoxification unit deals with heroin addicts; the racial distribution appears to be proportional to the problem (i.e., mostly non-Hispanic white males and black males). Most of these have had extensive criminal justice involvement, and many have been referred by probation and parole authorities.

Table 4

SUMMARY TABLE OF CLIENT DEMOGRAPHICS

| | Sacramento Methadone | Open Door | Camarillo Family and Short Term | Camarillo Detoxification | Walden Youth | Walden Adult | Walden Outpatient | Aquarian Crisis line |
|---|---|---|---|---|---|---|---|---|
| Age 15-19 | | | | | | | | |
| Hispanic White | 0 | 14 | .8 | 1.0 | 9.0 | 0 | 0 | 1.5 |
| Black | 0 | 0 | 1.6 | 0.4 | 7.2 | 0 | 0 | 0 |
| Non-Hispanic White | 0 | 26 | 7.0 | 3.8 | 51.6 | 1.4 | 9.7 | 19.1 |
| Others | 0 | 0 | 0 | 0 | 3.6 | 0 | 0 | 1.5 |
| Age 20-29 | | | | | | | | |
| Hispanic White | 8.3 | 10 | 3.8 | 15.7 | 1.8 | 2.8 | 3.2 | 1.5 |
| Black | 2.4 | 2 | 5.7 | 4.6 | 1.8 | 8.4 | 19.3 | 4.4 |
| Non-Hispanic White | 26.8 | 38 | 63.2 | 45.0 | 19.6 | 56.6 | 45.4 | 54.3 |
| Other | 1.2 | 0 | .8 | 0.5 | 5.4 | 8.4 | 3.2 | 0 |
| Age 30 or over | | | | | | | | |
| Hispanic White | 18.9 | 4 | 5.4 | 9.3 | 0 | 2.8 | 0 | 4.4 |
| Black | 9.6 | 0 | 4.5 | 9.0 | 0 | 4.2 | 6.4 | 1.5 |
| Non-Hispanic White | 31.6 | 10 | 7.2 | 10.5 | 0 | 11.2 | 9.6 | 10.3 |
| Other | 1.2 | 0 | 0 | | 0 | 1.4 | 3/2 | 1.5 |

The Walden House units tend to serve clients with substantial drug use habits (intensified, compulsive) as well as considerable histories of criminal justice involvement. The units maintain a racial distribution proportional to the area population, with females making up about 30 to 40% of the client population. The youth residence serves primarily juveniles and young adults referred by local agencies. The adult group primarily serves adults under 35 years of age. Most have a long history of drug abuse and criminal justice involvement.

Sacramento Methadone clinic provides service primarily to clients with long histories of heroin addiction. The clients have proved to be unreachable by the methods of drug free programs. The clinic population includes proportionate fractions of non-Hispanic whites and blacks; however, black clients do not remain in the program as long as white clients. The average age of the client population is over 30 years. Many of the clients are referred to the clinic by the local probation and parole authorities.

Camarillo family and short term programs provide services to clients with intensified or compulsive drug use, primarily heroin addiction. Many of the clients have long histories of criminal justice involvemnnt. The adolescent program provides a therapeutic community for youthful drug abusers and non-users considered to be incorrigibles. The client population exhibits a proportionate distribution of blacks and non-Hispanic whites. A less than proportionate number of Hispanic whites are referred to the therapeutic communities at Camarillo. There has been a feeling that they do not do well in treatment there because of cultural conflicts. To whatever extent this is true, it appears to have had an adverse effect on referral policy, particularly in Ventura County.

E. Comparison of Staff Attributes

Staff capability is often overlooked in reporting and evaluating drug treatment projects, and yet the staff is the most essential feature determining success or failure. A conceptual model that pictures staff as a "fixed asset" like the building housing the project is generally erroneous. Projects are almost always in a state of dynamic change caused by many factors both inside and outside the project (e.g., personality conflicts, variations in funding, new regulations, new perceptions of demand, etc.). Thus project staff must be expected to change, both in regard to the personalities employed and in regard to the capabilities of the staff to deliver effective service. This condition also means that measurements of staff attributes over time can provide some of the most sensitive indicators of project performance. Generally, these indicators tend to "lead" impact measures in that loss of staff capability will invariably be reflected in a reduction in impact of services at a later date.

The evaluation should be interested in the demographic characteristics of the staff, since these characteristics are helpful in determining the ability of the project to reach and provide effective services to the diverse client types in the surrounding areas. The project staffs generally have an age and race distribution proportional to the demographic groups present in the client population. However, some drug abuser types are not represented in the staff membership. For example, the staff sample interviewed at Sacramento Methadone Clinic had adequate representation of non-Hispanic white and black but lacked representation of Hispanic white. Of the 17 staff members of Aquarian interviewed, all were non-Hispanic white.*

* The project director stated that there was a representative number of minority staff members. However, none were available for interview during evaluation team visits.

At Camarillo, of the 27 staff interviewed, 26 were non-Hispanic white and 1 was Hispanic white. However, in the family and short term programs at Camarillo, most treatment is provided by the more advanced clients who give a better representation of the black race. As indicated in Section III, there are few Hispanic staff or clients. Open Door has an appropriate mix of non-Hispanic and Hispanic white staff. There are no black counselors and an under-representation of black clients. However, other local facilities tend to compensate for this deficiency. Walden House staff is composed primarily of non-Hispanic white and black counselors. Walden's clients in their residence programs are primarily non-Hispanic white with a small representation of black and Hispanic white clients. The outpatient program at Walden has a much higher composition of black clients (26%).

The quality of the services that can likely be provided by project staff can be estimated by several staff attributes: prior training and experience, in-house training and supervision, and general suitability of a staff member for providing service. The on-site staff interviews provided a basis for assessing these factors. Table 5 summarizes these factors for each treatment unit in the cluster. A significant portion of the staff of the cluster projects have college degrees of B.A. or higher (24%-79%) and many have drug treatment or mental health training (25%-59%). However, individuals on joining a project generally have much to learn about counseling skills and project procedures in order to be completely effective members of the staff. Thus, in-house training and close supervision are important elements of the well-run project.

At Sacramento Methadone, the levels of education and mental health training are high. However, most of the mental health training is not

Table 5

STAFF ATTRIBUTES

| | Sacramento Methadone | Aquarian | Camarillo | Open Door | Walden |
|---|---|---|---|---|---|
| Race | | | | | |
| Hispanic white | 0% | 0% | 4%[c] | 10% | 0% |
| Black | 15 | 6 | 0 | 0 | 27 |
| Non-Hispanic white | 80 | 94 | 96 | 90 | 67 |
| Other | 5 | 0 | 0 | 0 | 6 |
| Age | | | | | |
| Under 20 | 0 | 0 | 4 | 5 | 0 |
| 20 - 30 | 38 | 81 | 49 | 60 | 50 |
| Over 30 | 62 | 19 | 47 | 35 | 50 |
| Adequate Rating | | | | | |
| % Good to Excellent | 58 | 65 | 81.5 | 90 | 66 |
| Background | | | | | |
| Drug use history | 0 | 94 | 40 | 35 | > 27 |
| Drug treatment or mental health treatment | 50 | 53 | 60 | 25 | 80 |
| High school or less | 7 | - | 22 | 15 | 27 |
| Some college | 14 | 76 | 4 | 30 | 33 |
| College graduate (BA or higher) | 79 | 24 | 74 | 55 | 40 |
| In-house training % | 5.4 | 3.6[a] | 6.5[h] | 11.9[d] | 2.7[e] |
| Staff-client ratios | 12.5 | 0.6[b] | 7.5[i] | 11 | 4.3[f] |
| | - | 11 | 3.7[j] | - | 2.7[g] |
| | - | - | 1.2[k] | - | 10 |
| | - | - | 2.1[l] | - | - |
| Mean retention (months) | > 14[m] | 14 | > 15 | > 24 | 5.9 |

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a. Detoxification.
b. Crisis line based on registered client's individual therapy.
c. Does not include clients providing therapy.
d. Based on registered clients in individual therapy.
e. Adult residence.
f. Youth residence(full time equivalents; average attendance).
g. Outpatient/after care (full time equivalents; registered clients).
h., i., j. Family, short term, adolescent, residence.
k. Detoxification (paid staff; capacity).
l. Biased low because of short tenure of SSAs.
m. Estimate is low because of recent staff expansion. Actual retention is probably under 24.

drug-related. Inservice training, while substantial, is generally directed at other psychiatric problems rather than directed at character disorders and addictive personalities. Few of the staff have prior drug abuse or criminal involvement.

The staff of Aquarian also contains many with college backgrounds (24%) and with experience in drug abuse treatment (35%) or mental health treatment (53%). Almost all staff members have a history of drug use and many have had criminal involvement (35%). Many new members begin providing service with little counseling experience. They are under the general supervision of a more experienced counselor to whom they can turn for instructions when they perceive a problem. A training schedule is provided, but attendance is not mandatory.

The Camarillo staff involved with the drug abuse problem have an excellent educational background, with 74% holding degrees and 60% having had mental health training. Staff include both hospital employees and research staff of affiliated UCLA/NPI. The professional staff is augmented by treatment program graduates. These graduate social service aides, together with clients acting as providers of service in their own programs, give the program an impressive background in both professional and paraprofessional categories. Most of the training of providers is on the job, in keeping with the basic philosophy of therapeutic communities. However, the hospital does provide a psychiatric technician course. The research staff represent many disciplines including doctoral level members with degrees in sociology, psychology, and medicine. (However, the research personnel are involved primarily in research rather than treatment.) Social service aides entering the research program usually require two to three months to train for a

position as a research assistant.

At Open Door, 30% of the staff have some college education, and 19% have college degrees (B.A. or higher). New staff members are selected carefully but often have little drug treatment experience. Site visit statistics showed 35% with prior drug histories and 25% with criminal histories. Supervision of the staff is very tight but unobtrusive. The high quality and extent of the in-house training program is a notable feature of this project (23% of staff time is spent in training or program meetings). The staff training program is carefully structured, and attendance is mandatory. All activities of trainees are carefully supervised; in particular, counseling sessions by trainees are assisted and monitored by experienced counselors.

About 40% of the Walden staff have college degrees (B.A. or higher) and another 30% have some college training. Over 80% of the staff have had some drug or mental health therapy training, and at least four of the staff are graduates of therapeutic communities. Therapy is guided by the staff but clients make a contribution to therapy and to the evolution of the therapy program. Staff training includes a monthly 5-hour meeting of all staff to discuss program philosophy, problems, and long and short term goals. Orientation of new staff members includes a requirement for participation as a resident, self analysis of deficiencies, and a 90-day probationary period. Staff membership is augmented by consulting arrangements with several highly trained and experienced clinicians and researchers.

Other important staff indicators that relate to project performance include: staff to client ratio, percent available time that is spent delivering direct service to clients, and staff turnover rates. The ratio

of staff to clients indicates the degree to which the staff is being utilized and can be an indicator of over-utilization leading to deteriorating quality. The proportion of available time spent with clients is useful as an indicator of the efficiency of the organization and its management. Staff turnover is a sensitive indicator of project problems having many possible causes.

Staff to client ratios are often useful in evaluation of drug treatment facilities but are not without difficulties in interpretation. Comparisons that are made are best restricted to projects using the same modalities of treatment. Open Door and Aquarian both have outpatient facilities featuring individual and group counseling. The staff to client ratio for the Walden outpatient clinic is similar (1:10). However, a direct comparison on this basis alone is misleading since the estimates do not take into account unregistered drop-ins or the total fraction of provider time spent delivering counseling service. In reality, Aquarian counselors have more diverse responsibilities because there is a larger proportion of unregistered drop-ins and because counselors also work on the project's very active crisis line phone service at which they spend over half their time.

Aquarian and Camarillo detoxification units are also similar modalities. The inpatient staff to client ratio at Aquarian is 1.7:1 compared to the ratio at Camarillo of 1:2.1. The difference is primarily due to the larger capacity of the Camarillo unit and the associated economies of scale in client supervision. In addition, the Aquarian unit engages in a considerable amount of follow-up counseling that is not included in the overall ratio.

At Walden and Camarillo therapeutic communities, the staff to client ratios are low (1:3.7 and 1:2.7 for Walden units and 1:1.2 to 1:7.5 for Camarillo units). These figures may be compared with ratios obtained in the New York study* for residential units (1:2.3 to 1:3). The Camarillo adult unit (1:7.5) reflects the high level of self-treatment in this unit, compared to the more extensive supervision in the adolescent unit (1:1.2) and in the Walden residential units.

The proportion of staff time that is devoted to client service also varies by project and by treatment modality. Open Door has achieved a good level of staff utilization with 49% of staff time devoted to providing counseling service to clients. Based on the provider sample, Aquarian crisis line counseling staff spend about 25% of their time in counseling. Shift logs indicate that another 63% of staff time is spent in the crisis line phone and intervention activities. Because of other tasks (e.g., methadone dispensing, etc.), about 17% of the staff time at Sacramento Methadone Clinic is devoted to client counseling. However, a total of about 42% of staff time is spent on direct client services. The staff at Camarillo spend about 60% of time providing client services, including about 39% of time in client counseling. Walden staff also spend about 40% of time in delivery of client services, including 22% directed toward individual counseling.

Staff turnover rate and mean retention rate are good measures of project stability. Open Door has achieved an adequate level of staff stability for its programs, with a mean retention time of 2.3 years (i.e., turnover rate of 22% per year). Because of the expansion rate

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* Comparative Analysis, op.cit.

of Sacramento Methadone clinic, it is difficult to make an accurate estimate of retention, but it appears that a mean retention time of 2-3 years would be approximately correct (i.e., 25% turnover per year). Aquarian has had some problem retaining staff. Based on the staff sample, mean retention time is 14.4 months (i.e., 42% turnover per year). Camarillo has a stable staff situation since turnover is rare among regular hospital staff. Most turnover is among the SSAs whose term of service is set at 9 months. Walden House has also had problems retaining staff, with a mean retention time of 6.9 months (i.e., 87% per year). The staff problem that affects Walden, Aquarian, and other projects is a result of such factors as job insecurity, lack of fringe benefits, heavy work, and poor pay. Other factors that can affect a specific project are changes in management policy, personality conflicts, lack of motivation, and lack of a sense of accomplishment.

F. Evaluation Components

In this effort, the study team has used the classification of levels of evaluation suggested by OCJP.* That is, the lowest level of evaluation is monitoring, the next higher is assessment and the highest is evaluative research. In this classification,

> "Monitoring is defined as the process of reviewing project activities in progress to determine consistency with contractual obligations (both fiscal and programatic) and the probability that predetermined objectives will be achieved."

The intermediate level of assessment includes:

> "...research designs which involve collection of data through survey instruments (generally structured interviews with project staff and/or clients serviced by the project). Assessments do not utilize control groups for the purpose of comparison or appropriate statistical tests to provide the evaluator with the means for determining which project results are significant."

The highest level is evaluative research:

> "Evaluative research is characterized by a research design which typically involves comparison of an experimental group's data with that of a randomly assigned or matched control group. Furthermore, it generally involves: (1) use of valid test instruments, (2) an explicit awareness of relevant prior research, (3) application of conventionally accepted statistical tests to determine significance of project results, and (4) criteria for measuring project impact which make it possible to determine whether a project is successful or not."

The projects in the cluster exemplify all three types of evaluation efforts. (See Table 6.) In addition, other types of research will be found. That is, some of the project effort is research undertaken to contribute to basic understanding of clients, environment, and treatment processes, although such research is not directly related to the evaluation of a specific project impact. Another important consideration of evaluation

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* "Evaluation of Crime Control Programs in California: A Review," April 1973, CCCJ.

Table 6

TYPES OF EVALUATION EFFORT FOR PROJECTS IN CLUSTER

| | Sacramento Methadone | Aquarian | Camarillo | Open Door | Walden |
|---|---|---|---|---|---|
| Types of Study | | | | | |
| Monitoring | • | • | | | |
| Assessment | | | | • | • |
| Evaluative Research | | | • | | |
| Other Research | • | | • | | |
| Uses of Study: | | | | | |
| Reports | • | • | • | • | • |
| Feedback into program | | | • | | • |

studies is the manner in which the results are used. It is important that the results be used not only as report material but also as feedback into the project for improvements in treatment outcomes.

The evaluation effort at Sacramento Methadone is considered to be monitoring. Data are collected through questionnaires and progress records and are used to compile descriptive statistics, which in turn are used in reports that include presentations delineating the degree to which objectives are being met. These statistics also appear to be used for grant and proposal preparation. There is little evidence of feedback of evaluation information to modify the treatment program. The project has also been engaged in some research, called the driver simulation test program. This is a well-designed experiment to test psychomotor functions of methadone clients. (However, results have yet to be analyzed and published.)

The Aquarian Effort evaluation is considered to be minimal monitoring. The project's intent is to monitor its various services to assure compliance with grant obligations. In the case of the OCJP grant,

criteria for evaluation (see Section III.B.2) allow Aquarian to meet grant obligations without direct examination of impact of the project's services on client behavior. Aquarian's stated viewpoint on the utility of evaluation has been very pessimistic. However, data previously collected by the project, together with new data collected in order to meet new NIMH reporting requirements, could form the basis for more extensive evaluations. There is little evidence of systematic feedback of monitoring efforts to the provider staff.

The efforts of the Camarillo project are considered to be evaluative research. Whenever possible, client data are matched with comparable data from control groups. The test instruments used are valid and appear to be used knowledgeably; project staff are aware of, and make extensive use of, prior research, and apply conventional statistical methodology in their research work. Primary data sources are client and control interviews and direct observation during and after treatment. Field studies are made to follow up all family graduates, splittees, and short term graduates associated with the programs during the period under study. Summaries of the follow-up data are used in OCJP evaluative reports to demonstrate degree of treatment impact. Most of the data generated is used in more basic research which is presented in a separate research report. In some instances, research results have had an impact on program and treatment decisions (e.g., contingency contracting, video taping encounters, etc.). However, feedback of research results into the treatment programs is not a primary goal.

Most of the evaluation at Open Door is conducted by outside consultants. The two previous evaluations were made under the guidance of Gilbert Geis, Professor of Sociology at UC Irvine, with the assistance

of graduate students. The two studies can be classified as assessments. The studies include the collection of samples of client data at entry into the program and several months thereafter. The research design includes client surveys and extensive observations of the treatment processes, but little use has been made of controls, or baseline data for comparison, and statistical tests have not been used in describing data or testing statistical hypotheses. Results of studies are used for meeting grant reporting requirements; there is little evidence of use of findings for modifying treatment by management or provider staff.

Walden House evaluations have been made both by outside consultants and project staff. The two major evaluations can be classified as assessments. They have a research approach and tone, but do not employ experimental design features, such as control groups, baseline data, etc. Data sources in these efforts have been direct observations and client surveys using structured questionnaires. Random samples of clients were taken and client attributes and behavior modification were determined using pre-screening and follow-up interviews. Conventional statistical tests were used to describe client and treatment attributes and to test hypotheses on effectiveness or impact of treatment. Results of the evaluations have been used to comply with grant requirements and also have had an impact on services provided by Walden House. The project is running a third, more subjective evaluation of treatment processes that will be used as a basis for modifying treatment when evaluation results warrant.

G. Common Data Elements

Since the five projects have many similar objectives, it is to be expected that they would be interested in the same kinds of data for evaluation. However, the exact definitions of the data elements, and the way they are collected, generally vary from one project to another. There is a degree of commonality among many of the data elements, as illustrated in Table 7. The table indicates "related" data elements among the five projects and compares them with data elements that appear in the CODAP system.*

Symbols that appear in the same row do not necessarily mean that the sources are collecting the identical information; rather, it means that there is a "lowest common denominator" of information running through the data elements. Thus "type new arrests" in CODAP is divided into "property crime," "violent crime," and "other arrests," whereas Camarillo breaks down crime into five specific categories. In this instance, the Camarillo data could be reformulated into the CODAP categories, if desired.

A distinction must also be made as to when the data elements apply. Sacramento Methadone and the CODAP system data apply principally to current clients. Data reported by the drug free projects (Walden House, Open Door, and Camarillo) apply principally to graduates and others who have terminated treatment. As will be noted in the table, Aquarian does not give impact-related elements in its reports to OCJP but is currently gathering data for the CODAP system. In subsequent paragraphs,

* Client Oriented Data Acquisition Process (CODAP), op. cit. CODAP is used here as a convenient basis for comparison since it does attempt to standardize definitions. This does not imply that the system meets all the state's needs or that the definitions will prove to be the most appropriate.

Table 7

COMMON DATA ELEMENTS (AS REPORTED TO OCJP)

| Units* | Sacramento Methadone | Aquarian Effort | Camarillo | Open Door | Walden House | CODAP |
|---|---|---|---|---|---|---|
| New arrests | • | | • | | • | • |
| Type new arrests | | | • | | | • |
| New arrests (frequency) | • | | | • | | |
| Prior arrests | • | | | • | • | |
| New convictions | • | | • | | | • |
| Prior convictions | • | | | • | | |
| Parole/probation history | • | | | • | • | |
| Parole/probation on entry | • | | • | • | | • |
| Current parole/ probation | • | | | | | |
| Current employment | • | | • | • | • | • |
| Type of current employment | | | | • | • | • |
| Prior employment | • | | | | • | • |
| Type of prior employment | | | | | • | |
| Current education | • | | • | • | • | • |
| Current salary ($) | • | | • | | | • |
| Public assistance | | | | | • | |
| Social adjustment | • | | • | | • | |
| Drug use by urinalysis (number of events) | • | | | | | • |
| Current average drug use (frequency) | | | | • | | |
| Current average drug use (amount) | • | | • | • | • | • |
| Prior average drug use (frequency) | | | | • | | • |
| Prior average drug use (amount) | • | | • | • | • | • |
| Current drug type used | | | | • | • | |
| Prior drug type used | | | | • | • | |
| Number of graduates (positive separations) | • | • | • | | | • |

* Units are in terms of numbers of clients, unless otherwise specified.

Aquarian will therefore not be discussed, although the project can presumably provide data elements in CODAP. Also, at Sacramento Methadone and Camarillo, data elements are gathered for essentially the entire population being examined. At Open Door, Walden House, and CODAP, data elements are gathered for a sample of the population.

Sacramento Methadone, Camarillo, Walden House, and CODAP report new arrest data in some form as a measure of performance. Only Sacramento Methadone and Walden House have been reporting arrest data both prior to and subsequent to entry into treatment (clients at Sacramento Methadone, and graduates at Walden House). Reports of both these data elements are needed to measure impact of treatment on criminal behavior. Open Door reports prior criminal involvement of clients but does not report their status subsequent to entry into the program.

All four projects give some indication of prior convictions or probation/parole status on entry to the projects. CODAP also requires an indication of probation/parole status on entry. The current number of employed clients is reported in a variety of ways by the four projects. All four projects report data on number of clients or graduates using drugs. Sacramento Methadone and CODAP report drug use based on urinalysis; the others base estimates on questionnaires. For all four projects, there is either a report or an implicit assumption regarding drug use prior to entry. Open Door and Walden House provide a breakdown of the type of drug used by clients prior to and after treatment. Sacramento Methadone, Aquarian, Camarillo, and CODAP report the number of graduates or positive separations from the projects. Open Door and Walden House do not provide this information in quarterly reports to OCJP.

H. Project Impact

For a period of 6 months, the evaluation team examined the five projects from many points of view. The team found a few activities of questionable value, but most activities are providing services useful to the communities. The evaluation also found that without exception, the five projects are staffed by dynamic and well-motivated people attempting to provide assistance in accordance with their own firmly held philosophies. Most of the staff members have experience (either prior or on-the-job) that is appropriate for providing service to certain classes of drug abusers. However, in some instances, this experience is not sufficient for the particular task that is to be accomplished. Most staff members have expressed a willingness to change their treatment approaches as the need becomes apparent and in fact were changing their approaches during the period of this evaluation. Changes are also occurring in the environment around each project, such as demand for services, drug abuser characteristics, local policies, etc. This continual change is a factor that must be taken into consideration in assessing the impact of each project.

The preceding section on project objectives outlined many of the criteria that can be used to measure impact of a project on the community. The use of measures such as reduction in criminal behavior or drug use requires the systematic collection of data over a period of years. As discussed in the section on self evaluation, data collection efforts have been quite uneven among the projects. Where possible in this study, attempts were made to augment the existing data with new information or new analysis of existing information. However, the efforts of a few months cannot make up completely for the deficiencies of years. For instance, it was not possible for this study effort to provide well-matched control groups where

none existed during some past period of observation of impact. To proceed with the cluster evaluation and to provide some basis for comparing projects in terms of impact, it has been necessary to re-analyze much of the data gathered by the projects, and together with the new information gathered, to modify the data as required to provide some degree of standardization. Thus, the measures of impact given here are based on the available data but are often the values derived by the study team rather than by the individual projects.

The general reasonableness of the values was also examined in the light of the knowledge of project treatment procedures, clients serviced, and staff experience, as well as observations by representatives of outside agencies having relationships with each project. After tabulation and review of the various measures, it was the view of the evaluation team that the value of any individual measure could be very sensitive to the way information was collected by the projects and to the assumptions that had to be made by the evaluation team. As a result, it is desirable to consider the set of measures as a whole, together with the interpretations and backup information, in appraising the worth of any given activity.

The criminal justice impact of the project services was measured primarily in terms of the decrease in arrests of clients after start of treatment. The principal source of the arrest information was from rap sheets of individual clients from probation and parole files, with supplementary information from client files at the projects. A number of reservations have been raised in the technical community about the use of arrest data for measuring impact. These reservations include police policy toward arresting drug abusers, variations introduced by level of police activity, changes in the drug use characteristics, etc. The measurements presented

here are largely subject to these reservations. However, efforts were made to examine baseline statistics on arrests to determine any major shifts in arrest frequencies over the period of interest. No major shifts were noted that would detract significantly from the decreases in arrest histories observed.

Comparisons of arrest rates of clients prior to and after start of treatment is a common method of examining the impact of services. This method has the advantage of being based on data that are reasonably available, at least in the aggregate sense. With reasonably large sample sizes (hundreds to thousands) and over periods of a year or more, the results of such comparisons can be useful indicators of trends in behavior of clients. However, with smaller sample sizes, such as have been available in this study, and over shorter time intervals, arrest rate data can be an unreliable indicator of performance. Table 8 indicates arrest rates before and after start of treatment for client samples and surveys taken at the various projects.

All modalities for which data were obtainable, except Camarillo short term unit, showed appreciable reductions in arrest rates for clients after start of treatment (1-23 months after treatment). The value for Camarillo short term unit, and to a lesser extent the other modalities, is affected by the high frequency of arrest of a few individuals. This is especially true of observations made over short time intervals. This result of a small fraction of the client sample contributing a large fraction of the total arrests was also noted in the BCS study of drug-related offenders.* The net effect of this condition is that the high arrest rate of a few can

* Arrest data provided specifically for this evaluation by Bureau of Criminal Statistics, Sacramento, California, 1974.

Table 8

SUMMARY OF CRIMINAL JUSTICE AND DRUG ABUSE IMPACT

| | Open Door (Probation/Parole) | Open Door (Clinic) | Aquarian Crisis Line | Camarillo Family (Probation) | Camarillo Short Term (Probation) | Walden Resident (Probation/Parole) | Sacramento Methadone (Probation/Parole) | Sacramento Methadone (Clinic) |
|---|---|---|---|---|---|---|---|---|
| Prior arrest rate | 79 | -- | -- | 221 | 202 | 148 | 193 | 85 |
| After arrest rate | 32 | -- | -- | 21 | 366 | 70 | 82 | 23 |
| Decrease in arrest rate (%) | 59.5 | -- | -- | 91.5 | | 53 | 57.5 | 73 |
| % Clients improved (arrest) | 87 | -- | 20 | 100 | 90 | 74 | 78 | -- |
| % Clients arrest free | 82 | 50-70* | -- | 86 | 57 | 58 | 41 | 80* |
| % Clients improved while in treatment (drug) | -- | 62* | 44 | 100 | 100 | 50-90* | -- | 91* |
| % improved (drug) (after one year or more) | -- | -- | -- | 86* | -- | 18* | -- | 67* |
| % Clients drug free | -- | 16* | -- | 86* | -- | 18* | -- | 91* |

* Results for clinic population obtained from project reports.

mask the improved behavior of the rest of the client population.

Better and more revealing measures of overall performance are: % of clients with decreased arrest rates after start of treatment (i.e., improved clients); and % of clients with no arrests after start of treatment (i.e., arrest free clients). These measures avoid the masking effect of arrest rate calculations. The values for improved clients in Table 8 are seen to be uniformly higher than the values for improvement in terms of arrest rates. The Camarillo short term sample that shows such a poor result in terms of arrest rate has a remarkable 90% of clients who have shown improvement. The numbers or percentage of arrest free clients provide a measure that is more closely related to the stated objectives of the projects. In Table 8, these values range from 41% for Sacramento Methadone to 86% for Camarillo family unit. The measure is meaningful and directly useful, but does tend to underestimate the actual impact being achieved by the project. For instance, the Camarillo short term unit shows 90% for improved clients but only 57% for arrest free clients; Sacramento Methadone shows 78% of the probation and parole sample with improved behavior but only 41% that are arrest free.

Another important consideration in defining the above impact measures is to specify the time interval over which the client is observed after start of treatment. Part of the reason for the high value of improved clients at Camarillo short term unit is that a substantial fraction of the sample began treatment not more than 3 months prior to examination of the arrest records. In the Sacramento Methadone sample, on the other hand, the majority of the clients had been in treatment 22 months or more. For most of the other modalities, the length of the observation period for clients is a mix ranging from 1 to 20 months. One of the important

factors in future evaluation design prior to extended studies by projects would be the determination and standardization of observation periods on clients, and the establishment of observation periods that are sufficiently long to permit representative results.

Comparisons among treatment units are restricted by the differences in modalities of treatment, type of clients, and other factors. Even within these restricted categories, interpretations must be made only in general terms because of the differences in the sample and survey methods used.

The comparison of impact of Open Door with Aquarian crisis line counseling has some basis since both are ambulatory counseling units. However, impact data for Aquarian are very limited because of the lack of properly identified records and the lack of any follow-up efforts by Aquarian crisis line counseling unit. The 20% figure for client improvement at Aquarian is an optimistic estimate by the evaluation team, based on the type and amount of treatment received by the client population (see Aquarian, Section III for a detailed explanation). Open Door appears to have achieved a higher success rate on the basis of the probation/parole sample and the project survey of a random sample of the client population. This observation must be moderated by the following facts: (1) Open Door tends to get clients who have no confirmed criminal life style and who tend to stay out of trouble--at least the clients on probation; (2) Aquarian is in an environment where other resources are inadequate, and thus tends to provide service to a wide variety of client types, including hard core users with confirmed criminal life styles.

The Camarillo family and short term units, together with the Walden residence units, are all different forms of therapeutic communities. The Camarillo family is modeled on the classical design; the short term program

condenses much of the classical approach into a 3 month period; Walden House is also a 3 month program but has moved to a more permissive, experimental approach to treatment. The Camarillo family shows the high quality of therapeutic community treatment for the few who can participate for extended periods. Values of arrest free clients and improved clients for the two modified therapeutic communities appear quite close in terms of impact. However, the period of observation for the Walden sample was generally longer (6-8 months). The Camarillo family program shows a very high rate of arrest free clients (86%) while the modified programs show significant but lower values (57-58%). These impact values for the modified programs fall considerably below the rates for improved clients (74%-90%), indicating that measurement of total impact of these modalities requires the acceptance of modified criteria for success.

At Sacramento Methadone, it is useful to compare impact results for the probation/parole samples with the information available for the clinic population as a whole. The prior arrest rate of the probation/parole sample is considerably higher than that estimated for the client population. Also, results in terms of decreased arrest rate and % clients arrest free are estimated to be superior to results achieved for the probation/parole sample. However, results for the probation/parole (57.5%) are consistent with results published for other methadone clinics showing reductions in arrest rates ranging from 57-82%.*

Criteria for reduction in drug abuse can also be stated in terms of % improved clients or % drug free clients. The same requirements exist for defining the periods of observation, type of clients, etc. In addition,

* Proceedings, 5th National Conference, op. cit.

to use an improved client criteria, a requirement exists to specify the drug usage conditions that are to be considered. Such a measure could include drug type, length of use, frequency, technique of administration, etc. In order to use available data, the definition of improvement required that frequency of use of all drugs must decrease. The implied assumption was that there was no escalation in the use of one drug while decreasing the use of others. This restriction eliminates many who might be categorized as an improvement, such as switching from heroin to marijuana. This is another reason for standardization of criteria prior to use in any in-depth study by projects.

Table 8 indicates values for improved clients and drug free clients for two periods: (1) during treatment, and (2) up to 1 year after start of treatment. Most modalities generally show high levels of improved or drug free clients during treatment. In the projects not requiring drug free results for continued treatment, the level of improved clients is in the 50-60% range for Open Door and Aquarian. Sacramento Methadone reports 91% that could be classified as improved clients, and 67% that could be classified as drug free. Walden surveys have indicated a range of 50 to 90% of clients in treatment with decreased use of drugs (other than alcohol and marijuana). Subsequent to treatment, the number of improved clients tends to decrease in most projects. Open Door reported 16% of clients with diminished drug use after a year from start of treatment. Sample data for Camarillo family showed that a high level of drug free behavior was maintained in clients who had graduated from the unit (85%), although a large fraction of the observation period was spent in treatment or in employment at Camarillo subsequent to treatment.

Another factor that must be considered with drug use histories in analysis is the potential unreliability of client-provided data due to lying and inability to remember details. This can sometimes be tested indirectly. For example, Camarillo client-stated arrest data compared very well with data obtained from probation, indicating that client responses in other areas might be trustworthy. When this same comparison was made at Sacramento Methadone, the opposite result was observed.

The lack of employment has been one of the major problems blocking the development of constructive life styles for clients of drug treatment projects. In the cluster, a range of results was obtained. The sample of records from Sacramento Methadone Clinic indicated that 31% of clients were employed at entry while currently, 60% of the client population had worked at least part time since entry. The Camarillo program places considerable emphasis on providing employment for the graduates of the family. The sample of client records indicated that 86.5% of family graduates were employed. About 60 to 70% of these are employed at the Camarillo facility under a program that provides 9 months employment as social service aides (SSAs). With the exception of a few who are SSAs, most clients of the short term program and detoxification unit are not assisted in finding employment. At the other projects--Open Door, Aquarian, and Walden House--a relatively small amount of time is spent on job counseling, training, or development, and there is little evidence that employment opportunities of clients have been greatly increased on completion of treatment. This problem, of course, is not one that can be solved by a treatment program operating in isolation. It is a problem for the entire community and requires communitywide attention.

Prevention and education are two additional areas where projects in the cluster have had an impact. The Aquarian public education effort has provided lectures, seminars, and counseling for 3,000 civic, social, and school groups over a period of four years. The Aquarian program of drug education and prevention with the Sacramento Unified School District has been instrumental in increasing the level of drug knowledge in several high schools and junior high schools. According to a survey,* the majority of students who contacted Aquarian representatives found the contact valuable to them. Open Door also has an active program of education and counseling with local high schools. During the year ending June 15, 1973, Open Door had 77 speaking engagements for an estimated 3,167 attendees. Direct contacts made by the evaluation team indicated that school administrators were impressed by the Open Door effort and had concluded that the effort had made a definite contribution. However, in neither project effort have measures of impact been devised. While the overall impact of such activities may not be felt for several years, more could be done at present to measure current impact.

Another important project activity that could have some impact on the community is the crisis line telephone services and associated services offered by Aquarian and Open Door. The Aquarian service receives about 2,500 calls per month. Of these, about 30 per month are crisis calls. Aquarian provides an experienced intervention team that answers these calls and provides the necessary emergency services. The lifesaving abilities of the intervention team are a valuable asset to the surrounding community. Open Door crisis telephone services receive about 400 to 600 calls a month. Open

* Sacramento CityUnified School District, Research Report, Series 1972-73, Drugs: Education, Prevention, and Rehabilitation.

Door has no crisis intervention team; the few emergencies are handled by telephone counseling or by enlisting the assistance of another agency. Since there are other crisis line operations in the area, the incremental effect of the Open Door service is probably minimal.

Detoxification services are provided by the Camarillo program and by Aquarian. The Camarillo provides services for about 1900 clients per year. This results in a short drug free period while in treatment and generally a period of diminished drug use for a short period thereafter. Without substantial additional aftercare, the evidence is that most clients will soon be back to the previous drug abuse and criminal lifestyles. At Camarillo, 26% of the detoxification clients move on into one of the two adult treatment units where the chances for improvement are much better. For those detoxified at Aquarian, there is a lack of treatment facilities in the community so that most of the clients will eventually return to their former condition.

## I. Cost-Benefit Measures

The purpose of this section is to present a set of cost-benefit values to point out the uses and limitations of cost-benefit results. In order to achieve the most benefits within the funds available to OCJP, it is desirable to consider the result of expenditures in terms of cost-benefit measures. Cost-benefit measures can indicate the dollar cost to achieve a given unit increase in benefits (e.g., $/arrest free client). Where there is only one kind of benefit to be achieved, the best policy is to allocate the available money to the projects that exhibit the lowest cost per unit increase in benefits.

In social fields, there are generally many benefits to be achieved and values to be protected, so that the evaluator must consider

not one but several ways of formulating cost-benefit measures. In the present study, several such measures have been applied to the data describing project impact. Each measure has some relevance to the fund allocation problem. When all the measures are considered together with other background information on the project, they provide the information needed to describe the utility of some of the major services provided by each project. In this study, cost-benefit measures have been devised to describe improvement in terms of the impact measures discussed in the preceding section. These cost-benefit measures include costs per units of time (client attendance days, or client years); number of decreased arrests per client; number of clients with reduced criminal behavior (improved clients, arrest free clients); and reduced drug abuse behavior (e.g., improved clients, drug free clients).

Table 9 indicates the values of these measures calculated for various project treatment programs. Dollars per client year gives the total treatment costs to treat one client for a year; $/attendance day is the same type of measure based on average cost of treating a client for one day. These measures provide a rough measure of efficiency of service but do not indicate the impact of service. They have been used for inferring cost-benefits by assuming some constant level of effectiveness of services for a given modality (e.g., a methadone maintenance clinic). As indicated in Table 9, these measures can differ greatly from more direct measures of cost-benefit in terms of arrests of drug abuse, but do have the significant advantage of being the most easily obtained and widely

Table 9

SUMMARY OF COST-BENEFIT MEASURES

| | OPEN DOOR | AQUARIAN CRISIS LINE | CAMARILLO FAMILY | CAMARILLO SHORT TERM | WALDEN HOUSE ADULT RESI-DENTIAL | SACRAMENTO METHADONE |
|---|---|---|---|---|---|---|
| Daily Attendance* | 30 | 15 | 30 | 45 | 32 | 300 |
| $ client year | $3,400 | $5,290 | $8,123 | $6,991 | $4,116 | $1,744 |
| $ attendance day | 13.00 | 14.50 | 22.00 | 19.20 | 11.68 | 4.98 |
| $ improved client (arrest) | 305 | 285 | 5,100 | 890 | 1,006 | 2,235 |
| $ arrest free client | 324 | --- | 5,920 | 1,415 | 1,291 | 4,252 |
| $ drug free client in treatment | --- | --- | 8,123 | 6,991 | --- | 2,906 |
| $ improved client (drug) in treatment | 429 | --- | 8,123 | 6,991 | 4,116 | 1,915 |
| $ improved client (drug) (1 year or less) | 1,660 | --- | --- | --- | --- | --- |
| $ graduates | --- | --- | 12,900 | 2,970 | 1,096 | 4,360 |
| $ drug free graduate (1 year or more) | --- | --- | 15,000 | --- | 5,850 | --- |

*Clients served daily. At Sacramento Methadone, take home doses count as a delivery of daily service.

available types of information. Such measures provide a basis for judging whether service costs are within reasonable bounds.

Costs per client year by modality are given in the recent New York study.* The range for ambulatory "drug free" treatment centers was given as $1,410 to $7,920 -- necessarily a wide range to cover the great variety of treatment and other services. This range may be compared with the values for Open Door ($3,400) and Aquarian ($5,290). The value of Aquarian is at the high end of the scale, partly because the large number of unregistered drop-ins were not included. Consideration of this group would reduce the cost per client year by about 50%.

The values for the therapeutic communities (Camarillo family, short term, and Walden residential units) can be compared to the range in New York+ of $2,102 to $8,257 with an average of $4,000. The Walden value of $4,116 per client year is about the same as the average for the New York units. The values of Camarillo are high ($8,123 for family, and $6,991 for short term) compared to the reference group. This result cannot be explained by the staffing patterns (staff to client ratio) and must be ascribed to the hospital setting and the costs associated therewith.

The costs per client year at Sacramento Methadone Clinic ($1,744) are within the recently reported range for such clinics ($500 to $2,000)

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* Comparative Analysis, op. cit.
+ J. Romm, "Alternative Measures of Effectiveness of Drug Abuse Treatment," presented at the 44th Annual ORSA Meeting.

and are close to the current costs allowed by NIMH ($1,700). Costs per attendance day for Sacramento Methadone and the other projects ($4.74 to $22.00/day) are all low compared to costs of supplying a habit on the street (variously estimated as from $30 to $300, depending on costs included).

A closer estimate of cost-benefits can be developed using changes in arrest characteristics prior to and after start of treatment. Changes in arrest rates or reductions in arrests have been examined* for their potential as a cost-benefit measure. As pointed out in the preceding section, arrest rate data can be misleading unless the sample size is large and the period of observation is reasonably long (1-2 years).

The tendency to overlook the substantial percentage of clients being helped when using arrest rate data gives rise to the need for other types of measures. The number of arrest free clients after start of treatment is a useful measure of this kind. The measure assumes at least one arrest in the observation period prior to treatment and no arrests for a like period after start of treatment. For this study, conditions could not be controlled since it was necessary to depend on data that had previously been tabulated and were available to the evaluation team. In most instances, arrest records were examined for a period of two years prior to treatment and a period ranging from 1 to 21 months after start of treatment.

The values of the measure, "$/arrest free clients," are highly variable over the cluster projects and are quite different from the corresponding values of $/client year. The value for Open Door

* 1973 Proceedings, Drug Abuse Council.

($324) is much lower than the client/year costs ($3,400) and also much lower than the values for the other modalities including Sacramento Methadone which showed itself to advantage in terms of $/client year. This observation must be tempered by the fact that most of Open Door clients do not have confirmed criminal life styles. An adjustment of the Open Door values for those not having an arrest in the prior period of observation could increase the value to about $600.

The values of $/arrest free client for the Camarillo family are closer to those of the Sacramento Methadone clinic than is true when comparisons are made in terms of $/client year. The values for the modified therapeutic community (Camarillo short term and Walden House residence) are much lower than the family or the methadone clinic. This results in part from the shorter treatment cycles (about 3 months) and the short and variable post-treatment covered by client records.

To ascribe utility only to drug free clients is to overlook other possible useful products of the project's services. Many clients who do not remain arrest free nevertheless show improvement through decreases in arrest rate after start of treatment. A measure suitable for this consideration is the $/improved client. In these terms, most of the modalities show marginal improvements compared to the "arrest free" criterion. However, Sacramento Methadone Clinic shows almost a factor of 2 improvement to a value of $2,235 per improved client. This result is due in part to the fact that the sample upon which results are based is composed of probation/parole clients with substantial criminal records prior to treatment. For

this group, the treatment was apparently successful in reducing criminal activity but not eliminating it entirely. In the clinic population as a whole, the rate of arrest free clients would appear to be about twice as high as the probation/parole sample, so that the associated cost per arrest free client could be closer to a value of $2,000, and the value for improved clients might be approximately the same as the cost per client year ($1,700).

Cost-benefit measures based on costs per graduate have also been used in gauging the utility of project efforts. As shown in Table 9, these measures can be quite misleading when used to compare performance of different treatment modalities. The projects with a short cycle of treatment will tend to show an advantage since the throughput of clients is likely to be larger in a year. Open Door and Aquarian do not define a class of clients as graduates and have no reliable figures on positive terminations. Walden residential program and the Camarillo short term program have a treatment cycle of about 3 months and show cost per graduate figures in the range of $1,000 to $3,000. This may be compared to the Camarillo family value of $12,000. For the optimistic assumption of positive termination (withdrawal) of clients after two years at Sacramento Methadone and a 10% per year attrition, cost per graduate would be approximately $4,360. Cost per drug free graduate raises the cost figures substantially and overlooks contributions such as improved clients who did not graduate from the program. The measure, however, does provide a more realistic comparison of the longer term results of treatment among modalities.

## J. Evaluation Strategy

### 1. Information Sources

The OCJP looks to evaluation as a means of facilitating funding and other planning decisions for the reduction of crime and the improvement of the criminal justice system. Current sources of evaluation information are the reports of the project's evaluation components, on-site monitoring reports by the state representatives, evaluations made by contractors for the state, and evaluation efforts by state personnel. These sources are designed to cover most of the relevant factors, such as fund expenditure, progress toward impact-oriented objectives, provider service activity, client types serviced, project staff attributes, and community relationships.*

An evaluation strategy must use the various evaluation activities efficiently in order to obtain the needed information at the proper time for decision making. The design of such a strategy must consider not only the type of decision to be made but also the alternative ways in which the information for evaluation can be feasibly obtained. In this regard, there are other sources of information and evaluation at the state and federal levels. CODAP is being installed by NIMH in all treatment units receiving federal funds. As indicated previously, this system provides, on a quarterly basis, considerable information about the current operations of a project including: client census, client case sample, and funding summary.** Information systems are under consideration by agencies of the State of California (State Office of Narcotic

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* CCCJ Memorandum to Regions, August 14, 1973, Subject: "Revised Quarterly Progress Report Procedures" and
CCCJ Form 520 and instructions regarding "on-site monitoring report," August, 1973.

** CODAP, op. cit.

and Drug Abuse, Department of Health). The system under consideration, called the Drug Abuse Program Management Data System (DAPMDS) will provide a variety of data including: project descriptions, cost and activity indicators, client attribute data, and measures of impact of treatment.

The relationships between these systems and the evaluation efforts of OCJP remain to be determined. However, a requirement will undoubtedly exist for OCJP to continue its own efforts at evaluation, with some consideration for compatibility with other evaluation efforts and information systems.

2. Factors for Evaluation Strategy

Regardless of the final arrangements, proper evaluation will require certain basic information related to three major factors: demand, impact, and performance. Demand refers to the numbers and types of drug abusers that are appropriate to the treatment modality and that are not receiving adequate treatment. Impact refers to change induced in conditions outside the project. That is, it refers to end results achieved by the project with respect to reducing crime, improving the criminal justice system, or improving other aspects of community life.* Performance refers to the treatment facility's services evaluated in terms of efficiency, quality, and other factors that measure project services adequacy.

The current information related to the factors of demand, impact, and performance helps to determine the compliance of the project with the grant and the grant objectives. The information developed by forecasting the future status of these factors helps to determine the potential of the project for expansion or replication in other communities. Examples of the types of information needed for each factor are given in Table 10.

* CCCJ Request for Proposal for Cluster Evaluation, 1973.

Table 10

INFORMATION NEEDS FOR EVALUATION STRATEGY
(SAMPLE)

Demand

- o Number of drug abusers by demographic, criminal justice, and drug abuse classifications
- o Crime levels by crime classifications (e.g., drug related, juvenile vs. adult, property, etc.)
- o Types of drug abusers suited to project treatment approaches
- o Numbers of abusers in waiting lists
- o Unmet demands from user agencies

Impact

- o Criminal justice involvement of clients before and after start of treatment
- o Drug abuse level of clients before and after start of treatment
- o Employment levels of clients before and after start of treatment
- o Other measures (social improvement, etc.)
- o Baseline data on crime, drug abuse, etc.

Performance

- o Staff experience and in-house training
- o Staff to client ratios
- o Duration and intensity of treatment
- o Expenditures for treatment and rehabilitation
- o Services provided (encounters, etc.)
- o Staff hours devoted to treatment
- o Number of clients receiving treatment; number completing treatment
- o Staff and client turnover

a. Demand

Demand estimates for the established project can best be made by examining current ongoing demand for services, waiting lists, and stated unmet demands from local referral agencies. In the event of an expansion of service to include a new treatment modality, or the establishment of a new project, other sources of information may have to be used. These would include baseline data on incidence of crime, overdose death statistics, hospital records, estimated numbers of drug abusers in the target group, etc. The best source in this instance would probably be estimates of unmet demand from possible referral agencies. However, none of these sources of information provides a guarantee that the services of the project will be used as predicted by the proper target groups. Therefore, the decision to fund is by its nature a tentative decision, and the current procedure of yearly review is certainly justified.

b. Impact

The limitations on the availability of client data significantly restrict the scope and accuracy of evaluations of impact. Client confidentiality will probably continue to restrict the information that can be determined about individuals, and the methods by which such information is made available. In the evaluation reported herein, obtaining access to client records required months of negotiation and the use of three different "intermediary" groups to gain access to client and criminal justice records. The development of appropriate methodology, including control groups and baseline data, often results in problems whose resolutions are beyond the capabilities of the project staffs. Evaluation strategy must therefore consider what is feasible for those

staffs, and what requires outside assistance. One constant problem is the obtaining of information on clients after they have left treatment. Such follow-up efforts, though not excessively expensive, are nevertheless generally beyond the service capabilities of most projects. This consideration generally dictates the use of well-designed sampling procedures and field work surveys that often require assistance of outside groups of consultants.

c. Performance

Performance factors, together with the associated external conditions (community relations, criminal justice policies, etc.), determine the ultimate impact of the project. Although evaluations of impact tend to uncover problems subsequent to their occurrence, performance factors can be examined before or during the occurrence of problems and therefore are useful in anticipating and correcting problems before serious degradations of impact occur. In this sense, impact measures can be considered "lagging" indicators and performance measures can be considered "leading" indicators. Performance indicators are also necessary to interpret impact results -- for instance, they are helpful in determining whether achieving expected impact or failing to achieve it is primarily a result of the project's own actions or of uncontrollable factors in the surrounding environment. If project success or failure regarding impact achievement is a result of some factor in the environment, then the OCJP decision might be to increase effort in the community rather than to terminate funding of the project being examined. For example, the lack of any significant impact by the Aquarian detoxification unit on hard core addicts is due more to absence of suitable follow-up treatment (such as

a residential unit) than to any shortcoming of the excellent service provided by the detoxification unit.

In other instances, quality of services would have an important bearing on the performances of projects. There are many examples of projects that can show large numbers of graduates at costs per graduate or per given service far below the unit costs of other similar programs. Closer examinations, however, will often indicate that little is being done to correct the clients' basic problems, with the result that suggested impact might be an illusion. The precise measurement of quality of service has never been achieved even in better understood fields such as community medicine. Nevertheless, from observation and review by experts, bounds can be set on the attributes influencing quality of care (such as staff qualifications, client counseling review procedures, etc.) as a means of assessing acceptability of performance. This "template" approach to identifying necessary treatment attributes and bounding the acceptable range of performance is an essential methodology used in on-site reviews in the community health and mental health fields.

Measures of efficiency should provide an indication of whether service is being provided to clients at a reasonable cost. What is reasonable in cost will vary considerably from project to project, as it does in other community service organizations such as neighborhood health centers. However, general bounds on unit costs can be determined from data readily available and also from cost trends over time in any given project. Costs and their proper allocation to services provided would follow the accounting rules established by local, state, and federal agencies. In recent work for NIMH and OEO, we have determined

# CONTINUED

# 1 OF 4

cost-effectiveness by apportioning all costs not otherwise earmarked in the grants as the costs of delivering treatment.* Although this is a gross measure of actual treatment costs, the difficulties involved in more exact measurement make greater refinements in cost measures unwarranted at this time. Budget and expenditures summaries required with the LEAA grant should be sufficient to identify costs properly attributed to delivery of service.**

The evaluation of efficiency also suffers from a lack of definition of standard units of service. In community health, "relative value scales" and other devices provide some basis for comparing various types of service. Knowledge of the drug treatment and rehabilitation processes and their impact is still too meager to permit much reliance on such approaches. Individual counseling may consist of 30 minutes with another client or 2 hours with a psychiatrist, and so forth. At present, evaluation must be based on several characteristics of the service provided, including type of service, type of provider, and duration of encounter. Some comparability of results has been achieved using several measures such as $/per treatment day, $/per graduate, $/per drug-free day, number of hours of provider time per client, etc. However, if these measures are to be compared, they must be carefully limited to treatment projects with similar treatment modalities, and to similar clients.

Evaluation should shed some light on the potential of the project as the basis for decisions regarding funding, re-funding, or replicating the project in other localities. In practical terms, the

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* CODAP, op. cit.

** (1) Application for Grant for Law Enforcement Purposes, CCCJ Form 502, and
(2) Monthly financial report required by LEAA projects.

potential of a project can be expressed in several ways. The capacity for expanding the service of an established project would be indicated by information on several factors, such as the degree of utilization of existing facilities and staff, the span of control of the existing management, ability to find additional staff and increase the scale of in-house training, funding required, etc. Potential may also be expressed in terms of the ability of the project to render assistance to others. Added support might permit the established project to help with the development of similar methods for a project in another locality, and to participate in training, writing grant applications, establish community relationships, etc. for the new project. The existing project may show potential as a model for initiation of similar projects in other localities. The key factors in success could be described and codified, and used as the initial planning for the new project. It is more likely, however, that certain activities of a project will be worth replicating while others may not be. In the experience of the evaluation team, the best model for a new project would probably be a composite of the activities of two or more similar treatment modalities. Finally, the project might show potential as the developer of basic knowledge about the drug treatment process. Information on these efforts would then form the basis for improvement of service at many different projects in the treatment community.

K. Approaches to Evaluation

There are several relevant sources of information for evaluation, each with its particular utility and areas of application. An evaluation strategy should be devised so as to make best use of all of these sources to provide the most complete basis for state planning. The principal sources are periodic project reports, project in-depth studies, project evaluations by a state agency or its contractors, and reports and information from other governmental agencies.

Project reports, as used here, are the periodic project status and progress reports required under the terms of the grants, together with any other periodic progress reports made by the project. They generally give information on recent activities and current clients. These reports have been, and probably will continue to be, the main source of information to the state. They are particularly valuable for providing "monitoring" information* for use by the state.

Project periodic reports are an efficient way of obtaining data on client attributes, certain staff attributes, project activity levels, funding information, and management policy changes. These reports can also present less reliable but useful information on past and current drug use of clients, and in some instances, information on past and current criminal justice involvement.

This information forms at least part of the basis for assuring compliance with the grant. The information can also be used as an initial basis for comparison of some feature of a project with the same feature in similar projects. In order to do this, however, it is necessary that definitions be standardized and data be reported in the

*"Evaluation of Crime Control Programs in California: A Review," CCCJ, April 1973.

same format. This condition does not now exist among grantees in their reports to OCJP. Standardization has begun to occur through the introduction of the CODAP and TCU systems by NIMH and SAODAP and presumably will be furthered by the introduction of the state's own information system.

Such reports have their deficiencies since they generally are not able to determine impact of treatment after clients leave the project. Also, because of staff and resource limitations, such periodic reports generally cannot provide the basis for in-depth understanding or statistical confidence of the results they present. They can, however, be very valuable as a means of "signalling" important changes in project operations. Indicators of performance or demand (e.g., number on waiting list, staff to client ratios, etc.) can be examined over time for a given project and among similar projects to determine significant changes. This approach, of course, requires that some basis be established for determining what changes in indicators are significant. At present, there is no body of criteria that would simplify this task. Determination of significance, under present conditions, resides in the experience of the state's evaluation staff and their consultants. The situation could improve with the emergence of standards by regulatory agencies, and with the buildup of historical information on various treatment modalities in the state and federal information systems. However, a continuing effort will be required at various government levels to standardize and coordinate this information to provide the basis for reasonable evaluation criteria.

Special evaluation studies conducted by the project or consultants can provide an in-depth understanding of impact of services, as well as added insight into current demand and performance. Properly designed studies

of this type will include on-site observation, client interviews, follow-up tracking of control samples and of former clients and base-line data, as well as the statistical methodology to assure significant results. These studies are not an easy undertaking nor can every project muster or afford the qualified staff to complete such studies. In the cluster of five projects, representing a superior class of projects in the State, only one project could be said to be doing evaluative research. In view of these difficulties, the State would be well advised to include in its grant application a specific requirement to review and to approve the qualifications of evaluators and detailed evaluation plans prior to their use.

On-site evaluation of projects by a state agency is the principal means of extending and corroborating results reported by the project, and also a means of identifying problems and isolating causes of these problems.

On-site evaluation refers to independent investigation at the project location, including staff interviews, observations of treatment processes, examination of project records, and information from local agencies dealing with the project. This approach is the best way to determine impact of treatment on criminal justice involvement of clients during and after completion of treatment. This approach is particularly effective in determining the quality of treatment through examination of facilities, staff, treatment processes, in-house training, staff supervision, project administration, and project records.

On-site evaluations under the aegis of a state agency are often better able to obtain fuller participation of other local agencies (e.g., criminal justice agencies) than would be possible for the project

or the project's consultants. In this present effort, through the good offices of OCJP, the evaluation team was able to obtain probation and parole records for project clients in counties surrounding every project.

On-site monitoring and reporting done by OCJP staff provide a reasonable basis for assuring that the principal conditions required for grant compliance are being met by the project. However, to identify all the important problems and their causes that will affect the potential of the program, there is a requirement for on-site evaluation of the type reported here. A broadly based team of drug abuse treatment professionals and paraprofessionals will be able to recognize important features of each program. A professional operations analyst or statistician is required to evaluate project reports and extend findings where possible.

Reports and observations of federal, state, and local agencies are important sources of information for estimating demand and for estimating certain elements of project performance (i.e., community relationships, referral policies, local support, etc.). Baseline information relating to demand in a given locality can be estimated using Bureau of Census data, Bureau of Criminal Statistics information, and specific information provided by local jurisdictions on requirements for referral agencies in criminal justice cases. Local agencies can also provide information about drug treatment projects operations in the locality. They are a primary source of information on the status of community relations of the project, referral policies, management ability, and local funding support, as well as knowledge about the impact of services of the project with respect to the clients referred by the agencies (e.g., probation/parole, etc.). These local sources should be used more frequently by the state in obtaining an appraisal of operations and problems of drug treatment projects, such as direct inquiry to related agencies about specific problems.

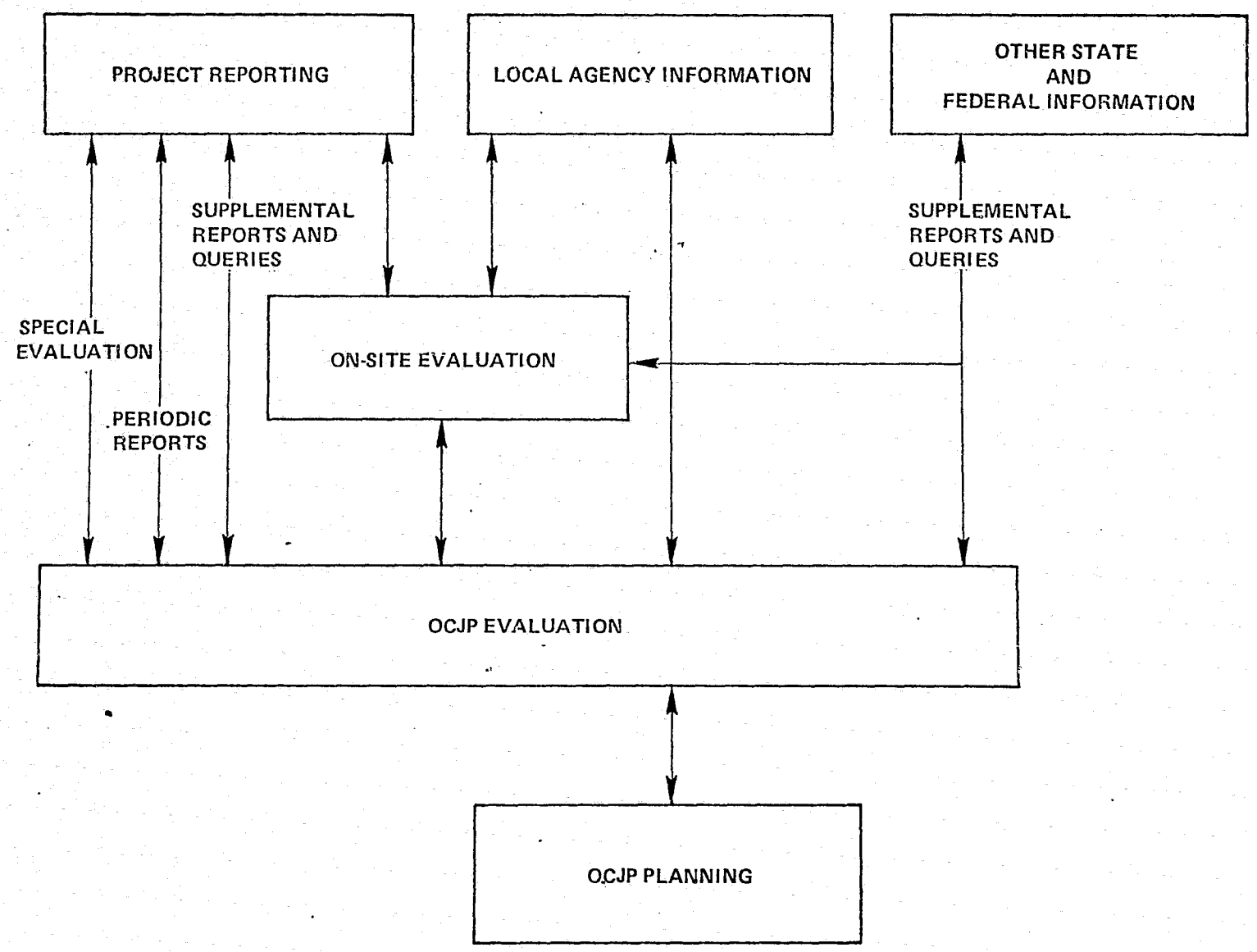
## L. Concept of an Evaluation Strategy

The evaluation strategy should make use of the various evaluation approaches in the way that meet state planning needs at minimum cost. The current system of obtaining evaluation can be used with some modifications to assure higher quality and consistency of reporting. A flow chart of evaluation functions and reporting links is shown in Figure 1. Periodic project reports would provide the state agency with information needed for grant compliance and would include indicators of project activity and impact needed to "signal" or "flag" important changes in operation (e.g., staff turnover, client population decline, etc.). The state agency evaluators would examine the standardized reports for each project. Wherever one or more indicators were judged to be out of the acceptable range and could not be explained, a standardized inquiry form would be sent to the project to determine the reason for the deviation, and (if the deviation was negative), the steps that were being taken to correct the underlying problem.

A persistence in unsatisfactory results would be the basis for undertaking an on-site evaluation of a project. Depending on the seriousness of the problem and the time since the last complete evaluation of the project, the on-site effort might be a simple monitoring examination similar to the present OCJP system, or might be an in-depth evaluation similar to those made in the present effort. The on-site monitoring as conceived in this concept would be focussed on the specific problems noted by the state evaluators in their examination of the project's periodic reports and reports from associated local agencies. The in-depth evaluation approach would consider all important attributes of the project's

Figure 1

EVALUATION FUNCTIONS AND REPORTING LINKS



operation. Results of on-site evaluation would be used by the state evaluators to make recommendations about the funding of the project and to plan changes in local-action efforts within the jurisdictions involved.

Table 11 lists some of the important data elements and indicators that should be provided by each project on a periodic basis. Other information could be provided by in-depth evaluations conducted by the project, or outside consultants or associated agencies. Included as part of these efforts should be occasional random selection of projects by the state for in-depth evaluation by outside consultants.

Table 11

DATA ELEMENTS AND INDICATORS

| Type of Information | Signal or Flag of Problem | Action* |
|---|---|---|
| Client demographics<br>Current clients (number)<br>New clients (number) | Hispanic white low in proportion to census, BCS data, other available treatment projects | Evaluate outreach procedures and evironmental factors screening out Hispanic whites. |
| Other Client Attributes<br>Drug abuse (prior)<br>Drug abuse (current)<br>CJS involvement (prior)<br>CJS involvement (current)<br>Client retention time<br>By drug class | No appreciable change prior to current time | Evaluate suitability of modality for client types. |
| By race, age, sex | Higher rate black dropouts | Examine suitability of environment for blacks. |
| Staff attributes<br>By demographic class | Hispanic white underrepresented on staff | Examine outreach and treatment of Hispanic white population. Check referral policy of local agencies. |
| By training | Low training and experience background of staff | Evaluate in-house training and supervision of trainees in counseling clients. Check experience. |
| By drug experience | | |
| Staff turnover rate | High rate of turnover | Check working conditions, supervision, salaries, in-house training, trainee selection. Check administrative overhead, organization of services, etc. |
| Staff utilization | Low percentage time on client service | |
| Project attributes<br>Waiting list | High loss rate from list | Review capacity of project, referral procedures, potential for expansion. |
| Funding | No applications | Determine management plans. Suggest grant possibilities. Contact grantors and help set up contacts. |
| Number & type (referrals) | Few referrals to outside agencies | Check outside agencies' experience with project. Examine appropriateness of client types treated. |
| Impact indicators (in-depth evaluation)<br>Follow-up comparisons (drug) | No improvement of heavy heroin users | Check treatment modality, consider limits on client types accepted. Check referral policy. Consider adding new modalities in local area. |
| Follow-up CJS | No improvement of users with major CJS records | Same as above. Check aftercare effort. |
| Recidivists in treatment | Substantial percent | Check availability of other modalities for continuing treatment. |

* Sequence of action is phone or letter inquiry, visit by state analysts, and finally full on-site evaluation by expert team, depending on the severity of the problem and the response of the project.

# III. INDIVIDUAL PROJECTS

## A. Sacramento Methadone Maintenance Program

### 1. Services Provided

#### a. Description of Services

The Sacramento County Methadone Maintenance Program is a well-organized outpatient clinic dispensing methadone to heroin addicts, and providing counseling services. The program has two clinics (V Street and Capitol Avenue), each having the capacity to treat 150 clients. At the time of the site visit, 146 were being treated at V Street, and 74 at Capitol Avenue. Currently, both clinics are operating at capacity and have a waiting list. At both clinics, patients average 4.5 visits per week, with an average duration of 1/2 hour. A new client is typically built up to a methadone dose of 50 milligrams, which is adjusted over a period of weeks to a level that is comfortable for the client but still pharmacologically effective. Clients visiting less than daily take home some of their doses.

Regulations require that a client be detoxified from methadone within two years after start of treatment. The staff members of Sacramento Methadone have accepted this cutoff date as a therapeutic goal for their clients. (In all cases where the cutoff date is not adhered to, justification is given.) At the staff's discretion (in cooperation with the director of the program), the client's dosage is reduced with his prior consent, but without his knowledge of the dose level, until it reaches a level of 30 milligrams. At this point, the client is informed of his dosage. From that time until complete detoxification, he can control the dosage, down to minute increments.

Other services include individual counseling and job counseling. About 30-40% of the clients get individual counseling

(1 hour per week) at the program or at the SMC mental hygiene clinic; 20% receive job counseling and assistance each week. Emergency services,* each lasting about 1/2 hour, are provided for about 33% of the clients each week.

Counseling services are currently undergoing change. Both clinics are setting up to provide group therapy to all suitable clients as required by NIMH regulations. Additional experienced staff will be required to organize and run groups and to select appropriate clients for different groups.

The V Street clinic is located in the mental health facility at the county hospital, which is operated by the U.C. Davis Medical School. The methadone clinic consists of several staff offices and a large room that is used for filing, dose preparation, and dispensing. Dispensing is done through a window in the wall, with the client standing in the hallway. The clinic area is crowded and inconvenient. There is no space for client activities or socializing except in the crowded hallway. The dispensing area is crowded. Counseling offices are shared and over-utilized.

The Capitol Avenue clinic is more spacious. It has a waiting room where patients can talk and drink coffee. Patients go to the dispensing area one at a time. There is a conference room, but not enough offices, although crowding is not as severe as at V Street.

Some potential problems arising from methadone dispensing procedures were noted during the site visit to the V Street clinic. Following are suggestions for avoiding these problems. Methadone doses

* Emergency services are unscheduled responses to psychiatric, psychosocial, and medical crises, usually in the form of brief counseling, and where appropriate, referral.

should remain under supervision until the moment they are ingested or locked in take-home boxes. The locking should be done by a staff member rather than by the client. (These problems were not noted at the Capitol Avenue clinic, whose setup and procedures are significantly different because of the different physical arrangement.) In both facilities, apparently as a matter of clinic policy, husband and wife clients are permitted to use the same locked box for their take-home methadone. It would be preferable to make each client separately responsible for his own box.

b. Referral and Screening

On the basis of the clinic client sample and information provided by parole and probation offices, at least 52% of the clients are referred by the criminal justice system.

Screening includes documentation of addiction and prior treatment, physical examination, chest x-ray, tuberculosis testing, laboratory work, collection of demographic data, collection of two urine samples, and orientation to the clinic rules. Most of these screening procedures are required by the state methadone regulations. Major requirements for admission are: clients must be 18 years of age or older; must have no history of violent crimes; must document two years of addiction; must have a documented history of two treatment failures; must demonstrate proof of current addiction by two dirty urines or by fresh tracks; must show adequate motivation over and above pressure from parole, probation, or family; and must have no pending criminal charge.

Fulfilling the requirements for admission to methadone treatment can take from two weeks to several months, with consequent loss of the less motivated applicants. The referring criminal justice agencies can do much to expedite a client's entry into treatment. In

the case of civil narcotics parolees, the parole board can rapidly provide the necessary proof and waivers. The Sacramento parole and probation offices have been very helpful in this respect.

In the past, Sacramento Methadone, like most such clinics, has had waiting list problems. These have largely been solved with the revision of the waiting list procedure. The project has developed a new waiting list format using one card that shows the status of the client and his position on the waiting list. Both clinics will operate their own lists, with appropriate coordination between them. This organized approach is a substantial improvement, since a client who is too long on a waiting list without information as to his status may be lost to the system.

c. Discipline and Rules

Random urinalysis is conducted once a week per client. Clients are required to give urine samples before receiving their methadone, and are also required to return their bottles. For the first dirty urine, the client receives a warning. For the second, punishment is usually a decrease in the privilege of taking home methadone. If a patient persists in abusing drugs, he is discharged from the program. Patients are promoted to take-home dosage on the basis of clean urines, no criminal behavior, and social stability as dictated by state regulations. Clients who go three months, six months, and one year without dirty urines are given commendations.

## 2. Treatment Philosophy, Objectives, and Criteria

### a. Treatment Philosophy

Although the original purpose of the program was to offer clients methadone maintenance with a minimum of supportive services, the program is shifting to a more psychiatrically oriented approach to meet the more complex needs of the majority of clients. However, the staff members feel that any form of psychotherapy should not be required of a client, as necessitated by NIMH regulations, but should be available to the client if he feels the need.

The project, in common with other methadone clinics, believes that social rehabilitation of clients can be achieved with the support of methadone maintenance together with other supportive services. After a period of rehabilitative effort of at least 6 months, the client is encouraged to consider withdrawal from methadone to achieve a drug-free life.

### b. Impact-Oriented Objectives and Associated Measurement Criteria

Objectives and measurement criteria for Sacramento Methadone were determined from the director's interview and various project documents (grant awards, protocol documents, annual and quarterly reports). Objectives and associated measurement criteria are listed in Table 12. Measurement criteria are those actually used in annual and quarterly reports.

Decrease in criminal behavior of clients is an objective that is appropriate to this project. In measuring this objective, reports from this project use number of arrests or incarcerations as a criterion. The terms arrests and incarceration tend to be used interchangeably, but in practice, the data presented appear to be for

Table 12

SACRAMENTO METHADONE

OBJECTIVES AND MEASUREMENT CRITERIA, WITH ADDITIONS

| OBJECTIVES | CRITERIA USED | ADDITIONS TO CRITERIA |
|---|---|---|
| A reduction in criminal activities to support heroin dependence | Decrease in arrests (incarcerations)<br>Decrease in convictions<br>Number of incarcerations in period (new offenses) | |
| (Reduction in illicit drug use)* | | Number of clients meeting clinic urinalysis standards in period<br>Number of "drug-free" weeks+ during period |
| Development of constructive model of life--employment and education | Number or percent employed or in school<br>Number or percent employed or in school since entry into program | Job turnover<br>Part-time, full-time or temporary employment (pre and post)<br>School status changes<br>Welfare status, dependent status |
| Improved social relationships | Number of clients with takehome privileges(?)**<br>Number regaining custody of children<br>Number of births among married couples(?)** | Goal-oriented system including family reunions, participation in group activities, etc.<br>Number of clients reaching goals in reporting period |
| Referral for psychiatric and social services(?)** | No criteria given | Number of contacts in period |
| Drug-free life--detoxification | Number voluntarily detoxified - graduation | Number of graduates continuing to meet other program objectives |

* It is suggested that this objective be added.

\+ "Drug-free" as used here really means number of weeks in period in which illicit drugs were not detected in weekly urinalysis.

** Question mark indicates questionable concept.

incarcerations. In annual reports (but not quarterly reports), comparisons are made of client records before and after entry into the program in order to demonstrate decrease in criminal justice involvement. Quarterly reports list only numbers of events for the period. In the listing of incarcerations after entry into the program, a valid distinction is made between incarcerations for offenses occurring before entry and incarcerations for offenses occurring after entry. Because of relationships with local police and clients' requirements for methadone, the project should be aware of essentially all incarcerations and convictions in the Sacramento area, but not necessarily all arrests. The measurement criteria chosen are appropriate for this objective. Reliability of the measurements is discussed later.

Reduction or elimination of illicit drug use is another aspect of criminal behavior that should be included as an objective. Measurement criteria could include the number of clients who have maintained such usage within limits set by the clinic in their protocol (i.e., detection of illicit drugs less than two times in a 60-day period and less than three times in a 90-day period). Because of the state regulations and CODAP requirements covering the frequency of urinalysis, Sacramento Methadone should be able to provide other convenient aggregate measures of performance, such as the number of "drug-free" weeks in the period summed for all clients. This estimate would be based on detection of illicit drugs in the weekly urinalysis. This testing schedule, of course, does not guarantee that the client is drug-free during the period.

The objective of improving social relationships is appropriate but is difficult to measure. The criteria of the number

or percentage of clients with take-home privileges reflect the requirement that the clients abide by clearly stated project rules (including regular attendance, good behavior in the project, and limits on positive urinalyses). This composite measure would be more suitable if broken down into its component parts (i.e., regular attendance, good behavior in project, etc.). As mentioned earlier, indication of illicit use of drugs (via urinalysis) is a more appropriate measure of criminal behavior. Other measures used, such as "regaining children," are useful events but should be part of a systematic evaluation procedure.

Basically, satisfactory measurement of the social relationships objective requires the application of a systematic "goal-oriented" approach in which goals are set for each client and success is recorded when these specific goals are reached. In addition to the goals mentioned earlier, others that might be included are events such as reunion of families, formation of new relationships, and participation in organizations and social groups. Measures might include number of patients reaching pre-set goals during the period.

Employment and education of clients is an appropriate objective for Sacramento Methadone. Criteria currently used to measure performance include percentage of clients currently employed or in school (quarterly report); and percentage of clients employed or in school since entering the program (annual report). These criteria are useful but should be supplemented by measures that explore the quality of the client's current status. For example, is the client fully or partially self-supporting? Is his job permanent or temporary? Does the job fit the patient's skills? What relationship does the job have to welfare? Measures related to these considerations would include job turnover rate, change in status at educational institutions, etc.

Referral for psychiatric and social services is a questionable indicator for Sacramento Methadone. If this objective is included, a better statement would be: "to provide supportive psychiatric, other counseling, and social services required by clients." The greater part of these services should be provided by the project itself. Currently, no criteria for measurement are provided in annual or quarterly reports.

A goal added in the third year grant request in response to state regulations was to offer the client an opportunity to lead a drug-free life through voluntary detoxification from methadone. Proposed criteria for measuring performance included: number detoxified and graduated from program (annual report), and number of graduates who continue to fulfill program objectives with respect to decreased criminal behavior, improved social relationships, and continued employment or education. This last criterion is appropriate but requires systematic follow-up which has not as yet been undertaken by Sacramento Methadone. Since follow-up on all graduates over an extended period of time is quite difficult and requires a significant effort by project personnel, it probably is not a feasible measure without considerable expansion of the evaluation effort.

3. Client Attributes

a. Client Criteria

The ideal client for Sacramento Methadone is one who: is older with much drug use experience; is dissatisfied with the criminal and street scenes and no longer finds that life exciting ("they have to hit rock bottom and no longer be getting high or wanting to"); has been unsuccessful with other forms of available treatment, such as CRC, state hospitalization, or The Aquarian Effort; has been in jail (usually at intervals for extended periods). Many clients, not necessarily ideal, enter treatment under legal pressure.

A client entry into the program is restricted by two factors: available openings in treatment (Sacramento Methadone has a limited capacity -- 150 at each of two clinics); and conformance with state regulations for entry. The regulations require that a client provide documented proof of at least two years of prior addiction; two prior failures in drug free treatment programs such as The Aquarian Effort; and current heroin use. In some instances, these requirements can be waived, such as in the case of a parolee designated as a civil addict, to expedite entry into treatment. The effort and time (from weeks to several months) to compile the required documents can be very frustrating to an addict, and many of the clients on the waiting lists are lost. This entry process also requires significant staff work.

The effort to satisfy entry requirements has an important advantage, since the effort is an indicator of the addict's incentive and desire to enter treatment. Those who complete the entry requirements are more likely to stay in treatment and observe the rules -- and perhaps eventually detoxify from methadone.

For many clients, methadone is not a total replacement for heroin and other drugs. Some clients will still occasionally take heroin secretly or use other drugs such as codeine, barbiturates, or amphetamines, especially during the early or settling in stages of treatment. Continuing and random urinalysis is used to check on this type of behavior. Alcohol abuse is also a major problem among methadone clients. The clinic staff stresses to clients that they should avoid these other abuses, and that excesses detected by the clinic may result in disciplinary detoxification from methadone and expulsion from the program.

Most methadone clients have a record of criminal justice involvement, and many have an extensive record. Over half of the clients at Sacramento Methadone are probationers or parolees. Many clients are involved in criminal activity while in treatment.

b. Client Demographics

A demographic description of the clients in Sacramento Methadone is given in Table 13 which is based on a random sample of 85 clients, from records at both locations (V Street and Capitol Avenue). The sample consisted of clients who were active during 1973 (70% were still in treatment at the time of sampling, December 1973, while 30% had terminated treatment). Table 13 shows that 74% of the sample were male, and 26% female; 59% were non-Hispanic white, 27% were Hispanic white, and 12% were black. The median (as well as the mean) age was 33 years. This corroborates the clinic's statistics from the third year grant request (August 6, 1973). The overall age and sex distributions in the client population agree very well with those published in other parts of the country.*

* "Dealing with Drug Abuse," A Report to the Ford Foundation, p. 204 (1972).

Table 13

SACRAMENTO METHADONE
CLIENT DEMOGRAPHICS

| Age | Hispanic White | | Black | | Non-Hispanic White | | Other | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | T |
| 20 - 24 | 1.2% | 1.2% | | | 6.9% | 3.5% | 1.2% | | 9.3% | 4.7% | 14.0% |
| 25 - 29 | 4.7 | 1.2 | 2.4% | | 11.7 | 4.7 | | | 18.8 | 5.9 | 24.7 |
| 30 - 34 | 1.2 | 1.2 | 2.4 | 1.2% | 3.5 | 1.2 | | 1.2% | 7.1 | 4.8 | 11.9 |
| 35 - 39 | 5.8 | 2.4 | | 2.4 | 10.5 | 2.4 | | | 16.3 | 7.2 | 23.5 |
| 40 - 44 | 3.5 | 1.2 | 1.2 | | 6.9 | | | | 11.6 | 1.2 | 12.8 |
| 45 - 49 | 2.4 | | | | 4.7 | | | | 7.1 | | 7.1 |
| > 49 | | 1.2 | 2.4 | | 1.2 | 1.2 | | | 3.6 | 2.4 | 6.0 |
| Total | 18.8% | 8.4% | 8.4% | 3.6% | 45.4% | 13.0% | 1.2% | 1.2% | 73.8% | 26.2% | 100.0% |

N = 85

Educational levels of clients were as follows: 10.5% had no high school, 32.6% had some high school, 47.6% had completed only high school, 7.0% had some college, and 2.3% had college degrees.

Clients in the methadone program tend to be older than those in other treatment modalities. At Sacramento Methadone, the median age is 33. However, an interesting fact is that the minority population tends to be substantially older, with a median age of 35 (the non-Hispanic white population has a median age of 24). A more extensive outreach program could result in higher minority participation at an earlier age. Ethnic differences might also be explained by sociological and criminal justice factors concerning the age at which minorities feel the

pressure to enter methadone treatment and at what age they best relate to it. Possible differences in criminal justice policy or client attributes are evidenced by the fact that of a sample of 30 probationers and parolees, the median age for non-Hispanic white clients is 26 vs. the median age of 41 for the minorities -- a difference of 15 years. (The mean age difference for these groups is 12 and is highly significant statistically.)

The overall older age of clients in the methadone treatment is probably advantageous, since experience indicates that older people generally do better than younger ones. For this reason, this group is given preference.

Another interesting feature of Table 13 is the disproportionately low number of female clients in the program, compared to the number of male clients. (The low number of females is not disproportionate relative to other methadone clinics.) Reasons for the low number of female clients are: fewer women are addicted; female addicts often support themselves by prosititution but are less likely to be caught and referred by the criminal justice system than males committing other crimes such as burglary; females have a dependent or subservient role in Hispanic cultures; getting off drugs is not as attractive financially or emotionally for a woman as for a man; lack of child care facilities may prevent some females from applying for treatment.

The initial observation of the site visit team was that the institutional atmosphere and middle class staff of Sacramento Methadone might turn away minority clients. However, comparisons made only with baseline data and other available statistics would not be sufficient to

test this observation. Table 14 compares client demographics with baseline Census population data for Sacramento County and shows that the proportion of blacks in treatment is more than twice their proportion in the county population. Moreover, heroin prevalence statistics collected in San Francisco by Newmeyer* imply that the addiction among blacks there is twice as high as among whites. Assuming that the relevant factors in Sacramento are similar to those in San Francisco, Table 14 indicates that blacks are adequately represented in treatment.

c. Drug Use

Table 15 shows as much drug history information as was available from the clinic files. The table presents only heroin use history and not other drug use, which is frequent among Sacramento Methadone clients even during treatment. Urinalysis reports during treatment provide a minimum estimate on the amount and type of abuse occurring during treatment, and summary statistics should be maintained on them. For comparison, more detailed drug profiles should be obtained on clients at intake. Most clients started daily use of drugs in the 15-24 age range, and there is no pattern to the time lapse between start of use and entry into treatment at Sacramento Methadone. However, many clients have extensive drug histories, and have been in and out of other treatment programs prior to entering Sacramento Methadone. Within the sample, the older clients tended to have become addicted at an older age. This tendency could be explained in many ways, but the most significant explanation is that it is probably

* John A. Newmeyer, "Estimating Opiate Use Prevalence in San Francisco: Five Methods Compared," Haight-Ashbury Free Medical Clinic, San Francisco, 1973.

Table 14

SACRAMENTO METHADONE

| Sex | Client Population | Census |
|---|---|---|
| Male | 74 % | 49 % |
| Female | 26 | 51 |
| **Race/Ethnic** | | |
| Hispanic | 27 % | 6 % |
| Non-Hispanic black | 12 | 5 |
| Non-Hispanic white | 59 | 84 |
| Other | 2 | 5 |
| **Age** | | |
| 15 - 19 | 0 % | 15 % |
| 20 - 24 | 14 | 13 |
| 25 - 29 | 25 | 10 |
| 30 - 34 | 12 | 9 |
| 35 - 39 | 24 | 9 |
| 40 - 44 | 13 | 10 |
| 45 - 49 | 7 | 10 |
| 50 - 69 | 5 | 24 |

Table 15

SACRAMENTO METHADONE
DRUG HISTORY

| Age at Entry | Age at First Daily Use of Heroin | | | | | | | Total Users |
|---|---|---|---|---|---|---|---|---|
| | 15 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | |
| 20 - 24 | 15.4%* | 61.5% | 23.1% | | | | | 15.7%** (13) |
| 25-- 29 | 14.3 | 23.8 | 57.1 | 4.8% | | | | 25.3 (21) |
| 30 - 34 | 6.2 | 43.8 | 25.0 | 25.0 | | | | 19.3 (16) |
| 35 - 39 | | 50.0 | 25.0 | 18.8 | 6.2% | | | 19.3 (16) |
| 40 - 44 | | 42.8 | 28.6 | 14.3 | 14.3 | | | 8.4 ( 7) |
| 45 - 49 | | 16.7 | 49.9 | 16.7 | 16.7 | | | 7.2 ( 6) |
| 49 | | | | 75.0 | | | 25.0% | 4.8 ( 4) |
| Total | 7.2%** | 38.6% | 33.7% | 15.7% | 3.6% | | 1.2% | 100.0% (83) |

N = 85
NR = 2

* Percentage of age group using heroin daily
** Percentage of total

an indication of the survivability of heroin addicts. There are few older addicts (40+) who were addicted at an early age and are both still alive and out of jail.

d. Client Retention

Client retention curves were constructed on the basis of a sample of 58 clients in treatment as of ovember 1972. Some of them were still in treatment at the time of the site visit a year later, so that the client retention curves represent an approximation beyond one year. Figure 2 is the client retention curve for the total sample and shows a median retention (CR50) of 21 months (the mean client retention being the same), and a 75% retention (CR75) of 17 months. At least 85% of the clients stayed in treatment for one year, and all clients in the sample stayed in treatment for at least 8 months. This is an unusually high period in view of the fact that some clients in treatment have trouble getting started and drop out of methadone treatment during the first few months.*

Figure 3 compares the client retention curves for blacks and non-Hispanic whites. The figure shows a much higher dropout rate among the blacks; 25% of the blacks drop out within 14 months, but only 5% of the whites; 45% of the blacks drop out within 22 months, but only 25% of the whites. Stated another way, 75% of the blacks stay 14 months, while 75% of the whites stay 22 months. These comparisons andd credence to the observation stated previously that the clinic's atmosphere and image might not appeal to black clients.

* In subsequent discussions, clinic administrators felt that this was largely true, but that there were a small number of clients who terminated within the first few months of treatment.

Figure 2

SACRAMENTO METHADONE — CLIENT RETENTION

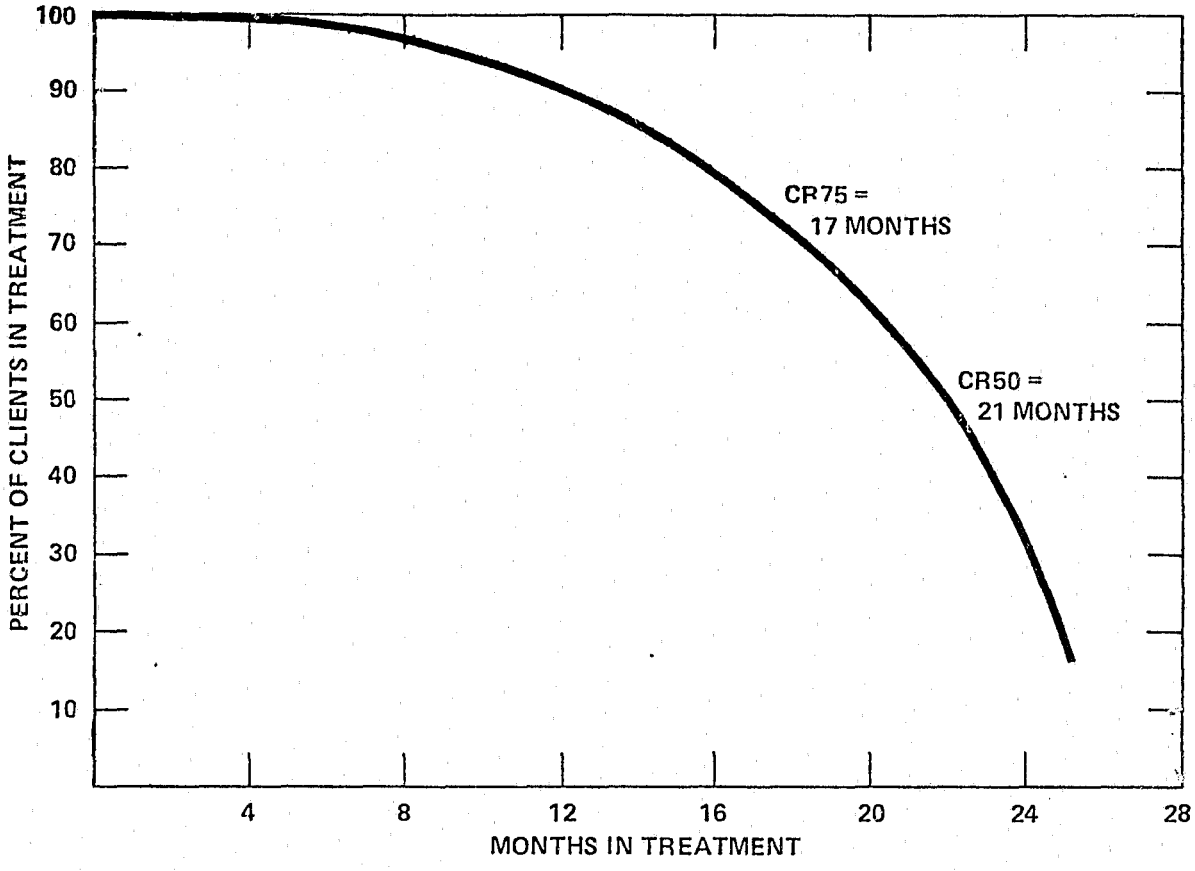
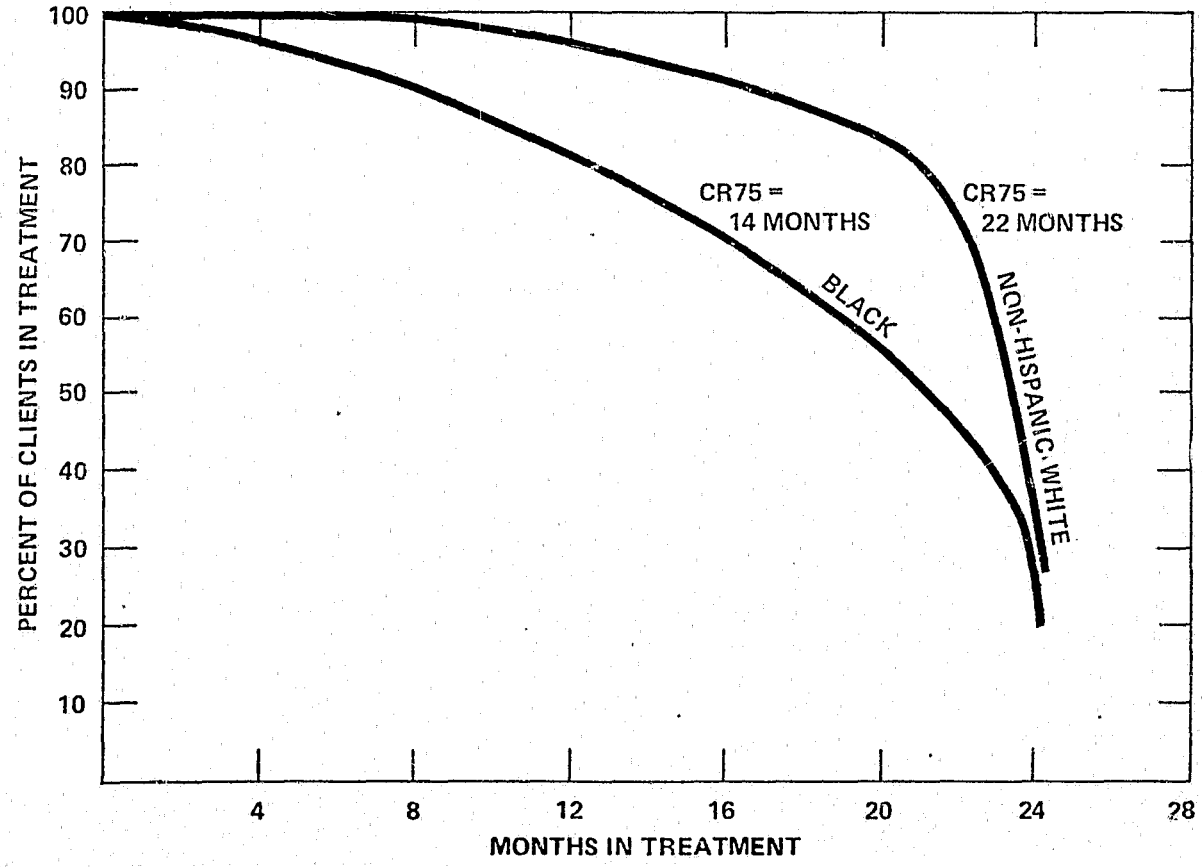



Figure 3

SACRAMENTO METHADONE — BLACK VS NON-HISPANIC WHITE RETENTION CURVE



4. Staff Attributes

Sacramento Methadone has a staff of 26 (16 at V Street and 10 at Capitol Avenue). A site-visit sample of 19 staff members showed 80% non-Hispanic white, 15% black, and 5% (one person) oriental. Females make up 61% of the staff, and all but one staff member are 25 years of age or older. Table 16 presents the detailed staff demographics. The physicians on the staff are each credited with giving half time to the program. Thus, the staff numbers 24 full time equivalents. On the basis of 300 clients (150 at each clinic), the staff-to-client ratio is 1:12.5.

The physicians on the staff include the director; a county mental health physician who works part time at the Capitol Avenue clinic and who is also the jail psychiatrist; and two part time psychiatric interns engaged primarily in conducting physical examinations and other nonpsychiatric work. The director is also a staff member of the Sacramento County mental health department. The former clinic director is the current director of county mental health.

The staff is well-educated. Aside from the physicians (who were not included in the sample), 79% possess degrees including RN, B.A., M.A., and Doctor of Pharmacology. Twenty-nine percent have no degrees. In the sample, only one person had more than five years of psychiatric experience; one had between two and three years; four had between one and two years; and eight had less than one year. Most of this psychiatric experience is not drug related. Many of the new additions to the staff are due to program expansion and not to staff turnover. This causes the current staff retention of about one year or less; probably two years would be a more accurate figure.

Table 16

SACRAMENTO METHADONE
STAFF DEMOGRAPHICS

| Age | RACE - ETHNIC | | | | |
|---|---|---|---|---|---|
| | Hispanic White | Black | Non-Hispanic White | Other | Total |
| 20 - 24 | | 5% | | | 5% |
| 25 - 29 | | 5 | 28% | | 33 |
| 30 - 34 | | 5 | 21 | 5% | 31 |
| 35 - 39 | | | 16 | | 16 |
| 40 - 44 | | | 5 | | 5 |
| > 44 | | | 10 | | 10 |
| Total | | 15% | 80% | 5% | 100% |

N = 19

Total staff = 26

Table 17

SACRAMENTO METHADONE
DISTRIBUTION OF STAFF TIME*

| TYPE OF SERVICE | PERCENT OF STAFF HOURS |
|---|---|
| Medical health care | 18.5% |
| Individual counseling | 17.2 |
| Maintaining client records | 13.5 |
| Client intake | 9.4 |
| Staff meetings - program-oriented | 7.3 |
| Staff training - trainee | 5.4 |
| Community relations | 5.2 |
| Clerical, etc. | 3.9 |
| Research and evaluation | 2.5 |
| Staff training - trainer | 2.4 |
| Diagnosis | 2.2 |
| Educational services | 2.0 |
| Outreach | 2.0 |
| Supervision of staff | 2.0 |
| Emergency services | 1.8 |
| Housekeeping, etc. | 1.7 |
| Family counseling | 1.0 |
| Other** | 2.0 |

* Based on interviews of 19 staff members.
** Group therapy 0.3%, job development 0.9%, social services 0.4%, client follow-up or aftercare 0.4%.

All clients are assigned to a counselor ("group leader") on admission. Each counselor has 15-20 cases. A counselor may be a psychiatric nurse, a psychiatric social worker, a psychiatric technician, or a vocational counselor. The counselor's job is to admit and screen a client, follow his progress, and deal with good and bad behavior. As needed, he presents his cases to the staff team conference for decision making. Naturally, much staff time is spent on methadone dose preparation, bottle labeling, collecting urine samples, mixing the dose with Tang, and dispensing the dose. Table 17 presents the distribution of staff time. Counselors are available during dispensing hours, and there is a full time vocational rehabilitation counselor to help the clients. The director and the jail psychiatrist play consultant roles and work with treatment policy, discipline, and dose setting. They counsel clients on problems only when the other staff members feel it necessary to refer clients to them.

The staff state that they devote 17% of their time to individual counseling. This percentage is equivalent to 96 hours per week, allowing about 100 counseling sessions at one hour per session. These figures corroborate the staff's previously reported statement that 30-40% of their clients receive about an hour each of individual counseling per week. Staff adequacy for counseling as appraised by the evaluation site visit team, shows 58% with a rating of good. All staff members were considered adequate.

Some of the staff members are assigned as liaison to outside agencies (probation, parole, etc.). These liaison personnel coordinate clinic policy and activities with the outside agencies through periodic meetings. In addition, some of the staff are active in community drug

treatment coordination efforts. Two of the staff work with the county adult diversion projects by giving drug education and counseling.

An inservice training conference of the staffs of both clinics is held each week for 1 to 1-1/2 hours. Topics at these conferences have been: rules and regulations governing the program; pharmacology of the various drug groups; confidentiality; and street experience of an addict. Inservice training is generally psychiatric. However, it does not greatly emphasize dealing with character disorders and addictive personalities.

Each staff member receives an hour of individual supervision weekly from senior nurses and social workers. The director gives an hour of psychiatric consultation in the form of a case conference to the staff of the V Street clinic every two weeks. The other psychiatrist does the same at Capitol Avenue.

In addition, each clinic has one weekly client-oriented conference, at which clients' cases are presented and discussed, as deemed necessary by their group leaders. Program problems are discussed informally as they arise. Another weekly meeting of both clinics combined has a heavier emphasis on program problems, and clients are discussed only if their cases point up such problems. The program director usually attends this joint meeting.

On the basis of the site-visit interviews, the staff members have many attributes in common (age, schooling, etc.). This makes for a pleasant environment, smooth working relationships, and mutual support. However, there is an evident lack of staff members with expertise or experience in addiction treatment. This lack of drug treatment training is probably an impediment to development of staff/client relationships

at Sacramento Methadone. This problem will likely continue because of the increased counseling load dictated by the requirements of the project's NIMH conteact. Many similar clinics obtain additional counseling help by using well-trained ex-addicts who provide role models for clients and are better able to communicate with addicts. Another suggestion would be to modify the current training program and conference discussions so that they would be more oriented toward treatment modalities specific to the management of addictive personalities.

5. Quality of Evaluation Efforts

In both design and execution, the evaluation effort at Sacramento Methadone can be described as monitoring.*

a. Data Sources and Validity

Compared with some of the other treatment modalities, Sacramento Methadone has abundant data, largely because regulations require substantiation of opiate addiction. The ties between this project and the criminal justice system are close; given the client's consent, the project obtains a current version of the client's rap sheet upon his entry into treatment. That consent is almost always given, since the rap sheet is missing for very few clients. Client data are also collected through questionnaires and progress records.

A typical client record contains:

- o Progress notes
- o Urinalysis records
- o Methadone prescriptions
- o Methadone transfer sheets for jail, hospital, etc.
- o Orders for, and results of, physical and psychological tests
- o Checklist of items required for entry into the program
- o Client attributes (name, age, birth date, drug history, etc.)
- o CODAP case sample form for third quarter, 1973
- o Letters and forms verifying prior heroin addiction
- o Confidential information release form signed by client
- o Consent to participate in a methadone research project signed by client
- o 6-page follow-up interview given to clients 6 months after entering treatment (if still in treatment)
- o 3-page evaluation interview including name, address, age, drug history, etc.
- o Record of milestones (follow-up interviews, annual physical, etc.)

* CCCJ evaluation report of April 1973. See Section II for excerpts from that report.

- o "Consent to Methadone Treatment" DHEW form FD2635 (12/72)
- o Request to CII for copy of rap sheet
- o Client's rap sheet at the time he entered treatment

Examination of the client data collected by the clinic showed that the data were valid within usual limitations, such as the credibility of client-reported information. Statistics from random samples collected for the evaluation agreed very closely with client demographic information (age, race/ethnic, sex), client education distribution, and length of addiction -- data that were published in the project's third annual grant extension request (January 1973).

In other comparisons, there were substantial disagreements between the evaluation statistics and those reported by Sacramento Methadone. Examples are estimates of client retention time and criminal justice involvement. Our figure for average client retention, calculated from the sample data, was about 10 months higher than the project's figure. The median is a better measure of the average retention time because a few clients who have been in treatment for a much longer time than others will distort the mean.

Regarding criminal justice involvement, our arrest rate estimate (85 arrests/100 client years) was also higher than Sacramento Methadone's (50 arrests/100 client years). The project's method of calculation was not given, but comparison with other published statistics and other factors leads us to believe that the project's estimate is substantially lower than the actual figure.

Our problem appears to be that some arrest statistics were compiled from client-reported data, and the client is known to be the

least reliable source for this type of information. As noted above, the CII rap sheets, a more accurate source of data, are available for most clients, and should be used to determine arrest rates. In view of the project's close association with the criminal justice system, updated version for client samples could be obtained to monitor criminal justice involvement during treatment.

Only a small portion of the data in the client's medical record is currently being used to compile evaluative statistics. Much of the background or historical data in the evaluation and follow-up interviews is not used in overall program evaluation, but may be required for policy reasons or for individual client assessments. Because of the large quantity of client data maintained, periodic reviews should be made in order to eliminate outdated items from the ongoing data collection system.

Some of the reports and other documents that employ evaluation-type statistics on clients, staff, and funding are:

- o Quarterly CODAP reports to NIMH as a requirement for NIMH funding.
- o OCJP reports.
- o FDA reports.
- o Protocol and reports required for Short-Doyle funding.
- o Grant requests for OCJP and NIMH funding.
- o State Department of Mental Hygiene reports.

Baseline data concerning population characteristics, regional criminal statistics, or information from other methadone clinics have not been used in evaluation. Such baseline data are readily available and should be used in conjunction with client and staff

data currently maintained by the project as part of its self-evaluation.

Additional data should be collected by the project for use in evaluation and reporting, or for use in prospective studies and evaluations by outside consultants. These data are:

- o Staff data including demographics, training, experience, turnover, education, and duties and activities. Although most of these data items are on hand there, they are not reported and are often not mentioned in a form allowing their use in evaluation.

- o More detailed client drug profiles, including year of first use, year of first daily use, frequency of use prior to and during treatment -- for all drugs, not just heroin. During treatment, data are available from urinalysis and should be regularly tabulated and compared in terms of trends and among client types.

- o Specific figures on the amount, type, and frequency of staff-client contact.

- o More statistics on other methadone clinics (staff, clients, procedures) for use in making comparisons.

- o Baseline population, crime, and vital statistics, as well as statistics on the clientele of other treatment programs, so that client outreach and referral policy can be aligned with the needs of the community. This information is readily available, with the possible exception of baseline criminal statistics.

- o Updated criminal justice data obtained for a sample of clients with the cooperation of local agencies. This information would be used to monitor current clients.

- o Contact data on a random sample of voluntary detoxifications, when possible. The data should be brief but organized under a few topics: drug abuse status, criminal justice involvement, treatment status, employment, future plans.

b. Methodology

In general, the project's methodology has consisted of the development of descriptive statistics using frequencies, means, medians, ranges, and percentages. An exception is the driver simulation test program, which was a well-designed experiment to test psychomotor functions

in methadone clients. Data analysis and publication of results have yet to be completed. Since driver simulation test results could be important in determining employability of clients, as well as preserving their rights and freedom, it is desirable that the experimental data and their analysis be made available. A similar experiment is being done by the Venice/UCLA project which could provide comparisons.*

The underlying assumption in the current self-evaluation effort is that project and client statistical tables plus descriptions are adequate to assess compliance with project objectives and outside requirements. This approach is satisfactory so long as it provides regulatory and funding agencies with needed information, and enables the project to appraise its own status and problems. In particular, Sacramento Methadone needs additional data, as described above, especially concerning the project staff and the community drug problem. The project also needs to array the data in tabular displays that are amenable to drawing conclusions (e.g., staff, client, and baseline demographics aligned on the same table). Examples of these displays are provided in this report. (See Section II.) Such presentations often provide insight into problems not otherwise evident, such as: client racial distribution, client recruiting, methadone handling and dispensing, staffing patterns, prospective client screening, and group therapy client distribution and attendance.

Considering the volume of data at Sacramento Methadone, periodic updating of client data and related tables and calculations can be made easier by using a computer. Many computer programs are available

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* "Venice/UCLA Comprehensive Program of Community Drug Abuse Treatment and Research," Second Year Evaluation, CCCJ-0541, April 1973.

for maintaining data and producing lists and tables, and these programs are inexpensive and easy to use.

The principal function of the evaluation component is to provide information in simple and understandable terms for project use and state and federal reporting. Where adequate funding and technical capabilities exist, statistical testing methods can be applied in assessing compliance with objectives, or can be used in other applications.

Monitoring of clients' criminal justice involvement requires that conviction, incarceration, probation/parole, and arrest data be obtained from such agencies as probation, parole, and sheriff's offices for periods prior to and during treatment.

When the volume of data is adequate, data should be broken down by client age, race, sex, and crime type, and placed on a comparable basis (e.g., per client years). Because of the high random error level in the data, only the simplest measures should be used. Examples are: fraction of clients with improved arrest rates; arrests per 100 client years before and after initiation of client treatment; frequencies of clients with specific arrest rates before treatment vs. frequencies after the start of treatment; comparison of client arrest rates by crime type with baseline arrest rates for the county.

Statistics related to improved social relationships and entry into constructive modes of life are somewhat harder to use. It is generally difficult to obtain systematic corroborative data, other than information relayed from client to counselors, although probation and parole keep such information. Also, there is little normative information with which to compare client-provided data. However, the

adoption of a goal-oriented approach would provide a systematic way of using client-supplied data.

With regard to monitoring of voluntary detoxifications, no record keeping system has been developed.

The main criticisms of the evaluations done to date by Sacramento Methadone are that the project (1) is meeting only minimal reporting requirements, and (2) is not using enough information to evaluate the project objectives and community needs. These shortcomings include lack of locally available Census and criminal justice baseline data, and problems of accurately assessing clients' criminal justice status and the consequent project impact on crime reduction.

With regard to perceived bias of the evaluators, the evaluation efforts are objective and show an extensive amount of data collection and record keeping. However, the evaluative results are prepared by the project and used specifically for its promotion.

c. Adequacy of Evaluation Funding

In both the CCCJ grant request and the Short-Doyle budgets, evaluation reporting requirements are minimal, and evaluation is a staff or administrative function that is not costed separately. The NIMH contract has an evaluation requirement that includes participation in the CODAP reporting system. Sacramento Methadone has responded, as prescribed, with periodic tallying of utilization and registration data, and preparation and submission of these data in appropriate formats. The project also uses these descriptive data in proposal and grant request preparation.

According to the staff interview statistics (Table 17),

2.5% of the staff's time is devoted to research and evaluation activities, primarily to satisfy funding and regulatory agency requirements. This time allocation is felt to be insufficient, especially since none of the evaluation results are used for program planning or feedback to improve treatment or to assess the needs of the community. To some extent, evaluative results are used to substantiate the fulfillment of stated objectives, but many evaluative problems are not addressed. Examples are: the adequacy of existing recruiting procedures in light of other available treatment (what addicts are being missed that could benefit the program); and the adequacy of the staff training program. Extensive data are maintained which could be used in productive research and evaluation efforts. The 13.5% of staff time spent in data collection and record keeping (Table 17) is disproportionately high compared to the 2.5% spent in evaluation.

Table 18

SACRAMENTO METHADONE

COMPARISON OF ARREST RATES FOR SACRAMENTO COUNTY POPULATION AND CLIENTS OF SACRAMENTO METHADONE BY CRIME TYPE AND RACE

| | Sacramento County Population* Annual Arrests/100 Population (people years) | Arrests per 100 Client Years Probation Clients | Arrests per 100 Client Years Random Samples |
|---|---|---|---|
| **Crime Type** | | | |
| Personal | 0.46 | 8 | 0 |
| Property | 0.57 | 68 | 26 |
| Nonvictim drug | 0.40 | 42 | 18 |
| Nonvictim other | 1.63 | 3 | 3 |
| Miscellaneous | 1.31 | 72 | 37 |
| Total | 4.37 | 193 | 85 |
| | | | N = 85 |
| **Race** | | | |
| Hispanic white | 11.83 | 250 | |
| Black | 10.70 | 233 | |
| Non-Hispanic white | 3.35 | 174 | |
| Other | 5.09 | 0 | |
| Total | 4.37 | 193 | |
| | | N = 37 | |

* Statistics provided by the California Bureau of Criminal Statistics (1972) and the U.S. Census Bureau (1970).

## 6. Project Impact

### a. Impact Measures and Samples Used

Impact of treatment on client behavior has been reported by Sacramento Methadone in terms of decreases in criminal behavior and illicit drug use, and increases in social functioning, employment, and education. The SSI evaluation team has reviewed project records in order to corroborate the project's reported findings, and to extend these results by independent checks of some clients through probation and parole records.

A sample of 37 clients on probation or parole was selected for the assessment of criminal justice impact -- 23 probationers, 14 parolees, and 6 both. Thirteen clients of this sample were also in the random client sample selected to describe client attributes (Section II.A.3). The arrest and related data (as described in Section II.A.5) were obtained from files at the main Sacramento County probation office and at the Sacramento area probation office. Data were generally collected for a period beginning at one year prior to treatment and ending with December 1973.

### b. Criminal Justice Involvement

Information on prior arrest histories of clients is needed to gauge the improvement reflected in later arrest data, and to obtain a differentiated picture of the client types best suited for Sacramento Methadone. Table 18 shows client arrest rate prior to treatment for clients in the probation/parole sample described above compared with the total population. Total arrest rate for the probation/parole sample was 193 arrests per 100 client years. By comparison, the third column of Table 18 shows arrest rates prior to treatment for the entire client population of Sacramento Methadone, as estimated from the random sample.

Here, the total arrest rate was 85 arrests per 100 client years. The probation/parole sample thus represents a group with more intense criminal life style than the total client population. Both estimates are significantly higher than the estimated arrest rate of 50 per 100 client years made by the project.* However, sample estimates are based on the year prior to treatment, and another source indicates that a sharp rise occurs in the arrest rate during the two quarters immediately preceding entry into treatment.**

The client arrest data show that total arrest rates for minority groups are substantially higher than for non-Hispanic whites. The difference between black and non-Hispanic white is particularly apparent in property crime arrests, where black arrest rate (122/100 client years) is over two times higher then non-Hispanic whites at 53/100 client years. However, arrest rate for blacks (11/100 client years on drug charges is 4 times lower than the rate for non-Hispanic whites (42/100 client years). This result might be due to differences in law enforcement in black and white areas, or to differences in types of drugs and drug use conditions in the two areas. Both of these possibilities were postulated by local county probation officers. The higher arrest rate of the blacks and Hispanic whites is also shown in the baseline criminal statistics given in Table 18, which shows a close correlation by race between client and general population rates.

The relation between Hispanic and non-Hispanic white arrest

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* Third year grant extension request, Sacramento County Methadone Maintenance Program, OCJP-0643, 8-6-73.

** R. G. Newman, et. al., "Arrest Histories Before and After Admission to A Methadone Maintenance Treatment Program," 1973 Proceedings, 5th National Conference on Methadone Maintenance.

rates is more regular, with the Hispanic group having higher arrest rates in both property and drug offenses in proportionate amounts. The consequences of drug use are illustrated by the differences in the importance of drug and property arrest rates between the client sample and baseline data for Sacramento County. In the baseline data, these arrests account for 22% of all arrests, while in the client sample, these arrests make up 57% of the total. This difference would be expected for heroin addicts, most of whom are nonviolent, and some of whom steal to support their habits.

Arrests records before and after initiation of treatment are compared in Table 19 by age group. In terms of total arrests rates, slight improvement is observed for the younger group (18-24 years) but a significant improvement is shown for the older age groups. Totals over the entire sample show a reduction in arrest rate from 193 to 82 arrests per 100 man years. This arrest rate, while a distinct improvement, is still quite high and is comparable to the arrest rate of the entire client population before entry into the project (i.e., 85 arrests/100 client years).

These figures are all much higher than those reported by the clinic for the total client population. A program report for the end of 1972 indicated that 6% of the clients seen up to that date had been lost because of convictions of a crime. Total arrests up to the time of the report were estimated at 50. This suggests an arrest rate of 10 to 20 per 100 client years. This figure is consistent with results of the clinic sample where rap sheets showed about 20% of the clients with at least one arrest and an approximate arrest rate of 23 per 100 client years. However, not all rap sheets are completely up to date, so that this arrest

Table 19

SACRAMENTO METHADONE
PROBATION/PAROLE CLIENT ARREST RATES
BY AGE GROUP
(Arrests per 100 Client Years)

Arrests per 100 Client Years by Age Group - Before and After Treatment

| Crime Type | 18-24 Years | | 25-39 Years | | 40 Years and Over | | Total by Crime Type | |
|---|---|---|---|---|---|---|---|---|
| | Before | After | Before | After | Before | After | Before | After |
| Personal | 12 | 0 | 9 | 9 | 0 | 0 | 8 | 6 |
| Property | 29 | 39 | 77 | 14 | 112 | 47 | 68 | 23 |
| Nonvictim Drug | 53 | 31 | 34 | 7 | 50 | 24 | 42 | 14 |
| Nonvictim Other | 6 | 0 | 3 | 7 | 0 | 0 | 3 | 5 |
| Miscellaneous | 53 | 62 | 86 | 32 | 50 | 0 | 72 | 34 |
| Total | 153 | 132 | 209 | 69 | 212 | 71 | 193 | 82 |
| % clients with decreased arrest rate since entry | 67% | | 77% | | 100% | | 78% | |
| % clients without arrests since entry | 33% | | 41% | | 50% | | 41% | |

rate must be considered a minimum value. A comparison of this latter estimate with the client population arrest rate prior to treatment (85 per 100 client year) indicates possible improvement for the client population.

A comparison of the Sacramento Methadone results with results reported for other samples of addicts is given as follows. The sample in one source* was a nonvoluntary criminal justice group, whose arrest rate was reduced from 250 per 100 man years to 47 per 100 man years--an 80% reduction, which is better than that for the probation/parole sample at Sacramento Methadone. Other samples of voluntary

* 1973 Proceedings, op.cit.

clients showed arrest rate reductions of from 57% to 82%. Voluntary clients with a lower arrest rate prior to entry into treatment achieved the same proportionate reduction in arrest rate as the nonvoluntary sample. Sacramento Methadone's client population as a whole indicate comparable results.

Arrest rate information must be interpreted with care since it represents an average result over a group of clients. Thus, a few clients who are doing badly tend to mask a real improvement in the performance of others. In this regard, as mentioned above, Table 19 showed little improvement for the 18-24 year group. However, the table also shows that 67% of this group had a reduction in arrest rates during the period examined, and 33% were without arrests during the period.

The decreased incidence in arrest with greater age is also exemplified in this table; 77% of the 25-39 year group and 100% of the 40 and over group showed lower arrest rates after beginning treatment. The proportion without arrests also increases with age--from 33% for the 18-24 year group to 41% for the 25-39 year group and 50% for the 40 and over group. On the basis of observed frequencies of probation/parole without arrest in the year prior to treatment, the probability of going a year without arrest, in the absence of treatment, is 0.08.

The arrest trend data in Table 20 indicate that nonvictim drug arrests are increasing, as well as total crimes. This tends to indicate an appreciable change in law enforcement during the period of this study, or an increase in the frequency of drug use.

Table 20

SACRAMENTO METHADONE
SACRAMENTO COUNTY ARREST TREND DATA*

Percent of Total Arrests for Given Years

| Crime Type | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 |
|---|---|---|---|---|---|---|
| Personal | 5.72% | 4.63% | 4.93% | 7.34% | 8.08% | 7.98% |
| Property | 11.65 | 11.20 | 12.19 | 13.45 | 11.31 | 13.61 |
| Nonvictim drug | 2.64 | 3.75 | 5.25 | 7.64 | 9.11 | 7.69 |
| Nonvictim other | 44.92 | 43.79 | 45.31 | 42.90 | 37.47 | 30.30 |
| Miscellaneous | 35.07 | 36.63 | 32.32 | 28.67 | 34.03 | 40.42 |
| Total number of arrests | 24,929 | 25,062 | 25,734 | 25,285 | 28,321 | 26,454 |

* Arrest data provided specifically for this evaluation by Bureau of Criminal Statistics, Sacramento, California, 1974.

c. Drug Usage

Reduction in illicit drug usage by clients is monitored by weekly random sampling of urine. The director interview established an approximation of positive urine samples at 30% positive for heroin, 10% positive for barbiturates, and 5% positive for amphetamines. The annual report to HEW (January 31, 1973) indicated that 67% of the clients who had been in the program for more than two months had no positive urines for a period of two months or more. Only 9% of these clients were found to have positive urines more than once a month over the reporting period. The reduction in drug usage is consistent with the 67% reduction in drug arrests in the probation/parole client sample.

Some clients have legal prescriptions for codeine from outside doctors and are allowed to get them filled. This is part of the client's effort to keep using other opiates, continuing to reinforce rather than reduce his dependence on and abuse of drugs.

d. Other Measures of Impact

Employment of clients has generally improved since their entry into the program. About 31% of the clinic sample were employed at entry. This compares with an earlier clinic estimate (September 1972) of 18% employed on entry. The clinic's CODAP report for the third quarter of 1973 shows 62% with full time employment and 8% with part time employment. Comparable figures from the clinic sample showed 60% of clients with at least part time employment since entry into the program.

Improved social functioning has been observed by the program staff in terms of maintenance of established schedules for treatment, behavior at the clinic, reports of improved family relationships, etc. However, these events are not generally recorded in a manner that makes them susceptible to quantitative description. (See suggested use of "goal-oriented system" in Section II.A.2.)

7. Project Potential

a. Cost-Benefit Measures

This section examines the unit costs to achieve the impact discussed in the preceding section. Table 21 compares several cost-benefit measures that can be applied to Sacramento Methadone. Funding figures are based on budget statements for the 1973 fiscal year. A breakdown of amounts and sources of funds is as follows:

| | |
|---|---|
| Medi-Cal (federal) | $ 48,955 |
| Medi-Cal (nonfederal) | 104,384 |
| Grants (OCJP, NIMH) | 96,465 |
| Short-Doyle | 273,251 |
| Total (treatment) | $523,055 |

Table 21

SACRAMENTO METHADONE
COST-BENEFIT MEASURES

| | |
|---|---|
| Total Funds (Fiscal year 1974) | $523,055 |
| # Graduates per year | NA |
| Total clients per year (capacity) | 300 |
| % Clients improved | 78% |
| % Clients arrest free | 41% |
| $ Client year | $1,744 |
| $ Graduate* | $4,360 |
| $ Improved client per year | $2,235 |
| $ Arrest free client per year | $4,252 |
| $ Attendance day | $4.78 |
| % Drug free | 67%** |
| # Drug free | 180 |
| $ per year drug free client | $2,906 |
| $ Drug free day | $5.74 |

* Assume withdrawal of 80% of clients after 2 years (10% split per year).
** In program 32 months.

Short-Doyle funds are figured on the basis of 65,382 visits for methadone treatment at a provisional rate of $8/visit. The NIMH grant, which covers the last 50 clients in the program, allows payment at a rate of $1,360 per patient year. This arrangement causes a front-end loading problem since generally more service is rendered to clients during their initial visits than at later times.

Definitions of terms and measures used in Table 21 are as follows:

- o Cost per client year - the cost to support one client in treatment for a year.
- o Cost per graduate - total budgeted treatment funds divided by the total reported number of graduates.
- o "Improved client" - a client whose arrest rate after start of treatment is lower than the average arrest rate in the two years prior to treatment.
- o "Arrest free client" - a client without arrests after start of treatment.

Cost per client year is based on the current condition of full utilization of capacity (300 clients). This approach results in a cost of $1,744 per client year. This result falls within the range of costs noted in a recent Ford Foundation report* ($500 to $2,000). Other sources quote a range of $500 to $2,500 per client year.** The range is caused in part by the amount of ancillary services provided. If the client was withdrawn from maintenance after two years as currently suggested, the total cost of treatment per "graduate" might be estimated to be about $4,360 (assuming 10% attrition in clients per year). This value is less than the unit cost associated with classical therapeutic communities but more than costs per graduate of ambulatory centers and the short term residential communities.

In relation to decreased criminal behavior, results based on the probation/parole sample yield unit costs of $2,235 per improved client and $4,252 per arrest free client. It is worth noting that these later measures give higher unit costs than the measure, $/client year. This is the opposite of the result for the other modalities, partly because most other modalities complete treatment in less than a year, while methadone maintenance runs generally for 2 or more years. Although measures such as $/arrest free client appear to provide a better basis for comparison among modalities, a definitive comparison cannot be made here because of the inherent differences in sample conditions. For instance, in such a study, clients in all modalities would have to be tracked at least two years subsequent to start of treatment to provide a common basis for comparing arrests records.

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* "Dealing with Drug Abuse," A Report to the Ford Foundation, 1972.
** 1973 Proceedings, op.cit., p. 1228.

In terms of decreased drug abuse, Sacramento Methadone indicates that 67% of clients in the program two months or longer have been drug free. About 90% of the clients were in this category, giving about 180 drug free clients or a cost of about $2,900 per year per drug free client. Sacramento Methadone also indicates that only 9% of the clients have positive urines more than once a month. On the conservative assumption that the remaining 31% are clean 75% of the time, a cost of $5.74 per drug free day is obtained. This value may be compared with the cost of the drug habit on the street, which has been varously estimated as $30 to $300 per day, depending on what cost items are included. It is also worth noting the comparison between cost per drug free day and $/attendance day ($4.78). This latter measure has been used as an approximation of cost per drug free day. The relationship between these two costs will depend strongly on the modality under consideration. These costs would be almost equal in an isolated therapeutic community but would probably be quite different in a drug free ambulatory setting, where clients had constant access to drugs on the street.

b. Suggested Project Modifications

This project (like The Aquarian Effort) suffers from the lack of a county drug abuse coordinator to develop the requisite group of complementary agencies. In this case the need is for a good therapeutic community to provide an alternative to methadone for the hard core addict. The therapeutic community would also provide the agency with a source of the type of staff (well-trained ex-addict) to round out Sacramento Methadone's current professional staff.

This project needs to implement the hiring of well-trained ex-addicts, some from minority groups. These additions will help create a

group therapy program (in which this staff can act as therapists) and will also help the project's image in the community and in its training program. The training program needs more emphasis on treatment of character disorders and addictive personalities. There is a need for development of legal services for clients, in some areas. There is also a need for improvement in relationships with law enforcement agencies. These improvements would be more easily achieved if there were a county coordinator.

A group therapy program should also create a slow methadone withdrawal therapy group, as the emphasis of the project shifts in this direction. Also needed is space expansion, since space is inadequate for current needs, and would be even more urgently needed for expansion into more group therapy. Part of this line of expansion is to create aftercare services for "graduates" of long term detoxification, who should remain eligible for group therapy and all other supportive services. These returning clients strengthen the program, acting as role models and support to other clients, in a way similar to the ex-addict staff.

When this qualititive line of expansion has been well implemented, the program should expand with another clinic, preferably in a minority area and with a heavier representation of minority groups on the staff.

B. The Aquarian Effort

1. Services Provided

The Aquarian Effort is a diverse community-based project for combating drug abuse, and consists of three facilities: a large house in downtown Sacramento, containing a six-bed detoxification unit; another large house about a block away, containing a crisis line counseling service on the main floor and a free medical clinic on the second floor; and the project's offices a few miles away, on the second floor of a four-plex. In addition to detoxification, crisis line counseling, and the free medical clinic, the principal services provided by The Aquarian Effort include a free legal clinic, and a drug abuse education program conducted in conjunction with local schools.

a. Detoxification Unit

The inpatient detoxification unit treats about 30 clients per month, most of them heroin abusers. One of the most impressive services of The Aquarian Effort, this unit is located in a clean attractive building, and has a calm pleasant atmosphere and a staff with high morale. These characteristics are not usually found in detoxification units. Until recently, patients were detoxified using Darvon N.* This drug was discontinued because of a federal regulation requiring projects to use this drug only for research purposes. To operate within this regulation, the Aquarian Effort has developed a research program in conjunction with the Haight-Ashbury Clinic in San Francisco for the use of Darvon N. If this research program is approved, Aquarian will resume use of Darvon N in the detoxification unit.

One of the major problems faced by the detoxification unit

* Darvon N has been found to be much more satisfactory in heroin detoxification than supportive medications, such as Valium, which are currently being used.

is a lack of treatment and rehabilitation projects in the Sacramento area, to which clients can be referred after detoxification. Some of the clients can be, and are, referred to the Sacramento Methadone Maintenance Program. Other alternatives, such as residential therapeutic communities and other drug-free modalities, are not locally available; these would provide follow-up treatment for those who could be helped without methadone. The Aquarian detoxification staff is also providing brief outpatient follow-up counseling for clients believed receptive to it.

b. Crisis Line Counseling

The 24-hour crisis line service receives 2,500-2,700 phone calls per month ranging from true crises such as drug overdoses to information calls concerning the hours of the free clinic. The name "crisis line" covers both the crisis telephone answering service and the outpatient counseling service of the Aquarian Effort. Both services are handled by the same group of people in four shifts over a 24-hour day, seven days a week. They have two vehicles that are used to respond to emergency medical calls, mostly first aid for acute drug reaction. They handle about 30 such calls per month and appear to be skilled in this area. They have no oxygen or resuscitation equipment but are trained by the Red Cross in cardio-pulmonary resuscitation. The physician in the medical clinic is sometimes available to give Naline for drug overdose. Additional crisis services include talking down bad psychedelic trips, giving emergency counseling, referral, and practical assistance, such as job and housing information.

The ongoing group and individual counseling service provided by this unit is an extension of the crisis phone service. Individual

counseling is the predominant therapy. About 250 individual counseling sessions are handled per month, directed primarily toward young adults with drug and emotional problems. These young adults include both drop-in or one-visit clients and registered clients who are interested in more extended therapy and who are given an intake interview. The present case load of registered clients in group and individual counseling ranges from 200 to 270.

Light group therapy is also employed and is being expanded. At the time of the site visit there was one facilitator running four therapy groups and three training groups. Currently there are five therapy groups, involving 48 clients (7-10 per group) and one group leader training group. They are striving for 8-10 groups.

c. Other Services

The free medical clinic treats 25 to 40 patients nightly for five days per week, and the free legal clinic, staffed by two paid lawyers, operates twice a week. The drug education program previously provided services to 23 schools in the district, but recently has been extended to cover all the schools of the Sacramento Unified School District on an as-needed basis.

Other services include public lectures on drug abuse, drug education in diversion programs, counseling assistance to the California Youth Authority for institutionalized juveniles with drug problems, and cooperation with local groups working to establish drug abuse treatment and rehabilitation policy.

d. Referral and Screening

Aquarian has referral agreements with about 50 agencies, including hospitals, physicians, welfare agencies, parole, probation,

and the Sacramento Methadone Maintenance Program. From some of these agencies, Aquarian receives individual client referrals or requests for community services such as drug education; and refers clients or inquiries to other of these agencies.

Most criminal justice referrals to Aquarian for detoxification are parolees and probationers with severe addiction problems. The crisis line counseling is appropriate for lighter drug problems and has received only informal referrals* from criminal justice agencies in the past. Recently, however, probation has formally referred six young adults, problem cases, to Aquarian for counseling. Most of these clients went through detoxification before entering counseling. Typically, light drug offenders handled by probation through the adult diversion programs are diverted to a County Mental Health outpatient drug program set up especially for the diversion programs. However, The Aquarian Effort does provide regularly scheduled senior counselors to this program for counseling and drug education, as does the Methadone Maintenance Program.

Table 22 shows the referrals made to the crisis line counseling service by type of referral. These figures are based on client responses on intake forms for a random sample of 69 registered clients. The referrals shown here are those stated by the client and could be either formal or informal. The interesting point here is the number of clients (72.5%) who come in on casual advice (family, friends, other client, self). This result, as well as the high utilization of the crisis phone service, is probably due in part to Aquarian's excellent public relations and educational efforts.

*Formal referral: sending a person to a specific agency with specific instruction to attend. Informal referral: advising a person to get help.

Table 22

AQUARIAN EFFORT
REFERRAL SOURCE COUNSELING

| Referral Source | Percent |
|---|---|
| Parole/probation/court | 10.1% |
| Medical | 2.9 |
| Community (treatment programs, lawyer, etc.) | 2.9 |
| Other Community Source (clergy, schools, etc.) | 11.6 |
| Family (friends) | 13.0 |
| Other client | 1.5 |
| Self | 58.0 |
| Total | 100.0% |

N = 69

We were unable to obtain estimates of the volume of external referrals made by Aquarian. Although the detoxification unit has referred several clients to Methadone Maintenance after detoxification, probably the total volume of external referrals is small, because of the lack of viable alternatives for treatment of people with heavy abuse problems in the Sacramento area. In view of this lack, Aquarian has established a brief outpatient follow-up counseling service in the detoxification unit, and a hot line counseling service. These groups appear to be counseling a substantial number of hard core addicts and others who could be referred to more suitable modalities if they were available.

The crisis line phone service will not usually provide referral agencies to callers by phone, but tries to get the caller to come in first, so that a decision on further help or referral can be made on a face-to-face basis. However, crisis line does make other referrals for community services, such as medical help. From observations during our first site visit and from subsequent review of client records, it would appear that referral efforts could be improved by more systematic referral procedures.

## 2. Treatment Philosophy, Objectives, and Criteria

### a. Treatment Philosophy

The Aquarian Effort began primarily as a counseling and referral agency, but found that these services were not adequate for the community. The director believes that traditional agencies are too slow in responding to changing drug use patterns in the community whereas the Aquarian Effort has changed its emphasis from psychedelics to heroin to polydrug users. He believes that drug abuse is one of a number of symptoms of social, economic, and psychological dependence, and also one of a number of forms of dysfunctional behavior especially affecting minority groups and youth. While the project's objective is non-drug use, some of the staff members seem willing to accept "responsible" drug use.

### b. Impact-Oriented Objectives and Associated Measurement Criteria

Current and suggested objectives and measurement criteria are summarized in Table 23. The objectives, while appropriate, are stated in too general a way, and therefore some modifications are suggested. The criteria for measurement deal mainly with activity level of the project, and therefore some impact-related measurements are suggested.

The first objective of the project is: " to create an intense awareness among responsible adults of the problems and ways to begin to correct conditions that contribute to the problem." This objective is appropriate but they should add that efforts are directed at motivating "responsible adults" to take effective action to reduce the drug problem in the community. Measurement criteria such as "number of speaking engagements" and "number of training sessions"

Table 23

AQUARIAN EFFORT
OBJECTIVES AND MEASUREMENT CRITERIA, WITH ADDITIONS



| OBJECTIVES | CRITERIA USED | ADDITIONS TO CRITERIA |
|---|---|---|
| Create awareness and ways of correcting conditions<br>ADD: motivate to take action | Number of speaking engagements<br>Number of training sessions<br>Responses to questionnaires*<br>Letters and awards(?)** | Number and source of referrals<br>Donations of funds and services<br>Number of employment opportunities<br>Number and type of support actions |
| Rehabilitate drug users and redirect toward solutions<br>SUBSTITUTE FOR SECOND PART:<br>Integrate into community | Number of admissions<br>Number of O.D. emergencies<br>Case load<br>Number of crisis calls<br>Number of counseling sessions<br>Number of counselors<br>Letters and awards(?)** | Number of positive client separations<br>Number of clients reaching goals<br>Number of arrests and convictions<br>Decrease in drug use<br>Number of reentering clients<br>Number of clients employed |
| Direct former users into youth preventive efforts. | Number of counselor training sessions<br>Number of speaking engagements to youth<br>Responses to questionnaires*<br>Letters and awards(?)** | Number of former clients in efforts<br>Number of other individuals in efforts<br>Number of man days of this activity<br>Number of youth in training sessions |
| Outreach to wide spectrum of drug users | | Number of applicants first time in any program<br>Number of applicants from neglected groups<br>Number of crisis telephone calls<br>Number of O.D. emergencies |

* The questionnaire approach has not as yet been implemented.
** Question mark indicates questionable concept.

measure activity rather than impact. The proposed effort to get "responses to questionnaires" could be useful if responses indicate a positive commitment of the person to take some specific action (e.g., contribute financial support, volunteer for some service, etc.). "Letters and commendations" are undoubtedly useful and rewarding to the project but cannot provide the basis for an unbiased estimate of impact. Suggested additional criteria are aimed at providing measures of actions taken by adults and organizations in response to the project's efforts. These measures could be summarized on a monthly or quarterly basis along with the currently used activity measures.

The second objective is: "to rehabilitate drug users and redirect their energies and talents toward the solution." The first part of this objective is, of course, basic since it implies most of the client-related goals including: reduction or elimination of drug use, development of socially useful life styles, employment, etc. The final portion of the objective, "redirecting . . . toward the solution," is not sufficiently specific. To the extent that this phrase implies that former users should be directed into drug prevention activities, it appears to overlap with the third objective. When viewed as part of the therapeutic process, these activities need not be included in the statement of the impact-oriented objectives. The criteria of measurement currently used are largely measures of activity. To the extent that an emergency situation is alleviated, the criteria of "overdose emergencies" and "crisis telephone calls" can be considered measures of impact. The table indicates other measures of impact that are appropriate for measuring progress toward rehabilitation from drug use. Data for making measurements are available in the project for at least some of these

measures (i.e., number of positive separations of clients from project, number employed, etc.). Other measures might require additional effort on the part of the project.

The third objective calls for "directing the most capable and effective former users and concerned individuals" in preventive efforts oriented toward youth. This objective is appropriate for this agency as long as it does not represent a policy of directing all "capable" former users into the drug prevention or treatment work. Evidence shows that many former users are better served by engaging in constructive activities not related to the drug field. Criteria currently used are predominantly activity measures. Again, with this objective, questionnaires are impact-related where they indicate a commitment to take some specific action in support of the objective. "Number of speaking engagements to youth" is appropriate where use is made of former clients. Other impact measures that would be appropriate would measure the number of individuals engaged in these preventive activities, and the total level of effort expended (i.e., number of man hours devoted to this activity during the reporting period).

An objective that might be added would be: "to develop an outreach capability to involve a wide spectrum of drug user types in treatment and rehabilitation." One of the great strengths of The Aquarian Effort is its ability to reach people. However, minority groups are not currently represented among clients in sufficient numbers. Involving neglected groups of users would be a first step in achieving an additional impact on the community and should be recognized as a positive contribution to any countywide drug abuse program. Suggested measurement criteria would include numbers of

applicants who are entering a program for the first time, and applicants from neglected user groups. Crisis telephone calls and overdose emergencies would also be appropriate for this objective.

3. Client Attributes

a. Client Criteria

Sacramento County has several treatment programs for specific client types (ex-convicts, Mexican Americans, diverted light drug offenders, hard core heroin addicts). However, these programs satisfy only a fraction of the county's treatment demand. The Aquarian Effort responds to the unmet demand by providing a variety of services for a broad range of clients, including: light abusers; addicts unwilling or unable to qualify for methadone treatment; users with criminal justice involvement too serious for diversion; and people with drug related crises. In addition, Aquarian attempts to reach potential users via education and information programs.

The crisis line counseling service devotes more than half of its time to operating the crisis line phone service and responding to crises; the remainder is spent in face to face individual and group counseling. The staff feel that their counseling is most successful with young, non-Hispanic white, middle class users of psychedelic drugs, abusers of amphetamines and barbiturates, and occasional heroin abusers who want help.

Client types in this unit range from one-time drop-ins who stay for only a few minutes to scheduled clients who come in for therapy over a period of months. In terms of problems, the types handled by the crisis line counseling service range from counseling light heroin abusers to hard core addicts; from heavy to light abusers of other drugs;

and from individuals and families with relationship or drug problems to individuals with emotional or drug crises including overdoses and bad psychedelic trips. There are also people needing advice on housing, welfare, V.D., abortion, and legal status (most of these are referred to Aquarian's free legal clinic). Much of the assistance provided, both by telephone and in person, is for one-time problems or advice. Counseling is done in person at the clinic and in some instances in outside visits usually related to crises. In addition to general advice, some counseling also takes place on the phone.

The detoxification unit deals exclusively with heroin addicts, ranging from recently addicted persons to hard core addicts with long term habits. Barbiturate detoxifications are done at the county hospital or other medical facilities because the high hazard of this service requires more intensive medical surveillance. Many detoxification clients are interested in eliminating their habits, and receive some outpatient follow-up counseling from the detoxification staff. Some others are possibly in detoxification to reduce their habits because their tolerance has become high enough to make their habits excessively expensive. There are a substantial number of criminal justice referrals to this unit.

The school team and other community education efforts of Aquarian have no specific clients, but rather groups of students, faculty, and other community groups with whom they work in a lecture or discussion format. Although some of this education effort deals with pharmacological and environmental aspects of drug abuse, most of it concerns value clarification, group dynamics, and other relationship oriented subjects that are only indirectly related to drug abuse. It is difficult to classify the diverse school and community audiences

to a more specific level than (1) people in an age group who are exposed to, and vulnerable to, drug abuse; (2) people who, because of their jobs (e.g., teachers), are associated with drug abuse problems; or (3) the general public who desire information concerning drug effects and abuses.

Other client groups are: diverted light drug offenders in treatment in the county mental health department's diversion program where some Aquarians help in counseling and drug education; some incarcerated juveniles who receive Aquarian counseling in coordination with the California Youth Authority; and clients using the free medical clinic's services.

b. Client Demographics

Client characteristics for those served by the crisis line counseling unit are described on the basis of a random sample of intake forms for 72 registered or scheduled clients.* Of these, 35 were currently in treatment at the time of the site visit, and 37 were in treatment in mid-1973 and have subsequently terminated. Table 24 shows the demographic characteristics of clients in this unit, with 84% non-Hispanic white, 38% female, and a median age of 22 years (less than 12% of the sample are over 35). These statistics compare very well with the counseling staff's demographics (see Table 29 ). Here again, the low level of minority participation is evident, and could be due to the distance of the project from minority neighborhoods, or to the emphasis of the project's outreach efforts.

The educational background of the crisis line counseling clients in the sample is: 22.5% have not completed high school, 22.4% have completed some college, and 11.6% have college degrees, with some

* Registered or scheduled clients are those for whom intake forms are filled out and who have received some face to face counseling. Intake forms are not made out for drop-in clients.

Table 24

AQUARIAN EFFORT
DEMOGRAPHICS FOR CRISIS LINE COUNSELING CLIENTS

| | Race/Ethnic/Sex | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Hispanic White | | Black | | Non-Hispanic White | | Other | | Total | | |
| Age | M | F | M | F | M | F | M | F | M | F | T |
| 15 - 19 | 1.5% | | | | 5.9% | 13.2% | 1.5% | | 8.9% | 13.2% | 22.1% |
| 20 - 24 | 1.5 | | 1.5% | 2.9% | 27.8 | 14.7 | | | 30.8 | 17.6 | 48.4 |
| 25 - 29 | | | | | 7.4 | 4.4 | | | 7.4 | 4.4 | 11.8 |
| 30 - 34 | | | | | 4.4 | 1.5 | | | 4.4 | 1.5 | 5.9 |
| 35 - 39 | 2.9 | | | | | | | | 2.9 | | 2.9 |
| 40 - 44 | | 1.5% | | | | | 1.5 | | 1.5 | 1.5 | 3.0 |
| 45 - 49 | | | 1.5 | | | | | | 1.5 | | 1.5 |
| > 49 | | | | | 4.4 | | | | 4.4 | | 4.4 |
| Total | 5.9% | 1.5% | 3.0% | 2.9% | 49.9% | 33.8% | 3.0% | | 61.8% | 38.2% | 100.0% |

N = 68
NR = 4

having postgraduate training. These data, coupled with the fact that the clients are generally young and many of them are still in school, imply a well-educated and therefore middle class or upper middle class clientele.

Attributes of clients is the detoxification unit, as estimated from a sample of 91, are presented in Table 25 . The client population is similar to that of Sacramento Methadone. The racial distributions are also similar between these two projects, compared to that of the Aquarian crisis line counseling sample where the minority representation is much lower. The clients in detoxification are younger, and there are more females than at Sacramento Methadone -- a condition that speaks for an alternative to methadone maintenance in the area for the younger or less severely addicted clients.

Table 25

AQUARIAN EFFORT
DETOXIFICATION CLIENT DEMOGRAPHICS

| Age | Race - Ethnic / Sex | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Hispanic | | Black | | White | | Other | | Total | | |
| | M | F | M | F | M | F | M | F | M | F | T |
| 15 - 19 | | | 2.2% | | | 3.3% | | 1.1% | 2.2% | 4.4% | 6.6% |
| 20 - 24 | 3.3% | | 2.2 | 2.2% | 14.3% | 14.3 | 4.4% | | 24.2 | 16.5 | 30.7 |
| 25 - 29 | 2.2 | | 4.4 | 2.2 | 12.0 | 5.5 | | 1.1 | 18.6 | 8.8 | 27.4 |
| 30 - 34 | 3.3 | | 2.2 | | 3.3 | | | | 8.8 | | 8.8 |
| 35 - 39 | 3.3 | | | 3.3 | 1.1 | | 1.1 | | 4.4 | 4.4 | 8.8 |
| 40 - 44 | 1.1 | | 1.1 | | 1.1 | 1.1 | | | 3.3 | 1.1 | 4.4 |
| 45 - 49 | 1.1 | | 1.1 | | 1.1 | | | | 3.3 | | 3.3 |
| Total | 14.3% | | 13.2% | 7.7% | 32.9% | 24.2% | 5.5% | 2.2% | 64.8% | 35.2% | 100.0% |

N = 91

Table 26

AQUARIAN EFFORT
COMPARISON OF CLIENT DEMOGRAPHIC CHARACTERISTICS WITH BASELINE CENSUS DATA FOR SACRAMENTO COUNTY (AGES 15-69)

| | Counseling Clients | Detox Clients | Census |
|---|---|---|---|
| Sex | | | |
| Male | 61.8 | 66.0 | 49% |
| Female | 38.2 | 44.0 | 51 |
| Race/Ethnic | | | |
| Hispanic white | 7.4 | 14.3 | 6 |
| Non-Hispanic black | 5.9 | 20.9 | 5 |
| Non-Hispanic white | 83.7 | 57.1 | 84 |
| Other | 3.0 | 7.7 | 5 |
| Age Group | | | |
| 15 - 19 | 22.1 | 6.6 | 15 |
| 20 - 24 | 48.4 | 40.7 | 13 |
| 25 - 29 | 11.8 | 27.4 | 10 |
| 30 - 34 | 5.9 | 8.8 | 9 |
| 35 - 39 | 2.9 | 8.8 | 9 |
| 40 - 44 | 3.0 | 4.4 | 10 |
| 45 - 49 | 1.5 | 3.3 | 10 |
| 50 - 69 | 4.4 | 0.0 | 24 |

Table 26 shows the differences between the Aquarian client demographics and baseline Sacramento County population statistics. Of significance is the high correlation between the Census racial breakdown and that of the crisis line counseling clients. They are racially representative of the county population. But as was described in Section III.A.3, heroin addiction among blacks is probably more than twice that among whites, implying that the client racial distribution is not representative of the abuse problem.

Table 27 is a summary of available drug history data (frequency of abuse at time of entry) for the Aquarian crisis line counseling client sample. The table shows that about 90% of the counseling clients are abusing some drugs (exclusive of alcohol and marijuana), and 68% are using drugs regularly, at least once a week, with 44% using

Table 27

AQUARIAN EFFORT
AGE VS. FREQUENCY AT TIME OF ENTRY - CRISIS LINE COUNSELING

MARIJUANA

| Age | Not Using | < Weekly | At Least 1/wk (Not Daily) | Daily | Total | | |
|---|---|---|---|---|---|---|---|
| 15 - 19 | 12.5%* | 12.5% | 56.3% | 18.7% | 23.2%** | (16) | N = 72 |
| 20 - 24 | 18.2 | 12.1 | 39.4 | 30.3 | 47.8 | (33) | NR = 3 |
| 25 - 29 | | 12.5 | 37.5 | 50.0 | 11.6 | ( 8) | |
| > 29 | 66.7 | | 8.3 | 25.0 | 17.4 | (12) | |
| Total | 23.2% | 10.1% | 37.7% | 29.0% | 100.0% | (69) | |

ALL DRUGS EXCLUSIVE OF MARIJUANA AND ALCOHOL

| Age | Not Using | < Weekly | At Least 1/wk (Not Daily) | Daily | Total | | |
|---|---|---|---|---|---|---|---|
| 15 - 19 | 18.6%* | 12.5% | 37.5% | 31.4% | 23.2%** | (16) | N = 72 |
| 20 - 24 | 6.1 | 27.3 | 18.2 | 48.4 | 47.8 | (33) | NR = 3 |
| 25 - 29 | 12.5 | 25.0 | 37.5 | 25.0 | 11.6 | ( 8) | |
| > 29 | 8.3 | 16.7 | 16.7 | 58.3 | 17.4 | (12) | |
| Total | 10.2% | 21.7% | 24.6% | 43.5% | 100.0% | (69) | |

* Percentage of "age at entry" group (percent of total in row).
** Percentage of total.

some type of drug daily. A point of interest is that, as shown in the table, 23% of the counseling clients were not using marijuana in the two months just prior to entering treatment. Considering the high frequency of marijuana use shown among the drug abuser population in other treatment facilities, this 23% seems unlikely and is an indication of the questionable validity of drug abuse histories provided by their clients, and abusers in general.

Based on the sample data, 25% of the crisis line counseling clients were heavy heroin abusers, using the drug daily, while the rest were using no heroin during the months prior to counseling. These fractions indicate that at least two distinctly different abuser types are in counseling there. Another point of interest, shown in Table 28, is that females reported a lighter level of hard drug use than males, but a higher proportional use of marijuana.

Table 28

THE AQUARIAN EFFORT
SEX VS. FREQUENCY OF ABUSE AT ENTRY - CRISIS LINE COUNSELING

| | | None | ≤ Weekly | At Least 1/Wk (Not Daily) | Daily | N |
|---|---|---|---|---|---|---|
| Marijuana | Male | 29%* | 7% | 39% | 25% | 41 |
| | Female | 14 | 14 | 36 | 36 | 28 |
| | | | | | | 69 |
| | NR = 3 | | | | | |
| All Drugs Except Alcohol/Marijuana | Female | 19 | 31 | 27 | 23 | 26 |
| | Male | 2 | 17 | 24 | 57 | 42 |
| | | | | | | 68 |
| | NR = 4 | | | | | |

* Percent of males (this row only).

d. Client Retention

Client retention in detoxification ranges from 2 to 9 days, with an average retention of 4.4 days. These figures are based

on a sample of 60 detoxification clients. By comparison, the average retention in Camarillo detoxification is 5-7 days. Aquarian detoxification provides follow-up counseling for clients receptive to it. Of the 60 clients in the sample, 27 received some follow-up counseling. These 27 clients each received an average of 2.5 follow-up individual outpatient counseling sessions from the detoxification staff.

Figure 4 shows client retention curves for the sample of crisis line registered clients in individual counseling. The lower curve represents the early sample from mid-1973, and the upper curve the sample of 35 current clients. The current curve shows an improvement for clients who stayed in treatment more than one month. For the early sample, 25% of the clients stayed more than one month, compared with the sample's median retention of 1.5 months.* Both samples show a high client dropout rate during the first month.

Aquarian's mean client retention of 1.5 months is much lower than Open Door's (over 5 months). At Aquarian, counselees made from 1 to 22 visits, and the median number of counseling visits per client was 1.5 visits. This would tend to indicate that treatment consists primarily of handling one-time episodes rather than providing short or long term counseling. As described above, many clients in the Aquarian crisis line counseling service are rather heavy drug abusers, and long term counseling should be available for some of these if they wish it. This situation relates back to the observation of the evaluators that available treatment modalities in Sacramento County lack diversity. The clients using Aquarian counseling for acute episodes on a short term basis are returning to the street.

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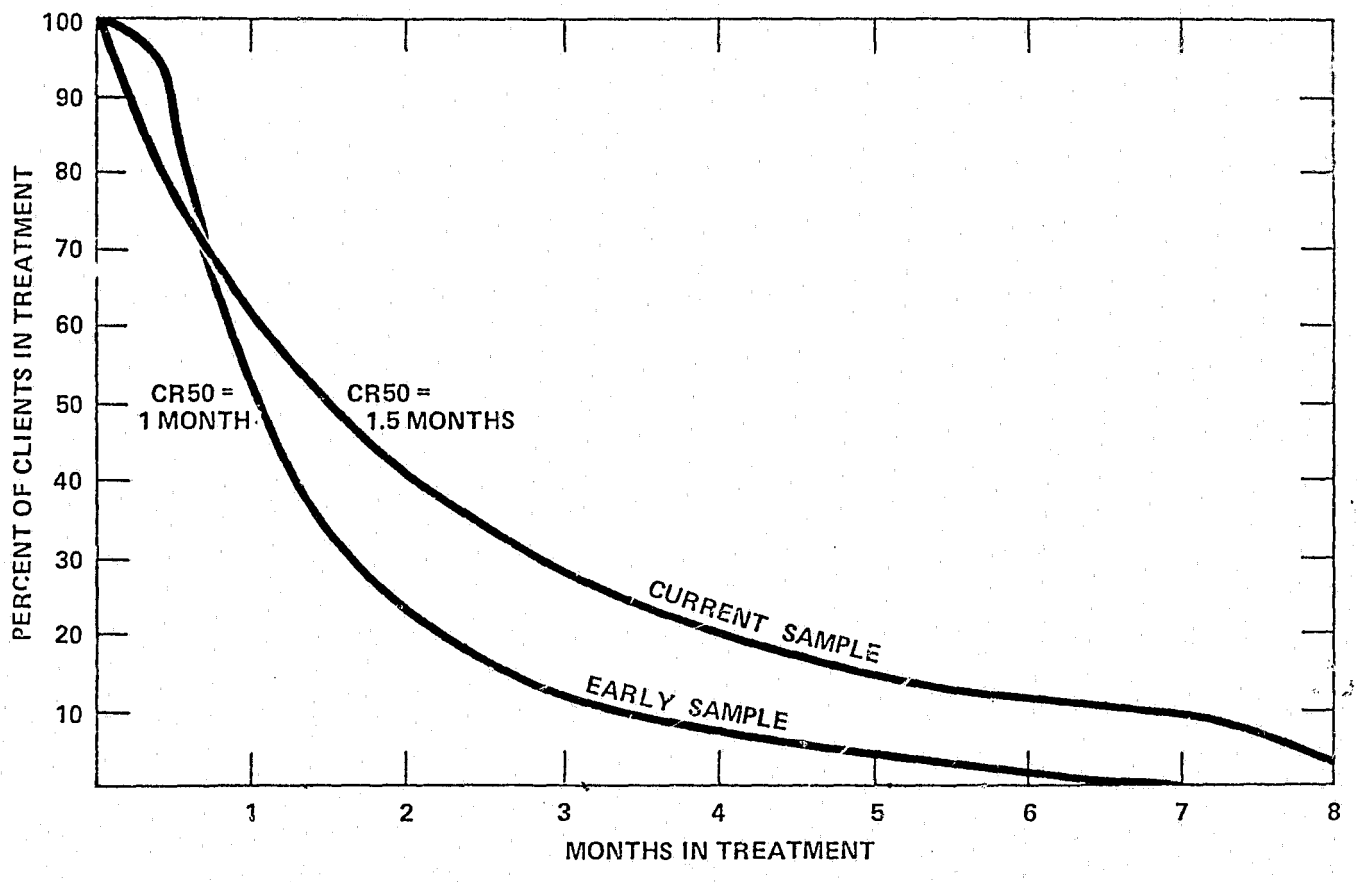
* Since these clients are still in treatment, the true retention curve for current clients would lie above the current sample curve in Figure 4.

Figure 4

AQUARIAN EFFORT – CRISIS LINE CLIENT RETENTION (REGISTERED CLIENTS)



4. Staff Attributes

The Aquarian Effort, with its many activities, has a paid staff of 50-60 and about an equal number of part time volunteers, most of whom work in the free medical clinic. The program has two co-directors -- one administering the total effort, and the other operating the crisis line counseling service. Other senior staff members include the medical director, who is in charge of the free medical clinic; the business manager; the director of the detoxification unit; and the director of the school team (educational unit).

Staff demographics are presented in Table 29, based on a sample of 17 counselors and supervisors representing detoxification counseling, and school team. As shown, all members are young (20-34 years old) and non-Hispanic white, with the exception of one young black counselor. The Aquarian Effort represents a significant portion of available drug abuse treatment in Sacramento, and on the basis of the sample interviewed, its staff does not contain a proper representation of the minority populations in the community.*

Of the staff interviewed, all have completed high school and have had some college education. Of these, 24% have completed college, and two members have done graduate work. There are 35% with some drug treatment experience, and 53% have either drug treatment experience or mental health training. All staff members except one have a history of drug use, and 35% have had criminal justice involvement.

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* The director has stated that his current minority staff is more than representative. (See footnote for Table 29.)

Table 29

AQUARIAN EFFORT*
STAFF DEMOGRAPHICS

| | RACE - ETHNIC | | | | |
|---|---|---|---|---|---|
| Age | Hispanic White | Black | Non-Hispanic White | Other | Total |
| 20 - 24 | | 6% | 35% | | 39% |
| 25 - 29 | | | 41 | | 43 |
| 30 - 34 | | | 18 | | 18 |
| Total | | 6% | 94% | | 100% |

N = 17

* Subsequent to the evaluations, the director stated that his staff contained 6 blacks and 3 Hispanic whites, which would result in an approximate distribution of 15% black, 10% Hispanic white and 75% non-Hispanic white. During our site visits, one or two minority personnel were noted who could have been staff members, but they were not available for interview.

Detoxification unit staff members include the director and ten counselors (one is an LVN). Work is in three eight-hour shifts per day, and counseling is provided. This includes informal problem solving groups. In addition, each counselor typically carries a load of four follow-up counselees, who are counseled on an outpatient basis

after detoxification. The director of the free medical clinic gives part time medical assistance to the detoxification unit for physical examinations, prescriptions, etc. The inpatient staff to client ratio is 1.7:1 (total counseling staff to beds), which is substantially higher than the ratio of Camarillo's detoxification unit (1:2.1), primarily because Camarillo has a larger capacity and because Aquarian's follow-up activities on outpatients are not accounted for in the ratio.

The crisis line counseling service is staffed by a case coordinator (an MSW who also conducts the therapy groups), 22 counselors including four shift supervisors, and two half time social workers. One of the social workers is paid by the county mental health department. Counselors work in four six-hour shifts per day with the shifts staffed according to demand (mid-week afternoon and evening shifts have the heaviest demand and early morning and weekend shifts the lightest). On the basis of 250 registered clients, this services's staff to client ratio is approximately 1:11, the same as that of Open Door's counseling service.

However, a direct comparison on this basis alone cannot be made since the Aquarian counselors have to contend with at least as many drop-ins as registered clients. The same counselors also operate the crisis line phone service, where the traffic is more than four calls per hour during peak hours, according to the Aquarian shift logs. In addition, any crisis needing direct intervention requires that at least two counselors go out on the call. Although counselors on night and early morning shifts were included in the staff to client ratio, these counselors do not schedule clients in for counseling during those shifts. Aquarian policy is that registered clients

should receive at least one hour of counseling every two weeks. Samples of the shift logs indicate no more than 250 individual counseling sessions per month -- or an average of, at most, one individual counseling session per client per month. This scheduled counseling would appear to be inadequate. By comparison, Open Door has a much lower volume of phone calls, fewer transients in counseling, and a work schedule of one shift per day for only five days per week. Even though both staffs have commitments to group therapy sessions and training, the staff to client ratio based only on registered or scheduled individual counseling clients is, in the case of Open Door, much more relevant to actual counseling given.

Table 30 shows the distribution of overall staff time (detoxification, counseling, and school team, as estimated from the sample). From this table, it is seen that the staff spends 28.3% of their time in counseling, 11.7% in training and program oriented meetings, and 18.9% in client intake and record keeping activities.

A survey of crisis line counseling staff time distribution, taken from a sample of their daily shift logs, shows 63% of their time in crisis line activities, 25% in counseling, and 12% in other activities. This diversity of activities, compared to the staff available, is excessive and indicates the necessity for either (a) restructuring and narrowing the objectives of the crisis line counseling unit, or (b) expanding the staff and reducing the number of activities per member.

Individual cases handled by the crisis line counseling unit are informally discussed on the spot with the other staff members, at the option of the counselor. Consultation is therefore not uniform or used in all cases. Consultation and co-counseling are also available

Table 30

THE AQUARIAN EFFORT
DISTRIBUTION OF STAFF TIME*

| Type of Service | Percent of Staff Hours |
|---|---|
| Individual counseling | 21.7% |
| Client intake | 11.5 |
| Maintaining client records | 7.4 |
| Emergency services | 5.2 |
| Staff training - trainer | 5.2 |
| Housekeeping, etc. | 5.1 |
| Client follow-up or aftercare | 4.6 |
| Group therapy | 3.9 |
| Clerical, etc. | 3.9 |
| Staff training - trainee | 3.6 |
| Supervision of staff | 3.6 |
| Management | 2.9 |
| Family counseling | 2.7 |
| Education services | 2.7 |
| Outreach | 2.2 |
| Medical health care | 2.1 |
| Job development | 2.0 |
| Research and evaluation | 1.9 |
| Community relations | 1.9 |
| Other** | 2.8 |

* Based on sample of drug-abuse counselors (detox, crisis line, school team).

** Diagnosis 1.2%, job training 0.7%, legal services 0.2%, and social services 0.7%.

from the case coordinator and half time social workers, and the consultant advisory board can be called in as needed. On the basis of the sample interviews, 65% of the staff were rated good at delivering light counseling and related services.

Counseling training for crisis line counselors consists mainly of on-the-job experience including ongoing supervision, case review, and occasional co-counseling by the primary counselors, the case coordinators, or the social workers. Although new staff members get their share of this assistance, the supervisors and professionals can cover only a

fraction of the client sessions handled by the junior members. As part of the training, seminars on a wide range of subjects relevant to the project have been given by the directors, the consultant advisory board members, and people from community agencies. However, training cycles are not given regularly and some new staff members miss out. As another part of the training, the case coordinators offer three ongoing training groups per week for interested staff members, but attendance is not mandatory. Crisis line counselors are well trained in their crisis management function. This includes first aid in drug related crises (as well as others), referral and consultation during crises, and familiarity with the types of cases likely to be encountered.

The school team receives the counseling training described above plus training in value clarification, communication, group dynamics, public speaking, and politics.

The amount of time that the Aquarian staff spent in training and in program oriented activities (about 12%) is low in comparison to the time spent by the Open Door staff, especially in the area of formally structured seminar type training. Also missing from the Aquarian Effort is the Open Door type of mandatory training and close supervision. Aquarian's training program could strengthen counseling referral policy by augmenting the training with regard to case consultation.

Few of those who apply for staff positions receive them. Staff members are chosen to be intuitive and self-confident -- good attributes for relationship and supportive therapy. A "constructive attitude" toward drug use rather than total abstinence is accepted. A new staff member usually starts as a volunteer in crisis line counseling ("alternate"). An alternate can be promoted to primary

counselor in 6 weeks to 3 years, depending on ability and openings. The shift supervisor makes this decision. The detoxification unit and the school program usually recruit their counselors from the crisis line unit. Based on the staff sample, staff retention averages 14.4 months. This result is low and is due to such factors as job insecurity, lack of fringe benefits, heavy work, and poor pay.

The school team director and the field assistant are both full time employees of the school district. The school team staff also contains six Aquarian members (compared to eight last year), who were drawn from the crisis line counseling service.

The staff of the free medical clinic consists of two co-ordinators, six senior people, and about 40 part time volunteers, including medical students, RNs, and nursing students. The free legal clinic is staffed by two lawyers who volunteer part of their time.

The Aquarian Effort is governed by a board of directors consisting of community leaders, representatives of agencies associated with the project, and people whose skills are useful to the project. The board deals with major policy problems and acts as ombudsman in Aquarian affairs.

The project also has a consultant advisory board that can be consulted concerning treatment and referral policy, the handling of specific client cases, and related matters. This board includes the chief of the county department of mental health and four or five others from his department, as well as representatives of other treatment facilities.

5. Quality of Self Evaluation Efforts

In terms of CCCJ's "Evaluation of Crime Control Programs in California: A Review", Aquarian evaluation would fall into the evaluation classification of "monitoring." The project's intent in evaluation is to monitor its diverse activities to assure compliance with grant and contract obligations and program plans. To a great extent, this monitoring has been qualitative. Very little quantitative impact information has been included in the Aquarian grant requests and periodic reports The project administrators have felt that statistical presentation of client and staff related data is not necessary for providing good treatment. Our review of the record keeping system revealed that Aquarian staff have been keeping good client attribute and staff activity data which would be valuable for evaluation of operation and treatment.*

The utilization, fiscal, client, and staff data that Aquarian does keep are used in satisfying reporting requirements, formulating grant requests, negotiating with regulatory agencies, and to some extent, program planning and treatment evaluation.

a. Data Sources and Validity

Client and utilization data maintained by the crisis line counseling service include client files and shift logs.

The client files are for registered clients (clients who desire individual counseling). Each file includes a fairly comprehensive intake data form with the client's age, race, sex, current drug use pattern, legal status, referral source, and other pertinent background information.

* Much of the data they do keep and the format in which it is maintained results from the CODAP reporting requirements to which they are obligated through their grant from NIMH.

Additional information that would be useful here for evaluation of client characteristics would consist of: a more detailed drug history including date of first use and first regular use; a history of other treatment including dates and modalities; a history of criminal justice involvement including arrests, convictions, incarcerations, and probations; and better identification of clients known by the criminal justice system to be in treatment, so that their records could be tracked to provide data for outcome measurements. Also included in the client file are progress notes on each counseling session, the date counseling began, the date the file was closed, and indication of whether the client dropped out or left with advice. The duration of each counseling session would be a valuable addition to the progress notes. The files are well organized, protected, and kept up to date. No individual records are kept on drop-ins. In most instances, this would be futile because many of the drop-ins are one time, brief visitors on matters not drug or treatment related.

Shift logs count staff activity during each shift in terms of in-house person to person activity, such as type of counseling; outside activity such as crisis intervention; crisis line phone calls by type of call, man-hours spent in different activities (crisis line phone, counseling, office related, and others); short descriptions of counseling sessions and crisis that occurred during the shift; and carry-over instructions for the next shift. There is also a crisis log cross-referenced to the shift log entries; this log contains a detailed description of each crisis in which the staff has intervened. The following changes of the shift log would be helpful in evaluation: counts of drop-ins distinct from registered clients and others coming to the project; number, type, duration, and attendance of therapy groups (staff and clients); number of clients in

individual counseling only, in group counseling only, and in both.

Client and staff utilization data maintained by detoxification include client files with intake data and progress notes like those of the crisis line counseling service. The client files also contain medication schedules; prescriptions; client physical examination records; and follow-up notes for clients counseled subsequent to detoxification. Other records maintained by the detoxification unit include the duration of a client's treatment, his condition on termination, referral data both in and out, and the number and dates of follow-up counseling sessions.

Aquarian maintains data on numbers and attendance at speaking engagements; staff schedules; school team activities; amount and nature of outside counseling efforts for other agencies such as assistance to the adult diversion drug program and California Youth Authority; and fiscal records (traditional fiscal accountability system).

Baseline population census data and criminal activity data are readily available and should be maintained by Aquarian for comparison with their client population attributes as an assesment of their outreach efforts with regard to minority groups and level of criminal justice activity in the area.

Referral data, including number of referrals by agency referred to or referred from and type of person or problem referred, are critical to good evaluation. These data are not being adequately maintained by Aquarian and should be.

For staff evaluation, organized data other than work schedules and payroll were not in evidence. The site visit team did not review personnel records but obtained desired information by staff inter-

view. For evaluation purposes, organized staff data that would be valuable would be staffing patterns; staff training schedules and attendance (including type of training); duration of staff activities by staff member and by type of activity, especially in counseling, training, and consultation; staff background and qualifications; views on drug use and abuse, individual strengths and skills; staff retention times; and reasons for termination.

With regard to corroboration of data, few quantitative statistics have been published in Aquarian reports, grant requests and other documents. The SSI evaluation term corroborated certain statistics using samples of Aquarian data randomly selected for this evaluation. These statistics include: an average of 2,500 phone calls on the crisis line phone service each; 20-30 crisis interventions per month; and an average of 30 detoxification clients per month. Most of the other existing statistics that we checked also agreed well with sample results. We were unable to corroborate the number of individual counseling sessions. The project states that approximately 14,000 clients are seen in individual counseling sessions each year, or about 1,167 per month. A substantial sample of shift logs stratified by day of week, shift, and time of year showed at most 250 individual counseling sessions per month, and we could not ascertain whether they were drop-ins or scheduled clients since the shift log does not distinguish between them. It was stated at the site visit that the crisis line staff tried to schedule individual counseling sessions at least once every 2 weeks. But with 250 registered clients and 250 individual counseling sessions each month, registered clients could be counseled on the average of once a month (or even less, since drop-ins might have been counted as counseling sessions on the shift

logs). During the site visit, one of the counselors stated that phone calls involving counseling were counted in with the face-to-face counseling sessions to determine overall statistics. However, the number of crisis line calls counted as "counseling" are not enough to make up the difference.

We were also unable to corroborate client educational background. Our client statistics showed that 22.4% of the crisis line registered clients had some college while the Aquarian estimate was 75%.

b. Use of Data and Methodology

As noted above, Aquarian collects a large amount of useful information regarding clients and operations. However, these data have not been used in the evaluation or research of its diverse operations and treatment, with few exceptions.* The project has taken the approach that the use and presentation of data for evaluation description, program planning, and research is difficult and cannot be meaningfully done without excessive expenditures.

In their evaluation efforts so far, the Aquarian staff have only calculated average values from samples of their existing data for use in reports required by regulatory agencies, in grant requests, and in negotiations with regulatory agencies to justify policy matters. An exception is a formal evaluation of the school team effort recently completed by the Sacramento Unified School District.** The SSI evaluation team found this report useful in evaluating impact of the school drug education pro-

* A research report by Dan Bergan, Director of Detoxification, prepared with staff members of the Haight-Ashbury Free Medical Clinic, "I Got A Yen for That Darvon-N": A Pilot Study on the Use of Propoxyphene Napsylate in the Treatment of Heroin Addiction.

** Sacramento City Unified School District, Research Report, Series 1972-73, Drugs: Education, Prevention and Rehabilitation.

gram, within the limitations of the questionnaire method used. That is, student responses to questionnaires depend at least partly on the way the questions are worded; and student interpretations are restricted to checking one of several answers provided: Yes, No, Very Great, Very Little, etc.

Listed below are several ways in which evaluation might help The Aquarian Effort in program and treatment planning and assesment:

- o Comparison of client demographics and backgrounds with those of the local population; and comparisons of different groups' knowledge of drug abuse problems in the area. Results of these comparisons could be used to modify outreach policy.
- o Assessment of client attributes to assist in establishing and modifying treatment modalities and regimens, and referral policies.
- o Assessment of staff attributes to improve their association and compatibility with different client types.
- o Assessment of adequacy of staff training to meet client problems.
- o Examination of staff distribution concerning work to be done and meeting of client objectives (e.g., should 60% of the crisis line counseling time be spent on crisis line activities rather than individual counseling?).
- o Placement of staff according to skills.
- o Modification of facilities to better meet needs (e.g., more isolation of phone service from counseling area).
- o Evaluation of staff turnover by comparison of retention rates among staff with different characteristics.
- o Small sample follow-up of clients known to the CJS in order to help assess treatment outcome.
- o Examination of client referral frequencies by agency to help in modifying referral policies.
- o Assessment of staff specialties and strengths to assist in proper client placement.
- o Periodic generation of utilization indicators to assist in management (e.g., average clients in detoxification,

prevalent drug problems, staffing relative to peak hours, median client visits for different problem types).

These applications and many more can be used in management and treatment at Aquarian. The statistics used are neither expensive to tabulate (if kept up on a regular basis) nor complicated. Most of them are tables of frequencies or averages and percentages of existing data.* When compared, they can often rapidly point out strengths and weaknesses that can be used in the formulation of policy, and they are always available for use in reports and other areas in which Aquarian currently uses its data.

In summary, The Aquarian effort is strong on data collection and weak on productive use of the data. Because of the size and diversity of The Aquarian Effort, the evaluation team recommends that Aquarian should extensively increase its evaluative efforts through the use of existing data to monitor and modify project treatment and operations.

* Inexpensive off-the-shelf computer programs that require little professional assistance are available at most service bureaus to maintain such data and produce tables of basic statistics. In some instances, these services have been donated to community based projects such as Aquarian.

## 6. Project Impact

### a. Impact Measures and Samples Used

Aquarian does not collect information that would allow adequate measures of impact of project services on the criminal justice system, the clients, and the community. In addition, the lack of proper client record identification has precluded the selection of sample clients for tracking through criminal justice files. Therefore, the SSI evaluation team has estimated impacts by inferences based on several factors: the type and duration of services delivered, the client retention time, the types of clients, and the impact of similar treatment programs (e.g., individual and group counseling). With this approach, we were able to provide some estimates of reduction of client criminal justice involvement and decreased drug usage. Other impacts were assessed on the basis of observation and checks of individual services.

### b. Criminal Justice Involvement

The crisis line counseling service consists of three activities: telephone counseling; on-site crisis intervention by a team responding to crisis calls; and "face to face" counseling. An average of 30 crisis calls is responded to each month by intervention. Although these calls are only a small fraction of the total incoming calls (2,500 per month), their crisis nature (overdose, bad psychedelic trips, etc.) would indicate a significant impact on clients, and hence the criminal justice system and the community. The lifesaving abilities of the crisis line counseling service, the free clinic physician, and other professionals in handling or referring these crisis problems are a valuable asset to the drug treat-

ment facilities in the Sacramento area.

In the case of Aquarian crisis line "face to face" individual counseling, the counseling is light and the client retention time is often so short that experience would indicate minimal impact on clients with prior arrest records. An estimate of maximum impact has been made for counseling by relating Aquarian crisis line counseling to the counseling features of the Open Door and to minimum levels and duration of treatment that could have significant impact on clients with prior arrest records.

With respect to levels and duration of treatment, there are a number of information sources. A recent experimental study of various group counseling techniques* required exposure of clients to 30 hours of counseling over a 10 week period. Many observers have considered this amount of exposure as too small for appreciable impact on most clients. In a New York study of ambulatory units,** the duration of a treatment cycle was 1 month to over 1 year. Even in ambulatory induction centers, which are the most superficial of these projects, the amount of time required of the client was more than 40 hours in counseling. Also, adult probation referrals to Open Door are typically required to stay in treatment for at least 10 weeks--a period considered minimal by the staff. The Aquarian crisis line counseling service provides an average of 1-2 counseling sessions per month to registered clients, and provides group counseling sessions that handle only 40-50 clients (about 20% of total clientele) each week. An examination of the individual encounter dates for former clients indicates that 10 to 12 weeks would be an optimistic estimate of

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* M.A. Lieberman, et. al., Encounter Groups: First Facts, Basic Books New York, 1973

** Comparative Analysis of 20 New York City Drug Free Drug Abuse Treatment Programs,System Sciences, Inc., Bethesda, Md., 1972.

the time required for an average registered client to receive 30 to 40 hours of individual group counseling.

Aquarian crisis line counselees (about 20% of the registered clients) are getting some form of regular group or individual counseling. On the basis of a review of records and the optimistic estimates given above, the remaining 80% make only one face to face visit to the Aquarian crisis line counseling service.

An examination of client retention curves for Aquarian crisis line counseling (Figure 4 of Section III.B.3) indicates that only 16% of prior clients stayed in treatment as long as 10 weeks; of current clients, 36% have been in treatment for 10 weeks or longer. If we adopt the optimistic assumption that Aquarian counseling has equal impact with that of Open Door, then the 20% of current Aquarian counselees receiving some regular counseling might be expected to show decreased criminal justice involvement. Factors tending to make this a maximum estimate are: (1) the more severe prior criminal and drug involvement of Aquarian clients compared to those of Open Door clients; (2) the assumption of equal qualifications of the two project staffs; (3) the lower staff turnover rate at Open Door, and (4) objectives of drug abuse reduction ("controlled use") at Aquarian vs. reduction or abstinence at Open Door.

c. Drug Usage

The evidence from Open Door indicates that community based light counseling modalities can bring about a substantial decrease in drug use among light users (i.e., experimental, social-recreational users, etc.). About two-thirds of the registered Aquarian crisis line counseling clients are in the category of light users. The other third are engaged in intensified use (daily use), including 25% who are heavy

heroin users. Aquarian light counseling is unlikely to result in reduced drug usage among these latter groups.

Crisis line counselors see 300-400 drop-ins, including transients, each month. This is a service to the community because Aquarian handles many of their problems in the absence of other treatment programs in the area. There is no graduation from Aquarian counseling as from a therapeutic community, but there is a planned separation for the client who stays in treatment until he has demonstrated a satisfactory ability to accept increased responsibility. In September, about 14% of the active clients during that month made a planned separation.

The detoxification unit is currently treating 30 clients per month, many of whom have a background of criminal behavior. Most of these clients complete the recommended schedule of treatment. Counselors make an effort to follow-up on discharged patients where this would be beneficial, and the staff is large enough to provide a limited amount of this help effectively. On the basis of experience elsewhere, without aftercare, most of these clients can be expected to return to their previous behavior patterns. However, some of them have been referred into methadone maintenance and to other treatment programs. The impact of the Aquarian detoxification program is that it keeps people off the streets while they are in treatment; provides incentive for information about available follow-up treatment; reduces or eliminates a client's habit at least for a time subsequent to treatment; and provides a more supportive setting for detoxification than available alternatives.

d. Other Impacts

Other Aquarian services with community impact are concerned with direct assistance to other agencies. The county mental health

department conducts a drug abuse counseling and education program for diverted adult probationers, and Aquarian assists in this effort by providing senior counselors on a scheduled basis. Aquarian provides similar services for the California Youth Authority by counseling incarcerated juveniles.

The free medical clinic provides services for 25-40 clients nightly, and is a valuable asset to the community. In addition to general medical care, the clinic provides services such as birth control information and devices, V.D. clinic, pregnancy testing and counseling, and premarital blood tests.

The Aquarian public education effort (generally a two-man speaking team) has provided lectures, seminars, and counseling for 3,000 civic, social, and school groups over a period of four years. Speaking engagements for the quarter ending July 1973 totaled 160, with 57.5% of these to adults and youth in schools, 39% to adults other than at schools, and 4% to youth other than in schools and penal institutions.

The Aquarian program of information and education for the Sacramento Unified School District consists generally of an 8-man team working with the school administrations. Some insight into the impact can be obtained from a recent report by the Sacramento City Unified School District* of drug education and prevention activities, of which the Aquarian school team was a part. Drug related activities and attitudes were compared for the years 1971-72 and 1972-73. No appreciable change was observed in the number of suspensions attributed to drug related reasons, as was the case with other comparisons cited in the report. After

* Sacramento City Unified School District, Research Report, Series 1972-73, Drugs: Education, Prevention and Rehabilitation.

the project year, the level of drug knowledge was judged to be adequate in 3 of the 4 high schools and in 1 of the 3 junior high schools under study. The Aquarian school team was well accepted on the campus. Also, according to survey results, the majority of the students who contacted Aquarian staff found that the contacts were valuable to them.

The most notable features of the project are the detoxification unit, the free clinic, the crisis intervention portion of the crisis line counseling service, and the project's community relations, coordination, and education efforts.

7. Project Potential

a. Cost-Benefit Measures

Funding information for this section is based on budget figures for the fiscal year ending April 1974. Sources of funds for Aquarian are NIMH, Short-Doyle, and other state and local agencies. Distribution of budget allocations among functions is given below:

| | | |
|---|---|---|
| Administration | $ 67,215 | NIMH & Short-Doyle |
| Detoxification | 145,286 | NIMH & Short-Doyle |
| Crisis line | 237,489 | NIMH & Short-Doyle |
| | | CYA, including CCJP |
| Other programs | 67,336 | Sacramento Schools, and |
| | | Revenue sharing (County) |

Prorating of NIMH funds for administrative expense between detoxification and crisis line counseling services gives an estimated cost of:

| | |
|---|---|
| Detoxification | $170,828 |
| Crisis line | 279,162 |

According to estimates presented previously, about 25% of staff time is spent in "face to face" counseling, 63% in telephone counseling, and 12%

in other activities. Prorating all time and costs between the two types of counseling gives a fund allotment of $79,300 to "face to face" counseling in the crisis line counseling unit.

Estimates of unit cost-benefits for Aquarian's crisis line counseling service (face to face) are presented in Table 31. Definitions of terms used in the table are presented below:

- o Cost per client year - the cost to support one client in treatment for a year.
- o Cost per graduate - total budgeted treatment funds divided by the total reported number of graduates.
- o "Improved client" - a client whose arrest rate after start of treatment is lower than the average arrest rate in the two years prior to treatment.
- o "Arrest free client" - a client without arrests after start of treatment.

Table 31

AQUARIAN
COST-BENEFIT MEASURES FOR CRISIS LINE COUNSELING
Face to Face

| | Crisis line counseling |
|---|---|
| Total treatment funds | $79,300 |
| Average attendance, clients | 15 |
| Total clients per year | 1,384 |
| % Clients improved (reduced arrest) | 20% |
| % Clients arrest free | --- |
| $ per client year | 5,290 |
| $ per improved client (arrest) | 286 |
| $ per attendance day | 14.50 |

The total cost per client year for Aquarian's crisis line counseling was $5,290. This may be compared with the Open Door costs of $3,400 per client year. The cost per client year reported in the New York study for ambulatory treatment units was in the range $1,410-$7,920.

Cost-benefit of Aquarian counseling efforts in terms of reduced arrests is unknown because of the lack of client identification on records maintained by Aquarian, and because of the lack of follow-up interviews on clients after treatment. An approximate estimate of unit cost may be inferred using the assumption developed in the last section that about 20% of the Aquarian counseling clients were likely to receive sufficient treatment to influence criminal behavior appreciably. Use of this assumption yields an estimate of $286 per improved client. This value is comparable with the Open Door result of $305 per improved client. Because of the possible error in the estimating process, the differences in the values per improved client cannot be considered significant.

A more reliable measure in this case would be the cost per client day. The value of $/attendence day for Aquarian was estimated at $14.50 based on service 7 days a week; the comparable value for Open Door was $13 for service based on a 5 day week. This measure has been used as an estimate of cost per drug free day; however, especially in the case of ambulatory programs, the variation between the two measures can be substantial.

b. Suggested Project Modifications

As mentioned above, Aquarian suffers from the lack of the necessary complementary agencies and a county coordinator, who would implement all interagency referral system. The excellent detoxification unit needs a good therapeutic community to refer into. The counseling service could use the graduates of a therapeutic community to enrich their staff.

The existence of a therapeutic community would also make it possible for this project, which has been overextending itself, to refer out hard core addicts (except for detoxification) and concentrate on prevention and counseling younger, lighter users.

Funds are needed to enrich and stabilize staff and improve their training. They need good salaries and fringe benefits. The project needs more professionals for consultation and a more formalized pattern of consultation. The training program should have a director with no other duties, to carefully structure both its didactic and its practical aspects.

Here too, space is a problem. The free clinic probably could be moved into another building, as it is a separate service. It is recommended that the phone service be consolidated in an area away from the rest of the counseling activity and that the phones be manned by a specific group (such as receptionists) dedicated to the telephone service, at least on a particular shift. This policy will prevent the splitting of time with other activities that dilute the efforts of counselors, and will provide a better utilization of staff.

It would be easy and appropriate to add beds to the detoxification unit.

C. Camarillo Resocialization Program

1. Services Provided

a. Description of Services

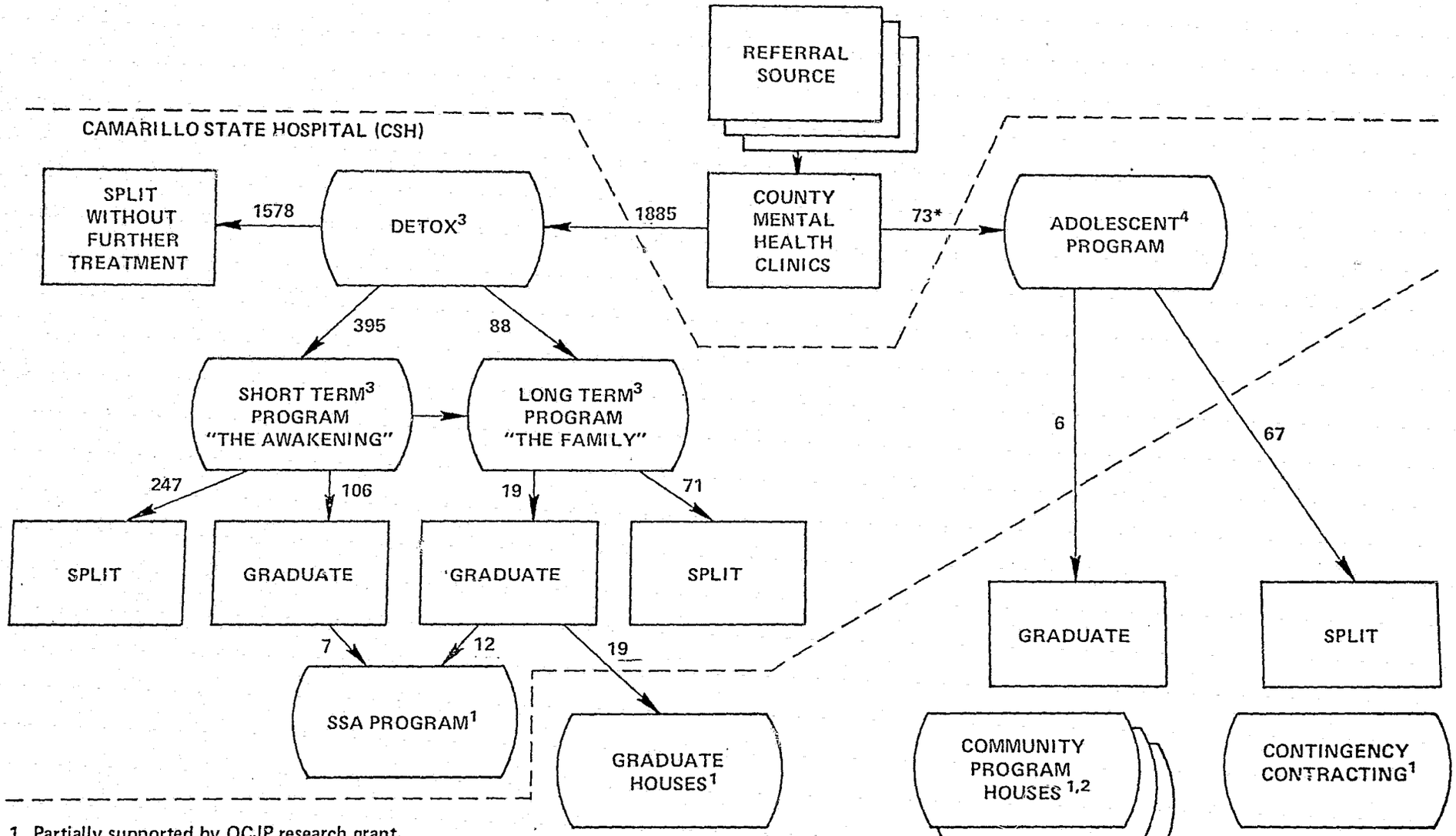
The Camarillo Resocialization Program for Drug Abusers is located at the Camarillo State Hospital, Camarillo, California, and has treatment and research programs that are closely interdependent. The treatment program consists of four units: detoxification, short term program (called "The Awakening"), long term program (called "the family"), and adolescent unit. These units, together with their annual client flows, are shown in Figure 5. The research program involves the Neuropsychiatric Institute of UCLA and Camarillo State Hospital. Figure 6 shows the interrelationships of these agencies as well as their relationships to the treatment program.

Other services shown in Figures 5 and 6 are: the SSA (Social Service Aide) program that provides interim jobs for graduates of the short term and family programs; graduate houses that provide communal supportive living arrangements on the outside for graduates of the family program; and a developing program of community houses that are staffed by family graduates and that will employ contingency contracting.

The treatment approach includes: (1) removal of the client from the reinforcing effects of prior neighborhood and associates, (2) detoxification, and (3) the experience of a healthy, extended, caring family, combining discipline and emotional support and acceptance.

Figure 5

THE CAMARILLO RESOCIALIZATION PROGRAM
FOR DRUG ABUSERS – TREATMENT PROGRAMS

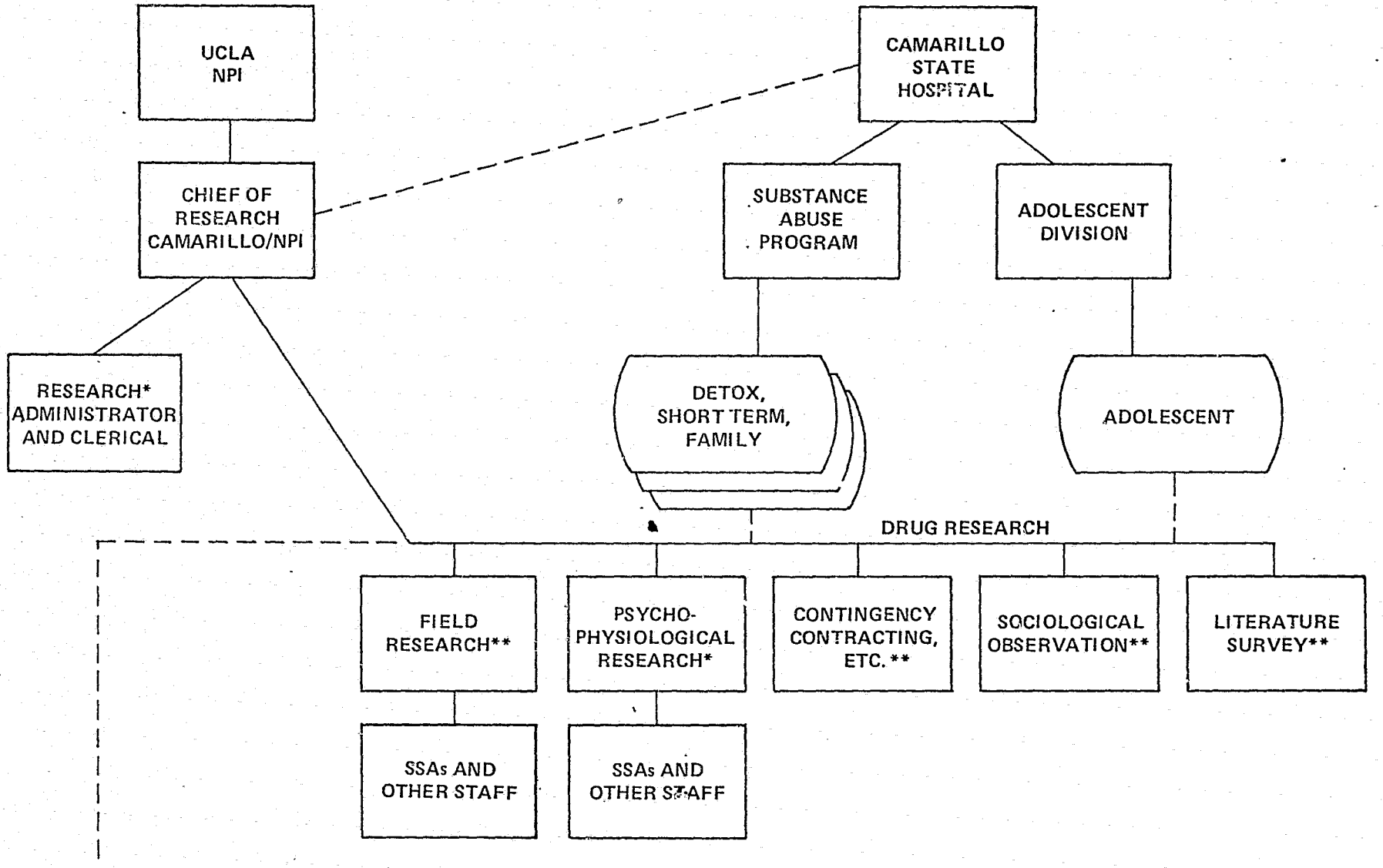



1. Partially supported by OCJP research grant.
2. Graduate-Probation Assistance Program.
3. Part of Drug and Alcohol Treatment Dev. CSH.
4. Part of Adolescent Treatment Dev. CSH.

* Total client flow (annual) – July 1, 1972 - June 30, 1973.

Figure 6

CAMARILLO-UCLA/NPI RESEARCH PROGRAM




Other research programs such as:

Hospital Improvement Project
Suicide
Chemical Research Unit
Behavior Modification in a Community Mental Health Center
Autistic Children's Research Center

* Salaries shared by OCJP grant and UCLA.
** Salaries paid by UCLA.

b. Detoxification

This admission and orientation program is mandatory for all adults coming to Camarillo State Hospital for drug abuse treatment. Methadone is used for detoxifying most of the patients in this unit; 90% are heroin addicts, but other addicts (particularly those on barbiturates) will be accepted. All clients come directly to the unit through the various county mental health departments, although referrals come indirectly from over ten agencies. All clients are officially voluntary. The patient signs a treatment agreement and is given a physical examination and appropriate medical and dental care.

Clients entering the detoxification unit will be discharged immediately if they will not give up their drugs and paraphernalia. Once they have left the unit, they can return up to six times if return occurs over 30 days from discharge. There are 1,800 admissions yearly; the waiting list usually consists of 30-50 people, with the average waiting time being 1-2 weeks. Figure 5 shows actual client flow into and out of detoxification for one year.

The detoxification unit is large and rather austere. There are male and female dormitories (30 beds and 14 beds, respectively) at each end of a large treatment and recreation area, which also contains the nurses' station. Those facilities are generally fully utilized.

A prospective client should be 18 years old, or if younger, must be the equivalent of that age in emotional maturity. About 50%* of the clients leave after 3 to 6 days and before completing their detoxification. About 26% of the remaining clients go into one

* Approximation based on a sample of client activity.

# CONTINUED

# 2 OF 4

of the two adult treatment programs, 5% go into the family unit, and 21% go into the short term unit.

c. The Family

This unit is bright, clean and pleasant. Although it has some unique features, it was originally modeled after the Mendocino family, and is a typical well-run therapeutic community. It is tightly structured, clients passing from one predetermined treatment stage to the next on the basis of peer decision, and experiencing the classic methods of therapeutic communities: encounter therapy, discipline, etc. The Family program is conducted by clients who assume increasing responsibility with each successive stage. Hospital staff involvement in the family is restricted primarily to record keeping and to liaison with other hospital services and outside agencies such as probation, parole, and the courts. The treatment stages are summarized in Table 32.

About 30-40% of the graduates take employment at the hospital as part of the graduate employment program (Social Service Aides) and the rest are employed elsewhere. In general, graduates leave in twos so that they can give each other psychological support. They are encouraged to live in one of the two graduate houses that form a post-graduate arm of the family unit. Frequent communication is maintained between these graduates and the family. Currently, seven people live in the houses which have a total capacity of 10.

The graduates can be used effectively in the family by coming back on scheduled days or evenings to feed back to senior family members the experiences of actual reentry. Their feedback

Table 32

CAMARILLO
SUCCESSIVE TREATMENT STAGES IN FAMILY PROGRAM

| Stage | Duration | No. of Clients* | Elements |
|---|---|---|---|
| Candidacy | 5 weeks | 4 | A probationary period, during which client's motivation is tested, and he learns about program. Not allowed to communicate. Humiliated by shaven head, menial tasks, etc. Client spends 12-14 hours per day in groups. Drop-out rate in this stage: 50%. |
| 4A | 4 weeks | 4 | Similar to candidacy but with less humiliation and fewer menial tasks. |
| 4B | 4 weeks | 2 | 40 hours per week in group daily discipline sessions. Client posts written commitments asking for help with desired behavior change, and writes "concepts" concerning mature and immature behavior. |
| 3 | 6 weeks | 4 | Called "responsible family member." Given responsibility in one of the Family departments,** or put in charge of candidates. |
| 2 | 6 weeks | 2 | More responsibility given -- e.g., in charge of liaison with detoxification unit; or named head of the family departments; or put in charge of clients in stage 3. |
| 1 | 6 weeks | 3 | Called "senior member." Spends one hour per day talking to elders (see below). Carries considerable responsibility. |
| Final stage | | | |
| a. Orange phase | $\leq$ 1 month | 1 | Alternative to eldership. Spends most of time seeking outside job so that he or she can graduate. |
| OR | | | |
| b. Elder | 2-6 months | 3 | Alternative to orange phase. Combines running the house with job seeking. |

* Number of clients in given stage at the time of our site visit.

** These are: baking, recreation, arts and crafts, and public relations. The first two are in charge of stage 4B and the last two are in charge of stage 3.

could warn of the pitfalls facing addicts leaving the program.

The family unit has no waiting list, and its maximum size has been 40 members. Candidates are best entered in groups of four so that they can support each other. Clients are automatically discharged for the use of drugs or chemicals; negative attitude detrimental to the family; violence; sexual acting out; or failure to follow the rules of the program.

Most of the problems faced by the Camarillo group are political. A political struggle between Camarillo and the Los Angeles Mental Health Department has been centered on a proposed plan to move the detoxification and family units to Tarzana in Los Angeles County. Recently, the transfer of some of the Los Angeles County funds (previously allocated to Camarillo) to the Tarzana detoxification and family units has decreased the morale of the clients in the Camarillo family unit. Some graduates have pressed for moving the Camarillo family unit to Tarzana, causing anxiety and uncertainty which have distracted the family unit from its goals. The family members have apparently worked out this crisis under a new coordinator (senior elder) and now number 32 clients, compared to 21 at the time of our site visit.

d. The Short Term Program

The short term program (lasting 30 to 90 days)is a therapeutic community with a capacity of 59 beds. The program was designed for treatment of patients not ready to handle the more rigorous long term family program. Thus, it is a modification of the family program and is more innovative and more acceptable to many clients.

The short term program was initially conducted in part by the family, and was considered as a preparation for some clients to enter the family. Thus, members of the family unit were allowed to recruit from the short term unit. This pattern has been discontinued. Both family and short term units recruit clients from detoxification. There is no consistent coordination of these efforts. Short term clients still have the option of graduating into the family if they desire and if they can get sponsorship from a referring agency.

The short term program is operated largely by clients who assume more responsiblity as they progress through treatment. It is not self-governed as is the family, but is peer group oriented, with final decisions made by the hospital staff. The hospital staff here also participates in the treatment more than in the family, providing the services of psychiatric social workers, RNs, psychiatric technicians, and SSAs from the graduate program.

Intensive peer group interaction in the short term unit is aimed at modifying social behavior. Days and roles are structured, and there is intensive group work (50 hours a week). There is no candidacy stage as in the family. Demands are made to which clients must conform or be disciplined. The treatment pace is more intense and concentrated than that of the family. Short term peer groups attack attitudes and value systems, and work on communication, relationships, and feelings.

This program is structured in three phases: (A) orientation (learning treatment modalities, and writing concepts daily); (B) intense work and growth phase; and (C) assumption of responsibility. Screening for change of phase and for volunteer status is done by a

council of five C phase patients and one staff member, usually a program graduate. In the C phase, the client can communicate with the outside, and has fewer menial tasks, but no decrease in therapy, unless he is a council member.

In addition to groups and program responsibility, this unit has recreation (gym, swimming, hikes, etc.), and intensive legal work with clients. A part-time social worker goes to court with the clients and works with probation and parole.

Clients are discharged for drug use or attempts to get drugs; violence or real threats of violence; destructive and negative attitudes; and some types of sexual behavior. There is about one disciplinary discharge each month. Patients can return to the short term unit, but if they complete this therapy and then relapse, they are referred to the family for treatment the next time.

e. Adolescent Unit

The adolescent unit is a therapeutic community similar to the short term program. It is administratively under the Adolescent Division of the Camarillo State Hospital (the programs discussed so far are under the Substance Abuse Division). Relatively few clients in the adolescent unit are heroin addicts; most clients use other drugs. Frequently, drug use is part of a picture of negative family relationships, broken homes, runaway behavior, and incorrigibility.

Treatment is divided into six phases, comparable to those in the family unit. Rather than the candidacy/no-communication phase of the family program, there is an orientation phase for new clients, during which adolescent clients can communicate, but within a disciplined framework. Therapy includes: groups, the writing of

concepts, recreation, cleanup tasks, individual counseling, silent reflection, two person (dyad) and three person (tryad) discussions, feedback sessions, alter ego, and role playing. Two hours per day are spent in school at the unit, with an outside teacher and an SSA assistant.

Peer government is practiced; the two top positions are senior coordinator and junior coordinator (these positions were unfilled at the time of our site visit). In addition to peer government, this unit is staffed and directed like the short term unit.

f. Other Services

Social Services Aides. The Social Service Aides or SSA program is an innovative program providing temporary jobs (9 months) for graduates of the Camarillo programs. The objective is to help graduates prepare for reentry by providing a period of stable, stimulating employment. Twelve SSAs are paid with research funds and six are paid with hospital funds. Ten of the twelve paid by research funds work as research assistants; the other two work in the hospital, where the other SSAs are also employed.

Ideally, the SSA jobs are seen as stepping stones to other jobs, but unfortunately, none of the trained research assistants have been able to go on to similar jobs in the outside world.

Community Program Houses. The Community Program Houses are currently being developed under a Graduate-Probation Assistance Program involving the Camarillo-UCLA Neuropsychiatric Institute research program, the family, and probation officers from Ventura and Los Angeles counties. As planned, the CPH program will consist of three residences for young adults. Treatment will involve, and

be a continuation of, the adolescent contingency contracting effort started by the Camarillo research program. According to the present plans, two of the houses will be located in Ventura County and one in Los Angeles County and will be staffed primarily by family graduates. The first house is currently being opened.

These houses might furnish prototypes that can be adopted by probation departments in other counties. The house program will be based on Camarillo TC type therapy in conjunction with contingency contracting (see subsection g. which follows).

g. Camarillo-UCLA NPI Research Program

The Camarillo State Hospital/UCLA Neuropsychiatric Institute research program is a full scale research program interacting with a full scale drug treatment program. The CSH/NPI drug abuse element uses the Camarillo treatment program to study the overall structure, philosophy, and policy of drug abuse treatment and rehabilitation; to study the sociology and psychology of primarily hard core abusers; to study the effectiveness of various forms of drug-free treatment; to study the sociology, psychology, and psychophysiology of clients while in treatment; to survey other relevant work done in the field; and as a result of these studies to bring about changes in the drug abuse treatment community through publication of their findings. Figure 6, previously given, shows the relationship of the research program to the hospital and the treatment (e.g., Chemical Research Unit in Figure 6).

The drug abuse research is being conducted in several subject areas.

Participant Observation. In this subject area, some researchers participate in the family program as clients in most respects.

The objective is to study and document sociological aspects of the treatment process. Topics include self-help in an institution, appropriate therapeutic models for programs in an institution, and the structure of communication networks within a program such as the family. Two of the principal investigators have lived as family members for extensive periods, and in doing so, have had to justify their personal and research goals before the skepticism of other family members.

Psychophysiological Research. The objective of this effort is to relate physiological responses (obtained by means of polygraph, videotape, and other devices in their well-equipped laboratory) with psychological and sociological characteristics as determined from psychological tests and client interviews. Some specific topics are: evaluation of videotape and psychophysiological feedback as a treatment modality; study of how clients change through therapy; and correlation of physiological measurements with personality data for clients in treatment. The studies are looking for indices of therapeutic progress and for psychological and physiological prognostic tools. This psychophysiological effort initially had difficulty picking up momentum because of the family members' resistance and desire for privacy. Nevertheless, the effort has now been accepted by the family and has become a substantial part of its program, with such devices as video feedback and a polygraph-actuated light located behind the "hotseat" to key the group to a subject's reactions. The gradual acceptance of the researchers by the family has itself been a topic of research there.

Contingency Contracting. The first phase of this program was an outpatient program for teenage abusers and their families in Ventura County -- an intensive pilot study of 25-40 clients for about a year. This project is being conducted in conjunction with the Ventura County probation department and involves clients whom probation considered unmanageable. The second phase has now begun, with a study of one to three of the Community Program Houses previously discussed and shown in Figure 5. Four adolescents and two family graduates will live in each house, according to individual plans. The contingency contracting modality works with the family or counselors of a youthful drug user; mutually agreed upon contracts govern the relationship between parent and child.

Field Research. The principal objective of this effort is to determine relationships among psychosocial characteristics of drug abusers by administering questionnaires and psychological tests to a large sample of Camarillo clients. These techniques are used to collect background data, drug history, family and personal history, demographic information, and behavior traits for the sample. This information was collected over a two-year period for all clients that entered the family and short term programs, and for most of the clients that entered the adolescent unit during that period. Most of the same type of information was collected for a control group of 200 college students. In addition, follow-up interviews with comparable data are being conducted for graduates of the short term program and graduates and splittees of the family program nine months to a year after they leave the program. This follow-up study is being made in

an attempt to relate client characteristics to treatment outcome. Specific topics are: description of the characteristics of those who finish the treatment program; relationship between success and finishing the program; and description of the family background of drug abusers.

Literature Survey. These four research efforts have required ongoing review of existing literature concerning the psychosocial and psychophysiological aspects of drug abuse and its treatment. This review has resulted in an extensive collection of current literature from which the researchers are compiling an anthology representative of current knowledge, to be published as part of the research program.

Interrelationships Between Research and Treatment. The research program has had substantial interaction with the treatment programs, especially the family program. The family program has been the principal subject of research for participant observations and psychophysiological research. Research has largely ignored the detoxification unit, feeling that any success associated with it would be so small as to be unidentifiable. However, in the field research follow-up study just described, researchers found that many of the clients have been recycling back through detoxification. Thus, the detoxification unit is a likely place to find subjects for follow-up interviews.

One of the major contributions that the research program has made to the treatment programs is to sponsor family and short term graduates as Social Services Aides, preparing them for reentry. Two graduates have gone from SSA jobs into permanent positions

because of their capabilities with computers and instrumentation. Most of the SSAs assigned to the research effort work on data collection and reduction in the psychophysiological and field research program. SSAs working in the hospital typically work in the short term, detoxification, and adolescent units. Some of them will be working as counselors in the Community Program Houses. The research program also supports a substantial part of the graduate houses, providing furniture and the like.

h. Referral and Client Flow

All of the people entering the family and short term programs enter via detoxification. Family members actively recruit there several times each week. Principal referral sources are legal (65% -- parole, probation, the courts) and informal (e.g., self, friends). Table 33 , based on our samples, presents referrals by source for the adolescent, short term, and family programs. The table shows a considerable variation in referral sources for these programs. All referrals come through county authorized mental health facilities according to state referral procedures.

All of the beds in the detoxification, short term, and family units are funded by Short-Doyle dollars authorized by the various counties. This funding has sometimes created complications, since some counties allow only a limited amount of treatment because of limited treatment funds. For example, one county allows only detoxification and no follow-up; another allows only the short term program and not the family, as in the case of current Ventura County policy which pays for six to ten beds in short term only. Each unit can take people only from the county that has beds available. This restriction is sometimes confusing to an addict in treatment.

Table 33

CAMARILLO
REFERRAL SOURCES

| REFERRAL SOURCE | TREATMENT PROGRAM | | |
|---|---|---|---|
| | Adolescent N = 25 NR = 1 | Short Term N = 49 | Family N = 32 |
| Probation officer/ courts | 52.0% | 40.8% | 9.4% |
| Clinics/mental health agencies | 16.0 | 14.3 | 28.1 |
| Informal (self, friends, etc.) | 16.0 | 34.7 | 50.0 |
| Other | 16.0 | 10.2 | 12.5 |
| Total | 100.0% | 100.0% | 100.0% |

Table 34

CAMARILLO
PERCENTAGE OF CLIENTS IN VARIOUS TREATMENT UNITS
BY COUNTY OF REFERRAL

| TREATMENT UNIT | PERCENTAGE OF CLIENTS* | | | |
|---|---|---|---|---|
| | Total Number of Clients | Los Angeles County | Ventura County | Other Counties |
| Family unit | 27 | 100% | | |
| Short term program | 26 | 88 | 12% | |
| Detoxification unit | 28 | 43 | 57 | |
| Contingency contracting | 24 | 54 | 46 | |
| Graduate program | 24 | 92 | 8 | |
| Adolescent unit | 21 | 76 | 5 | 19% |
| Total | 150 | 75% | 22% | 3% |

* Expressed as percent of total clients in unit (row).

Most of the clients in the treatment programs are referred from Los Angeles and Ventura Counties. Table 34 shows the number of people in the treatment units by county of referral (Los Angeles, Ventura, and Other) as of August 18, 1972. Current intake into the short term and family programs shows 84.7% from Los Angeles County and 9.3% from Ventura County. Thus, Los Angeles County is by far the largest source of clients for treatment. Eleven clients of the Camarillo short term program were recently moved to Tarzana as the beginning of a program whose structure will be modeled after the Camarillo family program. These developments may reduce the number of clients that enter Camarillo detoxification.

In addition to the Tarzana problem, the staff and clients at Camarillo are periodically subjected to proposed or rumored moves -- e.g., Camarillo State Hospital is being closed, or the units will be discontinued or combined. Although the staff members are well adjusted to these threats, the clients are frequently upset, with resulting interruptions of program continuity.

Clients in the adolescent unit are usually referred there as wards of the court. As shown in Table 34 , most are from Los Angeles County but a relatively high percentage (19%) are from counties other than Los Angeles or Ventura, unlike the other treatment units whose clients are virtually all from Los Angeles and Ventura Counties.

## 2. Treatment Philosophy, Objectives, and Criteria

### a. Treatment Philosophy

The four modalities (detoxification, short term program, family, adolescent family) influence the placement decision.

The staff members believe that drug addiction is an index of underlying emotional problems. A client must work through his problems so that he no longer feels the need to escape them through the use of drugs--he must become satisfied with himself.

The program believes that the addict can best be rehabilitated by isolating him temporarily from unhealthy sources of influence and surrounding him with an environment that is conducive to growth. The Family program, being similar in concept to Synanon, Daytop Village, and others, believes in providing the addict with a highly structured and disciplined environment. In this environment, the addict's behavorial problems can be eliminated or character can be reconstructed along a more self fulfilling and socially acceptable model. The philosophy of the short term program is similar although less is expected in the way of character reconstruction.

### b. Impact-Oriented Objectives and Associated Measurement Criteria

Current objectives and measurement criteria are listed in Table 35 together with suggested modifications. This program makes a great variety of measurements on clients and graduates; however, only a few of these measurements are used in preparation of reports to OCJP. Objectives were taken from grant award applications and the director interview. The project does not generally give measurement criteria specifically for each objective but a number of criteria are used in quarterly reports. SSI has matched up these criteria with the objectives

Table 35

CAMARILLO

OBJECTIVES AND MEASUREMENT CRITERIA, WITH ADDITIONS

| OBJECTIVES | CRITERIA USED | ADDITIONS TO CRITERIA |
|---|---|---|
| To decrease recidivism among drug abuse offenders | Arrests for drug offenses<br>Total arrests | Arrest rate prior to treatment<br>Drug use frequency prior to treatment |
| Provide background for employment and full-time employment for graduates | # graduates employed<br># graduates given employment assistance<br>Average salary<br># enrolled in education classes | # employed outside Camarillo facility<br># employed after 6 months<br>Job turnover rate<br>% employed prior to treatment<br># completing education classes |
| Provide clients with psychological and physiological abilities to cope with problems of society<br>ADD: and lead constructive lives in society | # graduates<br>Recidivism rate | # graduates meeting pre-assigned goals<br># joining constructive organized community activities<br># achievement index for testing procedures |
| To provide research data on re-socialization concepts | Data base and source information<br>Research reports and articles<br>Identified improvements in therapeutic procedures<br>Improved evaluation techniques | Concepts incorporated in other treatment programs |
| To provide consultation and education to other programs | General types of activities that have been undertaken | # and type visits to other programs<br># people in training sessions<br># requests for services<br># graduates in drug abuse field<br>Literature and media (TV) produced and utilized |

and has added other criteria that would be appropriate for reports to OCJP.

The first objective -- "to decrease recidivism among drug abuse offenders" -- is well-suited to this project since the principal thrust of the efforts is to cause a permanent rehabilitation of drug abuse offenders. Quarterly reports discuss this objective in terms of the low frequency of arrests of graduates for drug abuse and other causes. Discussion indicates that follow-up on graduates will be made for one to three years in order to determine success in meeting the objective. Our suggested additions reflect a need to compare behavior of graduates with their behavior performance prior to entry into treatment. For example, arrest rate information on graduates prior to treatment would allow determination of the decrease in arrest rate subsequent to treatment.

The second objective given was: "to provide the background for gainful employment as well as full-time employment upon completion of the program." This objective is appropriate and necessary. In fact, employment is an important condition for graduation from the family unit therapeutic community. This objective is discussed in terms of the number of graduates who have been assisted with employment, their average salaries, and the number enrolled in education courses. All these measures are appropriate. Consideration of salary is an important measure, often overlooked by programs, since it is a partial indicator of the adequacy of the employment. Other criteria that might be useful additions would include data on employment and education prior to entry into the program. For other measures of job suitability and satisfaction, it would be desirable to examine

job turnover rate and numbers of graduates employed outside Camarillo six months after leaving the project. The number completing educational goals would also be a more direct measure of project impact than the number enrolled in classes.

The third objective is: "to provide the drug abusers with the physiological and psychological abilities to cope with the problems of society they have and will encounter." While this statement implies a great deal, the "impact" aspect could be highlighted by including the idea of "leading a constructive life in society." Appropriate criteria for measurement that have been given by the project in quarterly reports would include number of graduates and recidivism rate. A range of psychological and physiological tests is used to monitor progress of clients toward this objective; however, SSI has not had the opportunity to examine the relationship of these tests to impact-oriented objectives. While the presentation of these latter data in a progress report to OCJP is probably not appropriate, some aggregate index of client test achievement might be helpful.

The fourth objective is aimed at providing research data needed to understand and apply concepts of resocialization. This objective is basic to the Camarillo approach of intermixing therapeutic and research efforts. Criteria for measurement that have been used include description of the size and variety of data bases; source information; and research reports and articles. In addition, mention is made of specific innovative techniques that have been successfully introduced into the treatment process (e.g., video tape replay). It is always difficult to measure the impact of research over the short term since application of findings tends to lag well behind the

discoveries. Over a period of several years, indicators of research impact might include (1) the extent to which research findings have been adopted by other groups in their rehabilitation efforts, and (2) the level of improvement in client outcome.

The fifth objective--"to provide consultation and education to other California drug abuse programs"--is an objective that this project is qualified to perform. Part of the effort under this objective is to develop graduates as leaders in drug abuse prevention, treatment, and training. No specific criteria for measurement have been specified, although the program alludes to speaking engagements, assistance to other groups with grant requests, training sessions, etc. It is suggested that these events be put in an appropriate quantitative form and included in reports to OCJP.

3. Client Attributes

a. Client Criteria

The clients entering the detoxification ward at Camarillo are heroin abusers ranging from heavy short term users to hard core long term addicts. Some barbiturate and amphetamine abusers are also treated. The detoxification ward is a mandatory orientation for all drug clients entering the adult Camarillo program, even though the ward specializes in heroin detoxification with methadone. Most clients leave detoxification and do not continue into the treatment programs; many of them leave even before the detoxification cycle is completed. Frequently, clients recycle through detoxification at Camarillo and other places several times during their addiction careers.

Many clients are criminal justice referrals via county (primarily Los Angeles and Ventura) mental health clinics. The clinics do a cursory screening of referred individuals to determine their assignment to a treatment project. Factors considered in the screening include legal status, place of residence, available county funds, etc.

Both the family and the short term programs recruit all new clients from the detoxification unit. Recruiting requires both the desire of potential clients to enter treatment, and the programs' willingness to accept them. An additional controlling factor is the sponsoring county's willingness to fund a client's treatment. Recruiting is difficult and the two programs are seldom at capacity; most clients are not motivated to go beyond the detoxification phase. County referral policy is sometimes an additional deterrent to entry into these programs because of limited funds for treatment. Each county typically reserves a number of beds per program, based on available Short-Doyle funds and anticipated referral volume,

and will seldom approve a client's entry into a particular program if the reserved bed capacity has been reached.

The client most suited for treatment in the short term and family programs must be motivated and relatively sophisticated in the drug subculture. He must suspend outside ties. He is typically the kind of person who has had trouble functioning on the outside and needs the support of the therapeutic community to build up his self-esteem and prepare him for a successful drug free life on the outside.

The suitable family client, compared to the short term client, is older in terms of length of addiction, street knowledge, and drug use. The short term program is more desirable to many clients because of its shorter duration (maximum 90 days). Many short term clients are court referrals and are anxious to fulfill their obligation. Also, because the short term therapy is less confrontative and more supportive than the therapy of the family program, the short term program is better for the more emotionally fragile client and for someone with a shorter drug abuse history. Barbiturate, amphetamine, and hallucinogen abusers are usually placed in the short term program because their initial psychological state (spaced out) would likely make it difficult for them to contend with the humiliating and rigorous candidacy stage of family treatment. Clients can go on into the family from the short term program, and some have done so.

Except for age, client attributes in the adolescent program are similar to those of the family and short term programs. The juvenile clients are all wards of the court. Because of their ages, clients are more restricted and controlled than those in the other programs, and are typically incorrigibles for whom outpatient therapy has

proved unsuitable. The juveniles' ages and their mandatory court obligation make them less motivated toward eradicating their drug problems. Clients entering the adolescent program seldom enter via the detoxification unit, as is required for clients entering the adult programs. Other clients include two juvenile groups, most of whom are wards of the court, and are identified with one of the two phases of the contingency contracting program.

b. Client Demographics

Detoxification client demographic statistics are based on a sample of 1,306 (all clients who entered detoxification from May 1, 1972 to April 20, 1973), and are shown in Table 36. It is seen that 70% are male, and 66% are in the age range 20-29. The median age is 25. The racial distribution is 26% Hispanic white, 14% black, 59.3% non-Hispanic white, and 0.7% other.

Table 37 shows a similar breakdown for a combined sample of 138 clients from the family and short term units: 62.4% male, 75% in the 20-29 age range (median age of 25 for the family and 23 years for the short term). The racial distribution is 10.0% Hispanic white, 11.8% black, 77.4% non-Hispanic white, and 0.8% other. The family and short term data were combined because no statistical difference was discernible between their demographics.

Both the detoxification ward and the therapeutic communities contain a large majority of males. Some general reasons for this phenomenon at Camarillo and other treatment programs are given in Section III.A.3. The age distribution of the detoxification clients is very similar to that of clients in other Camarillo units. A smaller percentage of Hispanic whites than non-Hispanic transfer to other treatment programs.

Table 36

CAMARILLO
DETOXIFICATION CLIENT DEMOGRAPHICS

| | Hispanic | | Black | | White | | Other | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age at Entry | M | F | M | F | M | F | M | F | M | F | T |
| < 20 | 0.8% | 0.2% | 0.2% | 0.2% | 2.1% | 1.7% | 0.0% | 0.0% | 3.1% | 2.1% | 5.2% |
| 20 - 24 | 6.3 | 2.9 | 0.9 | 1.0 | 18.8 | 8.8 | 0.1 | 0.2 | 26.1 | 12.9 | 39.0 |
| 25 - 29 | 5.1 | 1.4 | 1.6 | 1.1 | 12.5 | 4.9 | 0.2 | 0.0 | 19.4 | 7.4 | 26.8 |
| 30 - 34 | 4.1 | 0.5 | 1.9 | 0.8 | 5.1 | 1.7 | 0.1 | 0.0 | 11.2 | 3.0 | 14.2 |
| 35 - 39 | 1.7 | 0.5 | 1.5 | 1.2 | 1.5 | 0.5 | 0.1 | 0.0 | 4.9 | 2.3 | 7.2 |
| 40 - 44 | 1.2 | 0.3 | 1.5 | 0.8 | 0.5 | 0.4 | 0.0 | 0.0 | 3.2 | 1.5 | 4.7 |
| 45 - 49 | 0.5 | 0.2 | 0.8 | 0.2 | 0.3 | 0.1 | 0.0 | 0.0 | 1.5 | 0.4 | 1.9 |
| > 49 | 0.2 | 0.1 | 0.3 | 0.0 | 0.3 | 0.1 | 0.0 | 0.0 | 0.8 | 0.2 | 1.0 |
| Total | 19.9% | 6.1% | 8.7% | 5.3% | 41.1% | 18.2% | 0.5% | 0.2% | 70.2% | 29.8% | 100.0% |

N = 1,306

Table 37

CAMARILLO
COMBINED SHORT TERM AND FAMILY CLIENTS

| Age at | Hispanic | | Black | | White | | Other | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Entry | M | F | M | F | M | F | M | F | M | F | T |
| 15 - 19 | .8% | .0% | .8% | .8% | 2.1% | 4.9% | 0 | .8% | 3.7% | 5.7% | 9.4% |
| 20 - 24 | 1.5 | 1.5% | 2.1 | 1.5 | 27.5 | 13.6 | 0 | 0 | 31.1 | 17.4 | 48.5 |
| 25 - 29 | .8 | 0 | 2.1 | 0 | 15.8 | 6.3 | 0 | 0 | 18.7 | 6.3 | 25.0 |
| 30 - 34 | 1.5 | .8 | 2.1 | 0 | 2.1 | 3.5 | 0 | 0 | 5.7 | 4.3 | 10.0 |
| 35 - 39 | 0 | 1.5 | .8 | .8 | .8 | .8 | 0 | 0 | 1.6 | 3.1 | 4.7 |
| 40 - 44 | 0 | .8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | .8 | .8 |
| 45 - 49 | .8 | .0 | .8 | .0 | 0 | 0 | 0 | 0 | 1.6 | 0 | 1.6 |
| Total | 5.4% | 4.6% | 8.7% | 3.1% | 48.3% | 29.1% | 0 | .8% | 62.4% | 37.6% | 100.0% |

N = 138

Table 38 compares the client demographics in the Camarillo treatment units with the baseline population Census data for Los Angeles and Ventura Counties, the two primary client sources. The detoxification coverage of the minorities is high relative to the area population, and would appear to be adequate relative to the minority drug problem.* However, the level of Hispanic white clients in the treatment units is lower than the Census level, and less than half the Hispanic white representation in the detoxification ward.

Ventura County has a large heroin addiction problem among its Hispanic white population, most of which is centered in the Colonia area of Oxnard.** Few Hispanic whites are being treated at Camarillo except in the detoxification unit. Of the early and current samples selected for this evaluation, 13.6% of the family unit and 7.5% of the short term unit were Hispanic white -- levels that are not excessively low proportionally.

The low fraction of Hispanic whites in the Camarillo treatment units was one of the subjects frequently discussed by many of the hospital administration and research staff members interviewed during the evaluation.+ The major reason for the concern was the close proximity of the hospital to a large addict population that the Camarillo treatment programs were unable to serve on a proportional basis. Reasons given for Camarillo's failure to attract Hispanic whites included: differences in cultural background of staff and clients; the Hispanic white client's

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* The addiction rate is higher among the black population.
** "Crime and Demographic Profile for Ventura County," No. 012-004, PSSI Report No. 012-004.
+ The Hispanic white representation at Camarillo has been the subject of a research paper in the NPI research program: W. Aron, "Chicanoizing the Therapeutic Community."

Table 38

CAMARILLO

COMPARISON OF CLIENT DEMOGRAPHICS WITH BASELINE CENSUS POPULATION DATA (AGES 15-69)

| | Los Angeles County | Ventura County | Detoxification | Short Term and Family | Adolescent | |
|---|---|---|---|---|---|---|
| **Sex** | | | | | | |
| Male | 48.5% | 49.5% | 70.2% | 62.4% | 65.1% | |
| Female | 51.5 | 50.5 | 29.8 | 37.6 | 35.9 | |
| **Race/Ethnic** | | | | | | |
| Hispanic white | 12.6 | 14.8 | 26.0 | 10.3 | 3.8 | |
| Black | 9.9 | 1.6 | 14.0 | 11.6 | 19.0 | |
| Non-Hispanic white | 73.1 | 81.1 | 59.3 | 77.4 | 77.2 | |
| Other | 3.8 | 2.2 | 0.7 | 0.7 | 0 | |
| **Age** | | | | | | |
| 15 - 19 | 12.7 | 15.1 | 5.2 | 9.4 | 7.6 | Age 16 |
| 20 - 24 | 12.3 | 11.3 | 39.3 | 48.5 | 31.1 | 17 |
| 25 - 29 | 11.2 | 11.4 | 26.8 | 25.3 | 42.3 | 18 |
| 30 - 34 | 9.1 | 10.9 | 14.2 | 10.1 | 15.2 | 19 |
| 35 - 39 | 8.6 | 10.4 | 7.2 | 4.2 | 3.8 | 20 |
| 40 - 44 | 9.2 | 10.3 | 4.7 | .7 | | |
| 45 - 49 | 9.6 | 9.3 | 1.9 | 1.4 | | |
| 50 - 69 | 26.8 | 21.1 | 1.. | | | |

inability to relate to the humiliating candidacy stage of the family treatment.* (However, as shown above, there are proportionately more Hispanic whites in the family program than in the short term program, which does not have the humiliating candidacy phase.)

Like most treatment programs, the Camarillo effort has developed modalities to meet the needs of a specific class of addict types with specific backgrounds, characteristics, drug use, etc. The prevailing feeling in Ventura County seems to be that the Camarillo treatment modalities are not appropriate for Hispanic whites, and they are seldom referred except to detoxification. However, Ventura referral policies are not wholly based on client attributes, but are governed by the availability of treatment funds (this subject is discussed in Section III.C.1 ). It would appear that some Hispanic white addicts in Oxnard (young, English speaking) would be amenable to treatment at Camarillo, and that the Ventura County authorities are underutilizing Camarillo resources in this regard.**

Table 39 shows the client demographics for the adolescent program, with 65.1% male, a median age of 17.5 years, and a racial distribution including 3.8% Hispanic white, 19% black, and 77.2% non-Hispanic white. The observations here are similar to the above, except that a substantial number of referrals to this unit come from counties other than Los Angeles and Ventura.

Table 40 shows the educational level of clients in the three Camarillo therapeutic communities. The short term clients have

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* The candidacy stage is somewhat inhumane and demoralizing for an addict right off the streets.

** All Hispanic white clients currently in treatment in the family and short term programs are Los Angeles referrals.

Table 39

CAMARILLO
ADOLESCENT PROGRAM CLIENT DEMOCRAPHICS

| Age at Entry | Race/Ethnic/Sex | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic | | Black | | White | | Total | | |
| | M | F | M | F | M | F | M | F | T |
| 16 | | | 3.8% | | 3.8% | | 7.6% | | 7.6% |
| 17 | | | | | 19.5 | 11.6% | 19.5 | 11.6% | 31.1 |
| 18 | 3.8% | | 3.8 | | 15.2 | 19.5 | 22.8 | 19.5 | 42.3 |
| 19 | | | 7.6 | 3.8% | 3.8 | | 11.4 | 3.8 | 15.2 |
| 20 | | | | | 3.8 | | 3.8 | | 3.8 |
| Total | 3.8% | | 15.2% | 3.8% | 46.1% | 31.1% | 65.1% | 34.9% | 100.0% |

N = 26

Table 40

CAMARILLO
CLIENT EDUCATIONAL STATUS

| | Family | Short Term | Adolescent |
|---|---|---|---|
| Some grammar school | 16.9% | 15.4% | 43.4% |
| Some high school (1-2 yrs.) | 32.3 | 26.3 | 52.8 |
| High school graduate | 32.3 | 45.1 | 1.9 |
| Some college (1-2 yrs.) | 16.9 | 10.3 | 1.9 |
| College degree or 3-4 years of college | 1.6 | 2.9 | 0 |
| | N = 89 | N = 175 | N = 53 |

educational backgrounds similar to those in the family except that there are slightly more high school graduates. The adolescent program has a large fraction of clients with some high school, but a low fraction of high school graduates.

c. Drug Use

The clients in Camarillo's treatment units have a long history of heavy drug abuse, especially in the family and short term programs. The clients in the adolescent unit, being young, have not become so heavily involved, but their abuse histories often are still substantial. Table 41 shows the frequency of use of primary drugs of abuse just prior to entry into treatment, for family, short term, and adolescent clients, respectively. Compared to the adolescent clients, the family and short term clients were generally heavy opiate abusers prior to entry (69% of the family clients and 55.5% of the short term clients used opiates more than twice a week, compared to 11.5% in the adolescent program). The major drug of abuse in the adolescent program is barbiturates, with 34% of the adolescent clients using barbiturates regularly prior to treatment.

Table 42 relates current age to age of first daily use of opiates for the family and short term clients. The tables are very similar. As with most groups of opiate abusers in treatment, the older clients tend to have become addicted later. Also, a few old clients who became addicted at an early age are in treatment. The mortality rate of the heroin addict is one of the reasons for this effect.

Since relatively few of the adolescent clients were heavy abusers of heroin, the data in Table 43 show the age of first daily use

Table 41

CAMARILLO THERAPEUTIC COMMUNITIES
FREQUENCY OF ABUSE OF PRIMARY DRUG
(2 Months Prior to Treatment)

| Primary Drug of Abuse at Entry | Frequency of Drug Abuse at Entry | | |
|---|---|---|---|
| | > 2 times/week | Daily | Total |
| **FAMILY PROGRAM** | | | |
| Alcohol | 0 | 6.3%* | 6.3% |
| Marijuana | 3.1% | 0 | 3.1 |
| Psychedelics | 0 | 3.1 | 3.1 |
| Barbiturates | 0 | 15.6 | 15.6 |
| Opiates | 3.1 | 65.7 | 68.8 |
| Depressants and stimulants | 0 | 3.1 | 3.1 |
| Total | 6.2% | 93.8% | 100.0% |
| N = 32 | | | |
| **SHORT TERM PROGRAM** | | | |
| Alcohol | 0 | 4.5%* | 4.5% |
| Marijuana | 0 | 2.2 | 2.2 |
| Amphetamines | 0 | 11.2 | 11.2 |
| Barbiturates | 2.2% | 22.2 | 24.4 |
| Opiates | 0 | 55.5 | 55.5 |
| Depressants and stimulants | 0 | 2.2 | 2.2 |
| Total | 2.2% | 97.8% | 100.0% |
| N = 49 | | | |
| NR = 4 | | | |
| **ADOLESCENT PROGRAM** | | | |
| Glue, inhalants | 0 | 3.8% | 3.8% |
| Alcohol | 0 | 11.5 | 11.5 |
| Marijuana | 7.7% | 11.5 | 19.2 |
| Psychedelics | 3.8 | 3.8 | 7.6 |
| Amphetamines | 3.8 | 7.7 | 11.5 |
| Barbiturates | 3.8 | 31.1 | 34.9 |
| Opiates | 3.8 | 7.7 | 11.5 |
| Total | 22.9% | 77.1% | 100.0% |
| N = 26 | | | |

*Percentage of total.

Table 42

CAMARILLO
FAMILY PROGRAM DRUG HISTORY

| AGE AT ENTRY | AGE AT FIRST DAILY USE OF OPIATES | | | | TOTAL ABUSERS | |
|---|---|---|---|---|---|---|
| | >15 | 15-19 | 20-24 | >24 | | |
| <20 | 15.6%* | 84.4% | 0 | 0 | 6.8%** | ( 6) |
| 20-24 | 0 | 83.0 | 17.0% | 0 | 52.3 | (46) |
| 25-29 | 0 | 43.5 | 47.8 | 8.7% | 26.1 | (23) |
| 30-34 | 0 | 57.1 | 14.3 | 28.6 | 8.0 | ( 7) |
| >34 | 16.7 | 50.0 | 16.7 | 16.7 | 6.8 | ( 6) |
| Total | 2.3% | 68.2% | 23.9% | 5.6% | 100.0% | (88) |

N = 92
NR = 6
* Percentage of "age at entry" group (percent of total in row).
** Percentage of total.

CAMARILLO
SHORT TERM DRUG HISTORY

| | >15 | 15-19 | 20-24 | >24 | | |
|---|---|---|---|---|---|---|
| <20 | 13.6%* | 54.5% | 13.6% | 18.2% | 11.5%** | ( 22) |
| 20-24 | 3.9 | 68.9 | 18.4 | 9.7 | 53.6 | (103) |
| 25-29 | 2.0 | 26.0 | 54.0 | 18.0 | 26.0 | (50) |
| 30-34 | 0 | 42.9 | 42.9 | 14.3 | 3.6 | ( 7) |
| >34 | 10.0 | 20.0 | 60.0 | 10.0 | 5.2 | (10) |
| Total | 4.7% | 52.1% | 30.2% | 13.0% | 100.0% | (192) |

N = 192
* Percentage of "age at entry" group (percent of total in row).
** Percentage of total.

Table 43

CAMARILLO
ADOLESCENT DRUG HISTORY

| | AGE AT FIRST DAILY USE OF ANY DRUG+ | | | | | | |
|---|---|---|---|---|---|---|---|
| | 9-10 | 11-12 | 13-14 | 15-16 | 17-18 | | |
| 16 | 0 | 100.0% | 0 | 0 | 0 | 4.5%** | ( 1) |
| 17 | 16.7% | 16.7 | 66.6% | 0 | 0 | 27.3 | ( 6) |
| 18 | 0 | 30.0 | 30.0 | 30.0% | 10.0% | 45.5 | (10) |
| 19 | 0 | 0 | 66.7 | 0 | 33.3 | 13.6 | ( 3) |
| 20 | 0 | 0 | 0 | 50.0 | 50.0 | 9.1 | ( 2) |
| Total | 4.5%** | 22.7% | 41.0% | 18.2% | 13.6% | 100.0% | (22) |

N = 26
NR = 4
\+ Including marijuana and alcohol.
* Percentage of "age at entry" group (percent of total in row).
** Percentage of total.

of any single drug (including alcohol and marijuana) vs. the age of entry into treatment. The median age of first daily use is 13 years, and the median age at entry into treatment is 18 years.

d. Client Retention

Figure 7 shows the client retention curves for the three Camarillo treatment programs. The short term curve shows a median retention of 2.1 months, 90% of the clients leaving within 90 days, in conformance with the program's policy. Retentions for the family and adolescent programs are similar, 50% of the clients leaving the family within 7.5 months, and 50% of the clients leaving the adolescent program within 6.2 months. In the three programs, 25% of the clients terminate as follows: short term, within 2 months; adolescent, within 3 months; and family, within 5 months.

The conditions under which clients terminate vary among programs. In the adult programs, the clients can terminate at will, but usually pressure is exerted by other clients and hospital staff to persuade a client to stay. The short term program has a 90 day limit on treatment, after which a client is obligated to terminate except for special cases of short additional residence. However, the short term graduate sometimes has the option of joining the family and continuing treatment there. Also, a number of short term graduates have entered the SSA program.

The adolescent program is more restricted since many of the clients are wards of the court. Such clients cannot legally leave treatment without the court's approval of a transfer to the client's home, a foster home, or another institution. The juvenile must have

Figure 7

CAMARILLO—CLIENT RETENTION

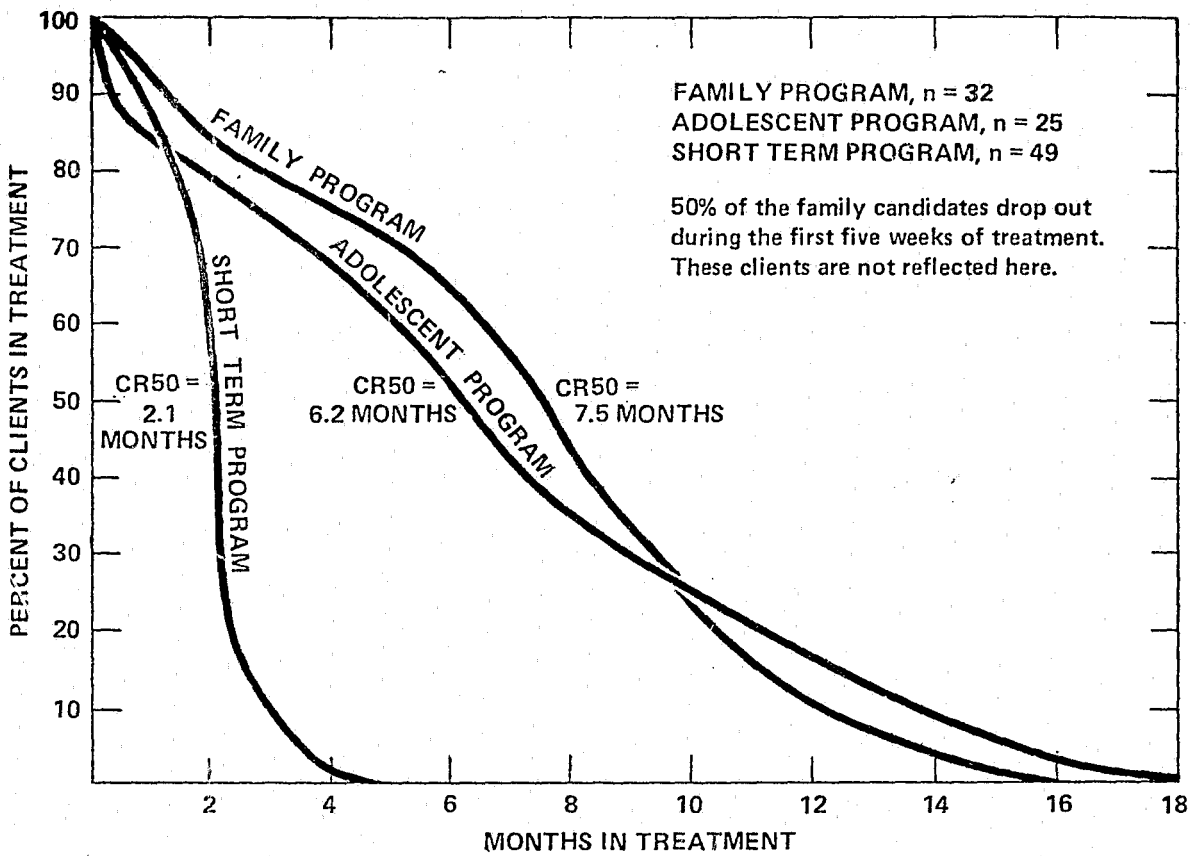
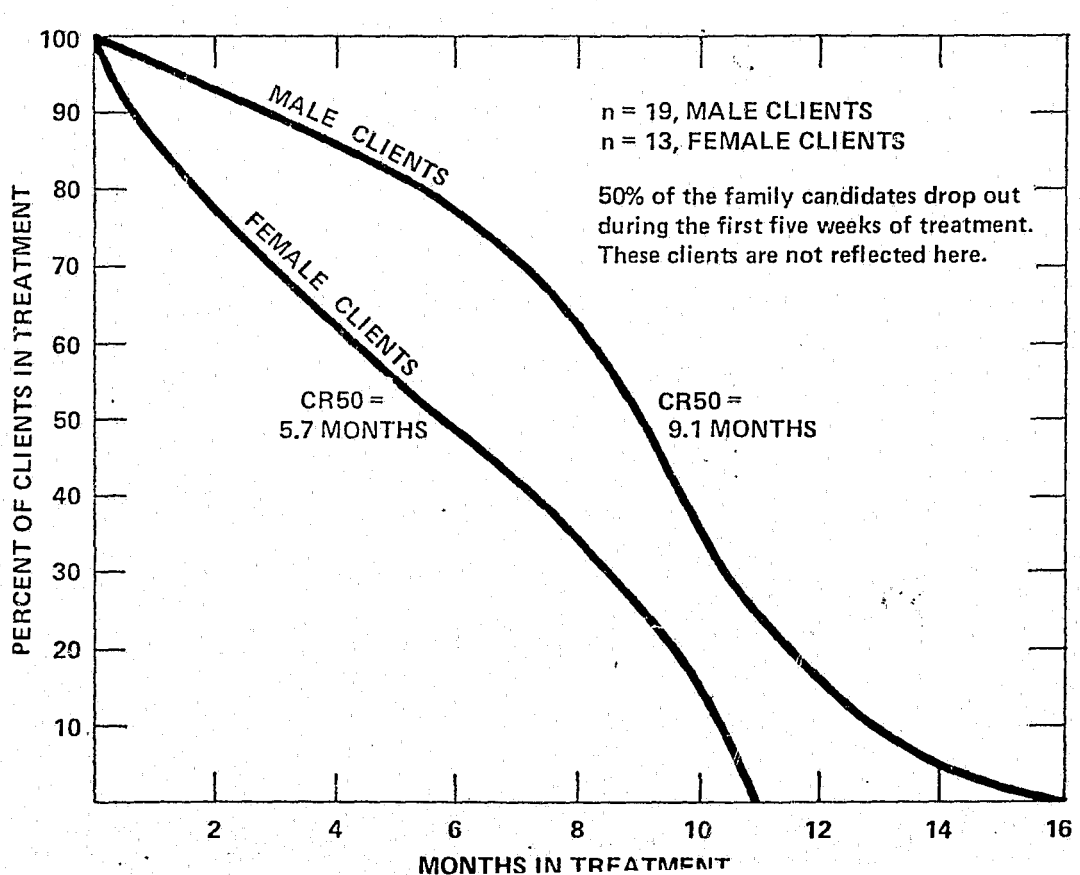



Figure 8

CAMARILLO FAMILY PROGRAM — CLIENT RETENTION



an approved place to go upon termination of treatment. Nevertheless, the program still has a number of runaways.

With respect to sex, Figure 8 shows that female retention in the family is much lower, with median retention of 5.7 months, compared with 9.1 months for the males. Some of the factors explaining this difference were given in Section III.A.3. In a therapeutic community, another factor is that women are frequently more distracted than men by close ties to children and others on the outside. The same difference in male and female retention exists to a greater degree in the adolescent program. But in addition to the outside ties, other causes are differences in maturity and in court policy with regard to sex.

Client retention in the detoxification unit is based on an average of two-thirds of continuous full capacity, or 30 client beds. From observations and interviews during the site visits, this fraction seems a reasonable estimate. On a two-thirds basis, the mean retention is 5.2 days (on a full capacity basis, it is 7 days), so that the actual average stay is probably between 5 and 7 days.* There are no set criteria for the duration of stay in detoxification. Many clients feel that they cannot accept the treatment and they leave early. For the others, the time required to detoxify varies more than 10 days in some cases, and their releases from treatment are based on the staff's assessment of their condition. Some clients who are entering one of the other programs at Camarillo need not be completely detoxified before moving into the other program.

* This is comparable to Aquarian's average detoxification of 5.3 days, based on continuous full capacity.

4. Staff Attributes

The staff of the Camarillo treatment units consist of members of the Camarillo State Hospital staff plus the SSAs previously mentioned. The hospital staff runs the detoxification unit, the short term program, and the adolescent unit, and provides only support services for the family unit, which is totally client-run. The total number of hospital staff for these four units is 54-56 and comprises many types of skills, as is shown in Table 44. In this table, and throughout this subsection, "staff" means hospital or research staff and thus excludes clients (such as in the family unit) who do treatment work.

Demographic data for the hospital staff are given in Table 45, which is based on interviews with a sample of 27 staff members. As shown, all of the staff are non-Hispanic white, except for one Hispanic white. This factor may contribute to the Camarillo program's disproportionately low attraction for Mexican-American drug abusers. Females make up 64% of the staff interviewed. About 74% of the staff have college degrees, 4% have had some college training, and 60% have had mental health training. These percentages indicate a relatively high educational level. About 40% (who are almost all SSAs) have a history of drug use.

The hospital staff spend about 39% of their time in counseling, 60% in providing client-related (support) services, and 10% in training and program-oriented meetings. This allocation appears to be a well-balanced approach to staff utilization.

The hospital staff, including the SSAs, are a highly motivated and compassionate group. Most of their training is obtained through on-the-job experience and courses supported by the hospital. Many staff members voluntarily spend time in the family unit as part of

Table 44

CAMARILLO
HOSPITAL STAFF TYPES AND NUMBERS*

| Staff Member | NUMBER OF STAFF MEMBERS IN TREATMENT UNITS | | | |
|---|---|---|---|---|
| | Detoxification | Family | Short Term | Adolescent |
| Treatment units | | | | |
| Registered nurses | 3 | 0 | 0 | 4 |
| Psychiatric social worker | 1/3** | 1/3 | 1/3 | 1 |
| Psychiatric technicians | 8-9 | 3-4 | 9 | 7 |
| SSAs | 7 | 0 | 3 | 3 |
| Volunteers | 0 | 0 | 3 | 1 |
| Teacher | 0 | 0 | 0 | 1/4 |
| Music therapist | 0 | 0 | 0 | 1/4 |
| Psychologist | 0 | 0 | 0 | 1/2 |
| Physician | *** | *** | *** | *** |

* Management: The detoxification, family and short term staffs are administered by the director of the hospital's substance abuse division. The adolescent unit staff is administered by the director of the hospital's Adolescent Division. Both directors have assistants and clerical staff and are responsible for programs other than drug treatment. They and their administrative staffs are not shown in this table.

** Fractions indicate part time contributions.
*** As needed.

Table 45

CAMARILLO
STAFF DEMOGRAPHICS

| Age | RACE - ETHNIC | | | | |
|---|---|---|---|---|---|
| | Hispanic | White | Black | Non-Hispanic White | Other | Total |
| 15 - 19 | 4% | 0 | 0 | 0 | 4% |
| 20 - 24 | 0 | 0 | 19% | 0 | 19 |
| 25 - 29 | 0 | 0 | 30 | 0 | 30 |
| 30 - 34 | 0 | 0 | 22 | 0 | 22 |
| 35 - 39 | 0 | 0 | 7 | 0 | 7 |
| 40 - 44 | 0 | 0 | 7 | 0 | 7 |
| 45 - 49 | 0 | 0 | 4 | 0 | 4 |
| > 49 | 0 | 0 | 7 | 0 | 7 |
| Total | 4% | | 96% | | 100% |

N = 27

the family or short term program. There is a three-week orientation period for new employees, who are usually transferred from other parts of the hospital. During this period, they spend time in all units and on all shifts, learning how their staffs and patients function. More formal training is given by weekly conferences at the Camarillo-UCLA NPI research program, which they may attend. They are also given educational time off (5 days) to go to conferences on drug-related topics. Finally, there is a one-year course for psychiatric technician training at the hospital, and the hospital will sponsor some outside schooling.

Staff turnover is rare among regular hospital staffs. For a sample of 27 members, the average retention on these programs to date is 15 months which is biased low because of the short tenure of SSAs. The administration tries to choose caring people who are in touch with themselves -- not rigid, nor excessively moral. Treatment staff adequacy, as appraised by the evaluation site visit team, shows 81.5% with a rating of good to excellent. All staff members were considered adequate.

Following is a summary of staff assignments in the drug abuse program.

a. Staff for Treatment Units

The detoxification unit is run completely by hospital staff. The adult units (family and short term programs) are administered by the Substance Abuse Division of the hospital, and the adolescent unit, by the Adolescent Division. (See Table 44, previously given.) The director of the hospital Substance Abuse Division is a registered nurse. She and an assistant direct the detoxification, short term,

and family units as well as the alcoholism program of the hospital. In the detoxification unit, she is assisted by staff as shown in Table 44. Part time personnel are: a recreation therapist, a physician on call, and a psychiatric social worker to help plan recreational activities.

For the family unit, hospital staff provide such support as medical, dental, and psychiatric aid, as needed; and a part time psychiatric social worker who acts as court liaison, helps to plan recreational activities, and participates in some group and individual counseling. For crisis situations, the program director or her assistant, plus nurses and psychiatric technicians, can be called. (Examples of crisis situations are potential splittees and psychiatric emergencies.) The family ward always has a staff member, usually a psychiatric technician, on duty in the staff office.

The short term program has a psychiatric technician in charge of the ward and is staffed as shown in Table 44 . There is also intensive legal work with clients. A part time social worker goes to court with the clients and works with probation and parole.

The adolescent unit is staffed like the short term unit -- i.e. peer government plus hospital staff: an RN coordinator; the nursing charge with a staff of RNs; psychiatric technicians; and SSAs. There is an outside teacher, from a school on the hospital grounds, with an SSA assistant. The adolescent unit also has a full time social worker and a part time consulting psychologist. One volunteer conducts communication and encounter groups one day a week while she is working on her master's degree. A part time music therapist is paid by the hospital to conduct different kinds of music encounter and music appreciation groups.

The staff to client ratio in detoxification is 1:2.1 based on total staff to number of beds. This ratio is lower than that of Aquarian Detoxification. The staff to client ratios for the family, short term, and adolescent units are 1:7.5, 1:3.7, and 1:1.2, respectively, based on total staff to average clients in treatment. This result reflects the high level of self treatment in the family as compared with the more extensive supervision in the adolescent program.

b. Staff of Camarillo - UCLA NPI Research Program

The research staff working on drug abuse represent many disciplines. Current principals working in the drug abuse areas include two sociology masters degrees, two sociology PH.D.'s, a psychology Ph.D. and an M.D. All of them have extensive backgrounds in drug abuse research and other aspects of psychosocial and psychophysiological research. They have been assisted in their work by other research associates with similar backgrounds, as well as by research assistants and technicians, SSAs, and others.

At Camarillo, the NPI research program has its own full time administrator to assist its director, as well as a substantial clerical staff. The research program there is also studying problems other than drug abuse; there are additional researchers in the program doing these studies. Also, some of the researchers doing drug abuse research are concurrently working on studies in other areas.

c. Social Service Aides

A significant fraction (nearly one-fourth) of the hospital employees in all the drug treatment programs and in the research program are SSAs. These are half-way jobs for graduates from the family program primarily, but also from the short term and adolescent programs. The SSAs are a distinctive feature of the treatment program at Camarillo,

and are an innovation of the research program. The positions are described by the research director as follows:

-- The clients are half-way toward being on their own.

-- Like many others, they learn the most when trying to teach others.

-- They have nine months of paid employment before fully re-entering society.

-- Even after entering society as a graduate, the program has influence on them, representing the "extended influence of the family on the street."

Twelve of the SSAs are paid by the research program and six by the hospital. Of these, ten work as research assistants in the research program and the remainder in the hospital drug treatment units. Over 60% of the family graduates have becomes SSAs. This work meets one of the major requirements for graduation from the family program -- that one must have a job.

As part of the treatment program, SSAs go through the standard hospital orientation process. SSAs entering the research program usually require two to three months to train for their position. Some of them do very well in this work. Two have become so valuable in their positions that they were converted to full time employees. Unfortunately, none of the research assistants leaving the program have been able to go on to similar positions on the outside, but some intend to pursue this career with further training.*

The SSAs meet weekly with the administrative coordinator of the research program to discuss current problems and to study aspects of obtaining future jobs, such as being interviewed and filling out job

* Research assistants leaving the program have been able to find consulting jobs in other drug treatment programs.

applications. The psychiatric technician training program offered by the hospital is also attended by some SSAs.

Duties of the SSAs in the treatment units are similar to those of the psychiatric technicians. In the Field Research effort, they primarily interview clients, track and interview ex-clients, tabulate data, and prepare data for entry to computer files. In the psychophysiological research effort, they set up and monitor instrumentation, reduce data from analog to digital for analysis, and even assist in some of the analysis on a small digital computer located in the program's laboratory.

5. Quality of Self Evaluation Efforts

In terms of the definitions provided in CCCJ's "Evaluation of Crime Control Programs in California: A Review," the evaluation effort at Camarillo is evaluative research. This conclusion is based on the following: (a) wherever possible, Camarillo's data are matched with those from control groups: (b) Camarillo's test instruments are valid and appear to be used knowledgeably; (c) project staff are aware of and make extensive use of prior research; in fact, they have developed an extensive bibliography and collection of drug treatment literature; (d) they are applying conventional statistical methodology in their research work; and (e) their attempt is as valid as any in the drug treatment field to determine whether their project is successful. The adequacy of their evaluation effort is mainly due to their large and well-funded research program. However, with respect to ongoing evaluation, as conceived by OCJP and some of the treatment projects, improvements could be made. The research program's own natural cycle of study and reporting is not particularly well-suited to ongoing evaluation of treatment with frequent feedback of findings to modify treatment, to assess utilization, to evaluate staff and staff training, etc. Because of the close association between the research program and the treatment administration, most of these evaluation needs are met, but treatment evaluation is a by-product of the research, so that priorities are set on the basis of research needs.

Examples of problems in this arrangement are:

- The research client survey ended in April 1973 so that data analysis could begin. At that time, they stopped conducting detailed intake interviews of clients, since their research client samples were complete. The standard hospital intake forms are inadequate for ongoing client description and evaluation, so that continuing evaluation in that area has closed.

- Research has taken little interest in detoxification since it has no studies in that unit; thus, the detoxification evaluation effort is the minimal amount required for hospital administration and treatment policy.

- Most of the research projects are rather long term (3-4 years under the OCJP grant) and they do not usually put out periodic summaries of their findings or summaries of current characteristics of treatment units, clients, and staff. This periodic description of status and characteristics is an evaluative tool which can help in identifying changes and modifying policy. In most of the other clinics, it is also necessary that periodic reports should be sent to OCJP and other agencies. But at Camarillo, the NPI Research program is the OCJP grantee and makes its own reports on its research activities.

Unlike the other projects in the cluster, the OCJP grant to the research program is primarily for drug abuse research rather than treatment. Our evaluation plan is primarily directed toward treatment through the cluster. At Camarillo we have evaluated the treatment programs, and to some extent, their interaction with the research program. We have not attempted to evaluate the research plan per se, with few exceptions, because the subjects being studied cannot by their nature be evaluated except by the traditional approach of peer review of published results and assessment of their validity in operation. To some degree, the method of research can be evaluated, where it interacts with treatment. Also, it is possible to evaluate the degree to which the objectives stated in the research protocol have been achieved.

a. Research Approach

The research program at Camarillo is rather loosely structured, with each researcher (principal investigator) formulating many of his own projects according to perceived needs with his specialty and managing them to completion. Each project must be cleared with the director and other staff members with regard to relevance, cost, duration, etc. For

this purpose, a protocol is prepared describing each major project, methodology, experimental subjects, hypotheses, etc. Each protocol must be cleared by a committee composed of senior hospital and research staff to insure that current standards for research on human subjects will not be violated. The projects then go through the usual steps of detailed planning and modeling, staffing, direct observation, collection of relevant data, reduction of data to a form amenable to analysis, search of related literature, analysis and formulation of conclusions, and report preparation and publication.

b. Research Topics and Products

The drug abuse research topics under study at Camarillo are numerous and diverse. They deal primarily with the psychosocial and psychophysiological aspects of drug addiction and addiction treatment. Table 46 lists specific topics or projects which are and have been the subject of research by the NPI research team at Camarillo. The table shows the current status of each topic in terms of progress from inception of a study plan through observation and analysis to final product. The product of each topic is also shown in general terms (e.g., journal publications).

The study topics are listed in approximate order according to principal investigator and the research plan from which the topic derived. The progress of the research effort can be measured by the fact that research reports and research findings to modify treatment have been produced for 67% of the topics undertaken. Also, in 85% of the topics, data collection either has been completed or has progressed sufficiently to permit production of research reports. Table 47 is a list of these sources, which are cross-referenced to the list of topics. Specific products (publications)

Table 46
RESEARCH TOPICS

| | STUDY PLAN | SAMPLE SUBJECTS IDENTIFIED | OBSERVATION OF SAMPLE POPULATIONS* | LITERATURE SEARCH* | DATA REDUCED TO FORM AMENABLE TO ANALYSIS | ANALYSIS | DOCUMENTATION OF FINDINGS | RESEARCH FINDINGS RESULTED IN PRODUCT** |
|---|---|---|---|---|---|---|---|---|
| 1. An anthology representative of current knowledge about the psychosocial aspects of drug use and abuse. (10) | X | N.A. | N.A. | X | N.A. | + | / | + |
| 2. A discourse on the administration of drug abuse programs. (10) | | | | | | | | |
| 3. A social structural analysis of the relationship between informal and formal communication networks, and the effect of these upon the operation of the family program. (113) | X | X | X | X | X | / | / | 2 |
| 4a. A study of participant observation and program evaluation. (10) An analysis of the contributions that participant observation can make in the area of program evaluation, based upon research in a therapeutic community. | X | X | X | X | X | X | / | 2 |
| 4b. A study on solidary opposition and formal inmate organization. (10) This study questions previous findings which suggest that the solidarity opposition model is not appropriate to therapeutically oriented institutions, and that solidary opposition is antiethical to treatment. | X | X | X | X | X | X | / | 2 |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
N.A. = Not applicable
* /=in progress, +=near completion, X=completed.
** Research products:
1. Research findings used to modify treatment process.
2. Research findings submitted to journal for publication.
3. Research findings published in journal or magazine.
4. Research findings published and circulated among own group only.
5. Research findings presented to symposium or seminar.

| | STUDY PLAN | SAMPLE SUBJECTS IDENTIFIED | OBSERVATION OF SAMPLE POPULATIONS* | LITERATURE SEARCH* | DATA REDUCED TO FORM AMENABLE TO ANALYSIS | ANALYSIS | DOCUMENTATION OF FINDINGS | RESEARCH FINDINGS RESULTED IN PRODUCT** |
|---|---|---|---|---|---|---|---|---|
| 5. A study on the possibility of self-help in an institution. This study attempts to determine the extent to which it is possible to develop a self-help ideology among drug addicts in an institution dominated by professionals. (10) | X | X | X | X | X | X | / | 1 |
| 6a. An evaluation of the use of videotape and psycho-physiological feedback as a treatment modality. This works well to examine the use of these techniques as research tools in the evaluation of a specific treatment modality (the family procedure known as "the Game"). (214) | X | X | X | X | X | X | / | 2 |
| 6b. Test of the hypothesis that videotape and physiological recordings will provide an objective index of patient performance during treatment. From this material, an accurate assessment of patient progress can be determined. (214) | X | X | X | X | X | X | / | 2 |
| 6c. Test of they hypothesis that self-confrontation will significantly increase patient's progress in treatment. (214) | X | X | X | X | X | X | / | / |
| 6d. Test of the hypothesis that experience of disparity between outward behavior and physiological behavior will facilitate self-disclosure. (214) | X | X | X | X | X | | | |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
N.A. = Not applicable
* /=in progress, +=near completion, X=completed.
** Research products:

1. Research findings used to modify treatment process.
2. Research findings submitted to journal for publication.
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| | STUDY PLAN | SAMPLE SUBJECTS IDENTIFIED | OBSERVATION OF SAMPLE POPULATIONS* | LITERATURE SEARCH* | DATA REDUCED TO FORM AMENABLE TO ANALYSIS | ANALYSIS | DOCUMENTATION OF FINDINGS | RESEARCH FINDINGS RESULTED IN PRODUCT** |
|---|---|---|---|---|---|---|---|---|
| 6e. Test of the hypothesis that by making videotape and and physiological recordings of a patient during videotape and physiological feedback, it will be possible to study the specific effects of such feedback. (214) | X | X | X | X | / | / | / | 1 |
| 7. Develop testable hypotheses concerning the relationship between dreams and drug abuse (217) | X | X | X | X | / | / | / | |
| 8. Assess the extent of sleep and dream disturbances. Examine dream content, changes in dream content as a function of treatment progress, and the use of dream material as a therapy. (217) | X | X | X | / | / | / | / | |
| 9a. A study to exploring whether psychological differences can be found between adolescents showing traits (i.e., continuing patterns) of aggressive behavior and those showing reactive (i.e., situations) aggressive behavior. (237) | X | X | X | X | X | X | X | + |
| 9b. Test of the hypothesis that adolescents differing in trait-state aggressive patterns will exhibit qualitatively different verbal and psychophysiological responses to projective stimuli. (237) | X | X | X | X | X | / | / | |
| 10. A study of the problems and potential of psychological and psychophysiological research in a residential treatment program. (4) | X | X | X | X | X | X | X | 2 |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
N.A. = Not applicable
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1. Research findings used to modify treatment process.
2. Research findings submitted to journal for publication.
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| | STUDY PLAN | SAMPLE SUBJECTS IDENTIFIED | OBSERVATION OF SAMPLE POPULATIONS* | LITERATURE SEARCH* | DATA REDUCED TO FORM AMENABLE TO ANALYSIS | ANALYSIS | DOCUMENTATION OF FINDINGS | RESEARCH FINDINGS RESULTED IN PRODUCT** |
|---|---|---|---|---|---|---|---|---|
| 17c. Test of the hypothesis that the rate and variety by adoptive behavior can be increased with contingency contractors. | X | X | X | X | X | X | / | 2 |
| 17d. Test of the hypothesis that drug abuse can be decreased with contingency contracting. (1) | X | X | X | X | X | X | / | 2 |
| 17e. Test of the hypothesis that the natural environment can maintain the adoptive behaviors initiated with contingency contracting. (1) | X | X | X | X | X | X | / | 2 |
| 18. Use of the Porta-Prompter in therapy. (5) | X | X | X | X | X | X | / | 2 |
| 19. Publication of an article that discusses the procedure by which the family contracting exercise is implemented. | X | X | X | X | X | X | / | 2 |
| 20. Assessment of personality, social, cultural, and background variables that are significant in the drug abuse lifestyle (222) -- in particular: | X | X | X | X | X | / | / | 2 |
| a. A comparison of the individuals in the short and long term programs. (222) | X | X | X | X | X | / | / | / |
| b. A comparison of the individuals who finish the program with those who leave early. (222 & 229) | X | X | X | X | X | / | / | / |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
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** Research products:

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|---|---|---|---|---|---|---|---|---|
| c. A comparison of the individuals who go back to using drugs with those who do not. (222 & 229) | X | X | X | X | X | / | / | / |
| d. A comparison of the individuals in the short and long term programs, and the adolescent program. (229) | X | X | X | X | X | / | / | / |
| 21. A follow-up and cost effective comparison for short and long term therapeutic communities. (3) | X | X | X | X | X | X | / | 2 |
| 22. A study of the therapeutic community as a mode of treatment for the Chicano addict. (6) | X | X | X | X | X | X | / | 2 |
| 23. A study to determine the optimum length of the sampling period for follow-up studies. (7) | X | X | / | X | / | / | | |
| 24. Questions to be discussed using the data from the questionnaires of the follow-up study in particular (7): | | | | | | | | |
| a. Who finishes the treatment programs and who does not? | X | X | / | X | / | / | | |
| b. After completing the treatment program, who succeeds and who does not? | X | X | / | X | / | / | | |
| c. What is the relationship between success and finishing the program? | X | X | / | X | / | / | | |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
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|---|---|---|---|---|---|---|---|---|
| 25. Determination of the difference in identity concepts between control and addicted females. | X | X | X | X | X | X | / | 2 |
| 26. Family disorganization and personal trauma of addicts in America. (7) | X | X | X | X | X | X | / | / |
| 27. An examination of the family background of drug abusers (10) | X | X | X | X | X | X | / | |
| 28a. A differentiation of personality/psychological characteristics associated with successful completion of the "adolescent" unit program from characteristics associated with failure to complete the program. (224) | X | X | X | X | X | / | | |
| 28b. Basic psychological evaluation of each patient involved in the "adolescent" unit program. (224) | X | X | X | X | X | / | | |
| 28c. Determination of the psychological changes, if any, undergone by patients through their involvement in the "adolescent" unit program. (224) | X | X | X | X | X | / | | |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
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* /=in progress, +=near completion, X=completed.
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|---|---|---|---|---|---|---|---|---|
| 28d. Test of the hypothesis that successful completion of the "adolescent" unit program is associated with such psychological characteristics as:<br>a. No overt, latent or borderline psychosis.<br>b. Minimal organic impairment.<br>c. At least average intellectual ability. (224)<br>.<br>. | X | X | X | X | X | / | | |
| 29. Resocialization and Adaptation in a Therapeutic Drug Community: an analytical study of the change and development experienced by an individual within a therapeutic community for drug abusers such as that at Camarillo State Hospital. (10) | X | X | X | X | X | / | | |
| 30. Operation of a community program that will employ a form of contigency contracting in the treatment of adolescents. The program will include three prototype community/probation sponsored houses staffed by family graduates. (9) | X | X | / | X | | / | | |
| 31. Long term (5 year). Follow-up of 40 family clients to Study Sociology and Recidivism (11). | X | X | / | | | | | |

NOTE: Numbers in parentheses refer to Sources of Research Objectives (following).
N.A. = Not applicable
* /=in progress, +=near completion, X=completed.
** Research products:

1. Research findings used to modify treatment process.
2. Research findings submitted to journal for publication.
3. Research findings published in journal or magazine.
4. Research findings published and circulated among own group only.
5. Research findings presented to symposium or seminar.

Table 47

SOURCES OF RESEARCH TOPICS

1. Protocol for "Contingency Contracting with Community Based Adolescents and Their Families."
2. Adolescent House Proposal.
3. Paper of same title by William S. Aron.
4. Paper of same title by Russell A. Lockhart.
5. Paper of same title by Weathers and Liberman.
6. "Chicanoizing the Therapeutic Community," Aron, et al.
7. Interview with William S. Aron, October 25, 1973.
8. Interview with Russell A. Lockhart, October 25, 1973.
9. Telephone conversation with Blake Boyle, October 31, 1973
10. The Camarillo Resocialization Program for Drug Abusers, California Council on Criminal Justice, Project Number 0566, Third Quarterly Report, Second Year.

214. Protocol for "Use of Videotape and Psychophysiological. . ."

217. Protocol for "Dreams and Dreaming in a Drug Abuse Population."

237. Protocol for "Projective and Psychophysiological Responses in Differing Patterns of Aggressive Behavior."

222. Protocol for "Longitudinal Study of Cultural, Social. . ."

224. Protocol for "Adolescent Psychological Characteristics and Changes in Drug Abuse Treatment Programs."

229. Protocol for "Longitudinal Study of Cultural, Social and Personality Characteristics of Various Types of Adolescent Drug Abusers (Addicts)."

11. Study by Lincoln J. Fry, Ph.D.

in which the results of the research will be presented are listed in Table 48 with titles and authors. Many of the research projects are well along toward completion. Among those that are lagging are the ones requiring extensive data collection, reduction, and statistical analysis; these are in the field research and psychophysiological projects.

c. Problems

Some problems that have been noted in methodology execution of some of the research programs are discussed below.

The analysis of the interview and follow-up data gathered by the field research unit began with attempts at multiple correlation and regression among factors as the data were computerized. These statistical methods were probably too sophisticated for the initial stage of analysis. Recently, a more basic approach that will amplify the effort was adopted. Factors are being defined in detail; data relating to each factor are being thoroughly searched for anomalies; two-way correlations between likely variables are being used with theory to postulate likely models that can be tested; data are being presented in tables and point plots so that possible relationships or patterns can be visually noted among data sets or subsets; etc.

Problems have arisen here, as elsewhere in obtaining a control group. The use of college students as an adequate control group for clients is questionable because of differences in criminal and drug behavior between students and clients. (Outcome evaluation uses family graduates, splittees, and short term graduates.) Short term splittees are not being considered because it is felt that the duration of their treatment was not long enough to have any effect. These splittees might make a more appropriate control group because of the similarity of their prior life

Table 48
RESEARCH PRODUCTS - PUBLICATIONS

Robert H. Coombs, Ph.D. and Patricia G. Lewis, M.A., The Psychosocial Context of Drug Abuse. In preparation.

I. H. Perkins, M.D., "A Unique Approach to Hospital Treatment of Narcotic Addicts." Published.

Robert H. Coombs, Ph.D., "The Camarillo Resosocialization Program for Drug Abuser." Published.

William S. Aron, Ph.D., "Short and Long Term Therapeutic Communities: A Follow-up and Cost Effectiveness Comparison." Accepted for publication.

Lincoln J. Fry, Ph.D., "Participant Observation and Program Evaluation." Accepted for publication.

Lawrence Weathers, M.Ed., "The Porta-prompter: A New Electronic Prompting and Feedback Unit." Accepted for publication.

Russell A. Lockhard, Ph.D., "Researching the Drug Abuser: The Problems and Potential of Psychological and Psychophysiological Research in a Residential Treatment Program (The Camarillo Family.)" Submitted for publication.

William S. Aron, Ph.D., et al., "Chicanoizing the Therapeutic Community." Submitted for publication.

William S. Aron, Ph.D., "Familial Background of Drug Abusers." In preparation.

Lincoln J. Fry, Ph.D., "Solidary Opposition and Formal Inmate Organization." In preparation.

Jay Abarbanel, Ph.D., "Resocialization and Adaptation in a Therapeutic Drug Community." In preparation.

R. H. Coombs, Ph.D., I.H. Perkins, M.D., and B.P. Boyle, M.A., "Administrating Drug Abuse Programs." In preparation.

Lincoln J. Fry, Ph.D., "Is Self-help Possible in an Institution?" In preparation.

Robert Paul Liberman, M.D. and Lawrence Weathers, M.Ed., "Contingency Contracting with Families of Delinquent Adolescents." In preparation.

Lawrence Weathers, M.Ed. and Robert Paul Liberman, M.D., "The Family Contracting Exercise." In preparation.

R. H. Coombs, Ph.D. and Lincoln J. Fry, Ph.D., editors, Junkies and Squares. In preparation.

R. H. Coombs, Ph.D., L.J. Fry, Ph.D. and Patricia G. Lewis, M.A., Becoming a Drug Abuser, In preparation. To be published by Schenkman.

William S. Aron, Ph.D., and Cynthia Scherscching, B.A., "The Female Drug Addict: The Effect of Family Composition on Sense of Self." submitted for publication.

with those under study.

Tighter control and coordination of the field research effort would have alleviated many of the data analysis problems they now face, and would have given more assurance of timely and meaningful findings.

The field research and psychophysiological elements of the NPI Research program spent the first two years of their three year projects collecting data. The general approach has been to collect detailed client data for a large number of factors (background, drug history, criminal justice involvement, psychological and other test results before and after treatment, and test results and characteristics during treatment), and to employ correlational or regression analysis to search for meaningful relationships among factors (e.g., sex and age and IQ vs. outcome). The usual alternate approach is to hypothesize models that relate the factors, and to design experiments for testing the models. In many instances, the second approach can be satisfactorily employed using data collected by the first approach, so that the two approaches are not necessarily independent. The first approach is by far the more expensive and time consuming. It has the advantage that size of the data base (number of factors) allows wider exploration which may provide significant results not anticipated from the modeling approach. The disadvantage, in addition to cost, is that the statistical tests available are generally weaker than those applicable under a planned design.

The first approach was the one used in the Camarillo field and psychophysiological research efforts. These are major and valuable efforts, and provisions should be made for adequate funding and time for completion of the extensive statistical analysis required.

d. Assets of the Research Program

The high quality of the research effort at Camarillo is due primarily to the caliber of the researchers working there. Contributing factors are the research projects' location and relationship with the hospital and treatment units' staffs and clients; the superior and extensive laboratory equipment used in the psychophysiological research; and the association with the UCLA NPI and its resources.

e. Adequacy to Evaluation Funding

Because of the extensive research project, the evaluation funds have been much larger than those of other similar projects. However, in terms of funds required to complete the research effort, funds are inadequate. In view of the valuable data that have been collected, and the highly qualified research team, much of the research should be supported with additional funding.

6. Project Impact

a. Impact Measures and Samples Used

In Camarillo's extensive research project, one element included follow-up investigtigations to determine treatment outcomes in terms of important impact-oriented objectives. The SSI evaluation team obtained samples of clients from the research project data base, and these were used for describing client attributes and for tracking clients through the probation offices of Los Angeles and Ventura Counties. A

summary of the samples furnished by the research project is given below.

| Sample | Camarillo Treatment Unit | | |
|---|---|---|---|
| | Family | Short Term | Adolescent |
| A. Camarillo primary field research file (June 1972 to April 1973). | 94 | 192 | 60 |
| B. Client sample for SSI evaluation (early 1973; subsample of A) | 33 | 49 | 26 |
| C. Probationers tracked through probation files (subsample of B) | 7 | 21 | 3 |
| D. Current (Feb. 1973) client sample (not in any of above) | 34 | 31 | |

The data provided for sample subjects consisted primarily of client history data prior to treatment at Camarillo, with the exception of clients in sample D above. Sample C was used in criminal justice impact assessment. Samples A and B were used for comparisons with C in impact assessment, and along with D (which contains no impact related data), were used in other parts of the SSI evaluation.

b. Criminal Justice Involvement

Table49 summarizes arrest data that show a decrease in criminal justice involvement, by age group, for the three therapeutic communities. In terms of percentage of client with decreased arrest rates since entry into treatment, the improvement ranges from 86% to 100%, depending on the age group. For the total sample, 90% had decreased arrest rates since entry. The measure "% clients without arrests since entry" is probably more meaningful for the therapeutic communities at Camarillo. In these terms, the total sample showed from 57% to 71% without subsequent arrests, and an overall average of 65%.

Table 49

CAMARILLO
IMPROVEMENT IN CRIMINAL JUSTICE INVOLVEMENT SINCE ENTRY INTO TREATMENT - COMBINED FAMILY,* SHORT TERM, AND ADOLESCENT CLIENTS

| Improvement | Percent of Clients by Age Group | | | |
|---|---|---|---|---|
| | 18-21 Years | 22-25 Years | Over 25 Years | Total |
| % clients with decreased arrest rates since entry | 90% | 86% | 100% | 90% |
| % clients without arrests since entry | 70 | 57 | 71 | 65 |
| | N=10 | N=14 | N=7 | N=31 |

* Applies only to clients who passed the candidacy stage (first 5 weeks). It is estimated that 50% of the family clients left during this stage.

Table 50

CAMARILLO
IMPROVEMENT IN CRIMINAL JUSTICE INVOLVEMENT SINCE ENTRY INTO TREATMENT - SHORT TERM AND FAMILY CLIENTS

| Improvement | Percent of Clients by Treatment Program | | | |
|---|---|---|---|---|
| | Adolescent | Short Term | Family* | Total |
| % clients with decreased arrest rates since entry | ** | 90% | 100% | 90% |
| % clients without arrests since entry | ** | 57 | 86 | 65 |
| | N=3 | N=21 | N=7 | N=31 |

* Applies only to clients who passed the candidacy stage (first 5 weeks). It is estimated that 50% of the family clients left during this stage.

** Sample size too small to permit inferences.

Table 50 shows similar data for the short term and family clients at Camarillo--and again shows improvement in all cases. In both Tables 49 and 50 older clients (family) showed the highest percentage improvement. Also, the family does much better in terms of clients without arrest after treatment, partly because of the jobs provided for graduates at Camarillo. But other evidence indicates that a high proportion of graduates remain arrest free after leaving Camarillo. Accurate estimates of clients arrest rates since entry into treatment could not be derived because of the small samples of probationers tracked, and especially because of the short time since many of the sample clients began treatment (the "after" time in the before-after comparison was too short for most subjects). There is also substantial inherent error in arrest data, and a tendency for a few clients with many arrests to bias results of arrest rate comparisons. Thus, large samples over a considerable period of time for each client are necessary for accurate estimates. (See Section III.C.5.)

The criminal justice involvement determined from the probation sample agrees reasonably well with results reported by the project for family members. According to recent quarterly reports, only 8.1% of the family graduates have had any involvement with the criminal justice system since leaving the family. The project's favorable view of results for the short term program appear to be justified by the data of Table 50 (90% of short term clients showed decreased arrest rates after entry). However, many in the sample have been tracked for only a few months.

Table 50shows the arrest data in terms of the three modalities: adolescent, short term and family. Arrest rates subsequent to treatment are shown to decrease substantially for the Family and adolescent programs and to increase for the short term program.

Because of the longer survey period ( 2 years per client), the pre-treatment arrest rate data for the probationer sample is believed to be more representative than the post-entry arrest data. Table 51 compares the probationer sample data with baseline arrest rates for Los Angeles and Ventura Counties (most Camarillo clients are recruited from these two counties).

The table indicates the higher proportion of total crimes among clients as in the nonvictim drug categories. However, the proportion of property arrests with respect to total arrest is lower for the family clients.

The following argument tends to support the hypothesis that the probation sample is representative of the client population as a whole:

> Hypothesis: On the average, all Camarillo clients had the same level of pre-treatment criminal justice involvement as the client sample C tracked through the probation files.

Table 51

CAMARILLO

COMPARISON OF BASELINE REGIONAL ARREST RATES WITH THOSE OF CAMARILLO CLIENTS (PROBATIONERS) PRIOR TO TREATMENT BY CRIME TYPE AND MODALITY

| CRIME TYPE | Los Angeles County Baseline | Ventura[a] Baseline | Family | Short Term | Evaluation Sample | NPI Research[e] Sample |
|---|---|---|---|---|---|---|
| Person | .56 | .31 | 71 | 14 | -- | -- |
| Property | 1.01 | .82 | 21 | 48 | -- | -- |
| Nonvictim drug | .86 | .82 | 129 | 138 | 104-122[f] | 108-126[f] |
| Nonvictim other | 1.94 | 1.42 | 0[c] | 2 | -- | -- |
| Miscellaneous | 3.15 | 2.03 | 0[c] | 0[d] | -- | -- |
| Total | 7.52 | 5.40 | 221 | 202 | | |
| N = 7 N = 21 | | N = 49 | N = 175 | NR = 17 | | |

a Arrests/100 population for 1972 (people years).
b Before treatment arrests/100 client years, as determined from probation records.
c 0 crimes per 14 client years.
d 0 crimes per 42 client years.
e Short term client-reported drug arrests/100 client years. Comparison in other than drug category not possible because of differences in crime type classifications.
f Estimates are based on total drug arrests reported by clients per 100 years of criminal involvement and on estimates of involvement.

Substantiation: The evaluation sample (B) and the total NPI sample (A) have drug related arrest rate ranges comparable to the nonvictim drug rates calculated from probation data (sample C).

The overall criminal justice involvement of the Camarillo clients was assessed by estimating arrest rates on the basis of the SSI sample of 49 short term clients (part of sample B), using drug arrest frequencies provided by the clients. These clients had an average of 6.7 (6-7) years of criminal justice involvement from the time they first began regular or daily use of some drug until their entry into treatment, and they reported an average of 6.4 drug arrests each prior to treatment. The estimated drug arrest rate on this basis was 104 to 122 arrests per 100 client years.

The same calculations for the sample of 192 short term clients (sample A) showed a rate of 108 drug arrest per 100 client years (assuming 6 years of criminal justice involvement) and a rate of 126 drug arrests per 100 client years (assuming 7 years of involvement). The clients reported an average of 6.5 previous drug arrests.

The Camarillo figure of 6.7 years rests on the assumption that years of criminal justice involvement of some kind are equivalent to years of heavy drug involvement. This is reasonable since heavy drug involvement is illegal. This assumption, however, is not entirely valid since there are many known cases where addicts have had extensive criminal justice involvement before becoming addicted. The prevalence of this phenomenon and the related time delays are not known here.

In conclusion, the basic assumptions of this argument are reasonable (if not sound) and the closeness of the probation data derived drug arrest rates to the client data derived rates tends to substantiate the hypothesis; all samples being random, the average criminal justice

involvement for all clients is the same as that of the probation sample. It also follows from this hypothesis, if valid, that on the average, the Camarillo clients gave an accurate or true description of their pre-treatment criminal involvement histories in their intake interview, which would tend to give credence to other interview information that they provide. This has been shown not to be the case in some other treatment projects, such as Sacramento Methadone, where probation/parole arrest data could also be compared with client provided data.

Tables 52 and 53 show baseline arrest trend data for Ventura and Los Angeles Counties, respectively, as an indicator of changes in crime rate or criminal justice policy that might affect inferences made here. The number of arrests in the nonvictim drug and property crime categories continued to increase through the 1972-73 period. This tends to indicate an increasing drug problem and no decrease in police activity relative to drug abusers.

In summary, the criminal justice impact of the Camarillo treatment programs has been difficult to assess quantitatively, because sample sizes were not large enough and the periods after start of treatment were not long enough. By improvement measures, the clients in all programs showed substantial improvement. Validity of the above hypothesis infers homogeneity of Camarillo clients with respect to criminal justice involvement and infers that client responses to research questionnaires is, on the average, honest and accurate.

c. Drug Usage

In terms of decreased drug use, family graduates generally remain drug free after leaving treatment.* In the sample, only one family

*However, there are few family graduates who have fully separated from the program and reentered society.

Table 52

CAMARILLO
VENTURA COUNTY ARREST TREND DATA*
Percent of Total Arrests for Given Years

| Crime Type | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 |
|---|---|---|---|---|---|---|
| Personal | 3.83% | 3.92% | 4.11% | 5.29% | 5.65% | 7.15% |
| Property | 12.16 | 11.57 | 12.68 | 14.39 | 15.32 | 22.72 |
| Nonvictim drug | 11.57 | 13.80 | 16.00 | 14.11 | 15.24 | 18.34 |
| Nonvictim other | 36.55 | 34.93 | 31.31 | 28.58 | 26.33 | 26.89 |
| Miscellaneous | 35.89 | 35.78 | 35.90 | 37.63 | 37.55 | 24.90 |
| Total number of arrests | 18,216 | 20,540 | 20,754 | 20,672 | 20,355 | 20,614 |

* Arrest data provided specifically for the evaluation by Bureau of Criminal Statistics, Sacramento, California, 1974.

Table 53

CAMARILLO
LOS ANGELES COUNTY ARREST TREND DATA*
Percent of Total Arrests for Given Year

| Crime Type | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 |
|---|---|---|---|---|---|---|
| Personal | 7.22% | 6.54% | 6.77% | 6.85% | 7.46% | 8.16% |
| Property | 14.61 | 12.82 | 13.63 | 14.14 | 13.41 | 16.41 |
| Nonvictim drug | 10.95 | 11.52 | 12.19 | 11.23 | 11.50 | 13.43 |
| Nonvictim other | 30.43 | 29.74 | 29.09 | 28.04 | 25.79 | 26.38 |
| Miscellaenous | 36.79 | 39.37 | 38.32 | 39.75 | 41.83 | 35.62 |
| Total number of arrests | 429,541 | 520,942 | 505,398 | 522,668 | 528,661 | 508,706 |

* Arrest data provided specifically for this evaluation by Bureau of Criminal Statistics, Sacramento, California, 1974.

graduate was arrested for drug-related offense. As with similar programs, most of the few clients who graduate develop successful drug free lives. The short term program appears to be less successful in achieving drug abstinence. Sample data indicate that 29% of the clients had one or more drug related arrests after starting treatment. Clients from the detoxification unit who do not go into some form of aftercare can be expected to revert to their drug use behavior shortly after leaving treatment. One of the important aspects that should arise from the follow-up study in the Camarillo research program will be the comparisons of drug use patterns before and after start of treatment. None of these data were organized enough to present at this time, but the structure of the research plan should detect changes before and after.

d. Other Impacts

The Camarillo family program shows concern for reentry of graduates into the community. All family members are assisted in finding employment (a job is one of the requirements for graduation). Recent quarterly reports indicate that 86.5% of family graduates are known to be employed, with an average salary of $440 per month. From 60% to 70% of these clients are employed as SSAs in the Camarillo Hospital as part of the reentry program (see Section III.C.3). Some of the short term graduates are also employed in SSA positions. In addition, 12 graduates and clients are currently enrolled in courses sponsored by the local community college.

The impact of the research program cannot be fully appraised here. Its impact will be realized in its findings and publications, to be judged by peers after publication, as is customary with basic research. One of the by-products of the research program is the accumulation of a

large body of current literature, which will be documented in an anthology of the psychosocial and psychophysiological aspects of current drug abuse treatment and research.

The research program has had extensive in-house impact on the treatment programs, especially the family, through its interaction with them. Many of the elements of the psychophysiological research effort have become important elements of the treatment process. There has been some mutual benefit between research and treatment:

1. SSA jobs give treatment program the unique asset of transitional jobs.
2. Clients provide data at no disadvantage to them. No detriment to therapy was noted.
3. Some research techniques are therapeutically useful.
4. Feedback from research has the potential of improving therapy.

However, there are also some disadvantages:

1. Although there is basic agreement in treatment philosophy between the research and treatment staffs, their goals are different. Therefore, data collection has been stopped arbitrarily because of the researchers' needs rather than the needs of ongoing evaluation.
2. Two heavy complex administrative superstructures--research and treatment--can only create problems for both programs, because of arbitrary political decisions and other actions not based on patients' needs.

Other impacts of the Camarillo research and treatment programs on the community, criminal justice systems, and drug treatment include presentations to community and law enforcement groups; consultation to others organizing treatment programs; participating on committees and advisory boards responsible for regional treatment planning; and periodic counseling assistance and training to other treatment programs (e.g.,

assistance to Zenith House, a therapeutic community for CYA clients in Ventura County).

The director of the research program has also been instrumental in negotiations with the Los Angeles mental health department concerning the transfer of Los Angeles funds to the Tarzana project, with the objectives of keeping treatment funds and client referral rates from Los Angeles at previous levels, and maintaining the stability of the program.

7. Project Potential

a. Cost-Benefit Measures

This section examines the unit costs required to achieve the impact discussed in the preceding section. Table 54 compares several cost-benefit measures for each of the treatment modalities at Camarillo. Definitions for the measures shown in the table are given below:

- o Cost per client year - the cost to support one client in treatment for a year.
- o Cost per graduate - total budgeted treatment funds divided by the total reported number of graduates.
- o "Improved client" - a client whose arrest rate after start of treatment is lower than the average arrest rate in the two years prior to treatment.
- o "Arrest free client" - a client without arrests after start of treatment.

Costs are given in terms of the total amount budgeted in FY 1973 for delivery of treatment in each of the modalities. In practice, because of the sampling problems using existing records, the types of client population from which the sample was drawn excluded those who left very early in the program (and presumably were not helped by the treatment). The remaining clients have been defined as "effective" clients.

Table 54

CAMARILLO
COST-BENEFIT SUMMARY

| | MODALITY | | | |
|---|---|---|---|---|
| | DETOXIFICATION | FAMILY | SHORT-TERM | ADOLESCENT |
| Total Treatment Funds | $396,832 | $244,793 | $314,597 | $237,000 |
| Average Attendance (For No. of Clients) | 30 | 30 | 45 | 20 |
| No. graduates per year | 943 | 19 | 106 | 9 |
| Total clients per year | 1,885 | 96 | 395 | 73 |
| Effective total clients per year[2] | 943 | 48 | 395 | 56 |
| % clients improved[3] | -- | 100% | 90% | 67% |
| % clients arrest free[4] | -- | 86% | 57% | 67% |
| $ per attendance day | $36.20 | $22.35 | $19.20 | $32.47 |
| $ per client year | $13,228 | $8,160 | $6,991 | $11,850 |
| $ per graduate | $421 | $12,884 | $2,968 | $26,333 |
| $ per improved client | -- | $5,100 | $885 | $6,316 |
| $ per arrest free client | -- | $5,930 | $1,397 | $6,316 |

1. Budget earmarked for treatment for fiscal year 1973.
2. Effective clients are the fraction assumed to remain in the benefit by treatment. In family program, those dropping out in candidacy phase are excluded (first 5 weeks.) In adolescent program, those less than 3 months in program were excluded from the sample and were assumed not to be helped appreciably.
3. An improved client is an effective client who has a lower arrest rate after treatment than before.
4. An arrest free client is an effective client who has no arrests since beginning treatment.

Cost-benefit of the detoxification ward is given in terms of $/client year and $/completion.* The cost per client year is high, but because of the short treatment cycle (6-7 days), the cost per completion is only $421. The cost-benefit measures given for the family program illustrate how important it is to use the most appropriate measure. Cost per client year and cost per completion are often used mainly because the data needed to compute these measures are most readily available. For the family, the dollar costs per client year and per graduate are given as $8,160 and $12,884, respectively. In recent New York studies,**the cost per client year (or equivalent client year) for therapeutic communities ranged from $2,102 to $8,257 and cost per graduate ranged from $8,249 to $29,285. The unit costs for the Camarillo family fall within this range. Both of these previous measures exhibit higher costs than those based on arrest data. In terms of arrest free clients or improved clients, the unit costs are $5,930 and $5,100, respectively. These costs indicate that basing results strictly on graduates of therapeutic communities tends to underestimate the value of services actually delivered. Clients that terminate prior to graduation from a therapeutic community generally are arrest free while in treatment and will often exhibit less criminal behavior for a time subsequent to leaving the therapeutic community. This favorable effect for the arrest free measure is partly a result of the close supervision of clients for many months, and the Camarillo job program that keeps many clients employed for 9 months after graduation.

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* Completion is a client who has completed the prescribed course of treatment.

**J. Romm, "Alternative Measures of Effectiveness of Drug Abuse Treatment," paper presented at 44th annual ORSA meeting, 1973.

For the short term program the costs per client year and per graduate are $6,991 and $2,968, respectively. These costs are also higher than unit costs using arrest data. The cost per arrest free clients is $1,397 -- a very low figure for residence programs. The cost per improved client is particularly low -- $885. A comparison of cost-benefit measures between the family and the short term programs illustrates one of the dilemmas of trying to make decisions on the basis of a few numbers. The short term program can show cost-benefit superior to the family in all four measures. However, the family generally treats clients with a higher level of criminal and drug involvement. If a comparison is made in terms of $/attendance day, then the results are more nearly the same for the two programs. In the case of many therapeutic communities where close supervision is maintained, the attendance days can be equated with drug free days. This measure may be compared to the estimated costs of the client maintaining his habit on the street ($30 to $300 per day depending on what costs are considered). In these terms alone, the modalities can be seen to be producing a net economic benefit. In addition, for a complete comparison, it would be necessary to make such calculations over about a 5 year period to compare the permanence of rehabilitation of clients in the two modalities.

The cost-benefit values for the adolescent program are predictably high. The high cost in terms of $/client year is due to the high staff to client ratio required in an adolescent program (1:1.2). The high $/graduate value is also due to the relatively small number of clients that manage to complete the schedule of treatment. The cost per improved client or per arrest free client is in a more acceptable range, largely because many of the clients remain under close supervision after terminating the unit.

b. Suggested Project Modifications

The detoxification ward's waiting list shows that more beds are needed. However, the addition of more beds in smaller units with a heavier motivational counseling component would be more appropriate than further expansion of the large impersonal unit they have, or creation of another similar one. Neither the short term nor the family are full, but until political pressures are removed as a factor, it is not clear whether these apparently well-run services should be expanded. Assignment to them should be clinical, not political, and detoxification should focus more on this goal.

The family should be modified in the direction of flexibility, especially in the candidate stage, which might even be eliminated and replaced by an orientation phase, without the features of humiliation. The job development program should be further implemented and should include the short term program. The latter program also merits a graduate residence like that of the family. The adolescent program probably should be smaller, since it is underutilized and has low client retention. A family counseling program and reentry facility might improve its impact. The didactic aspect of staff training could be readily improved by making videotapes of training sessions.

During the first two years of the three year NPI research effort, the field research and psychophysiological units have collected voluminous data. The units are devoting the third year primarily to correlational or regression analysis of these data in search of relationships. Our main concern is to assure that the valuable data are fully exploited to produce the maximum useful results for the technical community. To accomplish this task will require more time and funding, together with additional statistical expertise in the form of a general statistician, a biostatistician, or a statistically sophisticated experimental psychologist.

D. Open Door Drug Clinic

1. Services Provided

a. Description of Services

The Open Door Drug Clinic in Alhambra is a community based outpatient clinic serving the youth of the West San Gabriel Valley of Los Angeles County. The clinic is housed in an eight room one-story building on grounds shared with a fire station and a county medical clinic. As with most clinics of this kind, business is slow in the morning and builds up through the afternoon and into the evening. On some mid-week evenings when business is at its peak, some of the counseling is held in cars or on the lawns outside.

Treatment is geared toward primarily middle class high school students and other young adults who feel pressure from their peers to use drugs. Open Door also extends services to applicants with problems of personal relationships. The project receives an average of 550-700 visits per month (at 1 to 1-1/2 hours per visit) from 250-350 clients, with an additional 250-350 visits per month from drop-ins.

The primary services offered to clients are individual counseling; group therapy; family therapy; emergency services and referral via the clinic's hot line telephone service; counseling and drug education in local high schools; community information and outreach in the form of public lectures and other media; and assistance in coordination of community drug abuse treatment and rehabilitation policy.

The Open Door has no single therapeutic approach; the staff members will welcome any approach that will help. High priority and emphasis are placed on individual counseling. Most clients start

out with individual counseling and then move on into a combination of group and individual counseling or group counseling alone. Supervisors maintain an unobtrusive but tight control over the staff. Placement procedures are not strict; client request or chance usually determines which therapist starts working with a given client. However, a client will be transferred from one counselor to another to meet special needs, such as abortion and pregnancy counseling or job seeking. In many cases, the family is brought into the counseling after initial contact with the client. This approach is encouraged by the project.

There are several ongoing therapy groups (two to three per night except weekends when the clinic is closed to all but emergency calls). Most of these groups contain only invited members. The approach varies from group to group and includes psychodrama, transactional analysis, and other modalities. Groups have even been conducted in the high schools as part of the assistance given the schools by Open Door. In addition to these restricted membership groups (5-12 clients), an open rap group is conducted almost every evening during the week. In these sessions, almost everyone can participate. The average size of the rap groups is 10 clients. Most of the groups include two staff members as co-leaders or facilitators. In addition, there are usually one or two ongoing parent groups.

The clinic operates a 24 hours hot line telephone service during which counselors answer questions concerning drugs, VD, pregnancy, etc.; assist in crises (rare) such as drug overdoses by giving advice and making referrals; and provide information and referrals to other community services. During regular hours, phone calls are received and noted in a log by the receptionist on duty. In most

instances, she can answer the caller herself, but if not, she switches the call to one of the on-duty counselors. At night and on weekends, calls (an average of four per night) are switched by an answering service to a specified counselor at his home. Each counselor has this duty two or three times each month. Personnel providing the service are well-trained in taking such calls -- relating to the caller, getting necessary information, and resolving inquiries.

For use with the hot line, a rotary card file is kept up to date with the names and numbers of all local services, such as local drug treatment, emergency medical, and legal services.

The clinic receives 400-600 phone calls per month. About half of them are resolved as referrals to other agencies, mostly medical. This figure is distinctly lower than the Aquarian Effort's crisis line volume of 2,500 calls per month, primarily because of differences in the emphasis and size of the two phone services. Aquarian is not restricted to just giving referral but can respond to crises by car. In addition, the Open Door hot line service has much more competition from similar services in the San Gabriel Valley than The Aquarian Effort has in Sacramento.

Open Door has a good working relationship with the local school district which contributes a small amount of funding help. The work is primarily with four high schools on a contract basis, which varies from school to school and year to year. Typical efforts are counseling, class room presentation, meetings with school staff, rap room, and casual student contact on the campuses. For example, Open Door is currently providing counseling at San Gabriel High School, counseling and a psychodrama group at Alhambra High

School, and a rap group at Mark Keppal High School.

Legal services for the clinic's clients are volunteered by several attorneys, on call as needed. This service was previously used extensively for draft problems during the Vietnam War.

A primary problem being faced by the center at this time is lack of community support. Open Door is met with indifference rather than hostility -- it is not recognized as meeting a community need. There is this same lack of recognition among parents of many of the clients. This problem is reflected in a lack of adequate financial support from local agencies. A lack of adequate future funding from state and federal sources increases the problem.

b. Referral and Coordination

Open Door refers clients out for some counseling and other services including: medical, problem pregnancy counseling, legal counseling, general counseling, psychiatric care, detoxification, and crash pad accommodations. The referrals are made by telephone, and average 225 per month, including 77% to medical and dental services, 7% to legal services, 6% to problem pregnancy services, and 10% to other outside agencies (counseling and psychiatric services, detoxification, crash pad accommodations, etc.). Most medical referrals are made to the county medical clinic on the grounds. The high number of medical and dental referrals indicates that Open Door is being used as an information source by many who know about the project but are unfamiliar with its available services or the services of other centers in the area.

Psychiatric referrals and other counseling referrals are infrequent. Cases that are occasionally referred include: older

people who would fit better into a mental health clinic atmosphere; and people with evident serious psychological dysfunctions. These referrals are made to such nearby agencies as the Family Counseling Service of West San Gabriel Valley, Ingleside Community Mental Health Center, and the San Gabriel Mental Health Center.

Most detoxification referrals go to the Ranch Los Amigos Hospital, a large county hospital in Downey. One of the needs expressed by the Open Door staff is for a nearby detoxification unit, where they can provide supportive counseling to their clients in detoxification, and thus assure better follow-up and continuity of care. Emergency overdose referrals must be made cautiously because some hospital referrals will result in immediate arrest. Additional reserve is felt in some hospital emergency rooms because they know that Open Door has no way to pay for emergency care of overdose patients.

Incoming referrals result in an average of 40 clients who enter treatment per month. The primary referral agencies are: legal (probation, courts, police, etc.) 29%; schools (school deans, Open Door school program) 28%; and private (family, friends, self) 37%. The remaining 6% is distributed among other drug programs, and medical agencies, and mental health centers*.

There are a large number of probation (adult and juvenile) and other legal referrals, indicating a good relationship between the criminal justice system and Open Door. Many of these people are diverted with a mandatory treatment duration specified (typically, 10 weeks). Many of them are somewhat ambivalent about treatment and

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* These figures were derived from one year (1973) of monthly statistics maintained on referrals by the project.

leave after that time. Counselors write letters to judges and probation officers concerning clients' progress, but there is little personal contact with these officials. Counselors are in contact at least weekly with the public defender's office concerning various clients.

The high number of school referrals illustrates Open Door's stated interest in the high school student, and the project's good working relationship with the local school district. These referrals result both from informal referrals by school faculty/staff and from Open Door's on-campus work.

The high number of informal referrals is an indication of the project's outreach efforts and its popularity among clients. Five percent of the counseling clients came in for treatment after initial inquiry or contact over the hot line phone service.

The director and senior staff of Open Door have been instrumental in the formation of the West San Gabriel Valley Drug Coalition in cooperation with Ingleside Mental Health Center, the Family Counseling Service of West San Gabriel Valley, and other treatment and treatment-related community agencies. The objective of this group is to appraise treatment and rehabilitation requirements in the area, propose efforts to fill apparent needs, prepare proposals to secure funding, and coordinate plans with other agencies, such as probation and the County Department of Social Services. As part of the effort in achieving these objectives, Open Door was instrumental in starting a small residential treatment project, and a large diversion system (OCJP funded) for cooperative referral and treatment throughout the San Gabriel Valley. Open Door is helping to set up and staff these two efforts.

## 2. Treatment Philosophy, Objectives, and Criteria

### a. Treatment Philosophy

Treatment is geared toward the white, primarily middle-class high school student who feels pressure from his peers to use drugs.

The philosophy of the program is based on flexibility. The staff wants to help young people understand their needs, why they use drugs, and how drug use meets or thwarts these needs. The clinic is designed so that clients will feel minimal reluctance in asking for help. Once they have sought assistance, it is hoped that they (and their entire family) will become involved in counseling and treatment. The decision to stop using drugs is up to the individual client.

### b. Impact-Oriented Objectives and Associated Measurement Criteria

Objectives of this program are presented in Table 55 together with associated measurement criteria and suggested additions. Criteria are not always related to objectives, but we have related them where it seemed appropriate to do so.

The first objective is the rehabilitation of individuals who are dependent on the use or abuse of drugs. This objective is directed primarily at youth and minority groups, primarily Mexican-American. Most of the measurements given in quarterly and annual reports deal with the level of activity in the program (e.g., number of clients in counseling, number of sessions, number of calls). Annual and special reports give useful impact measures such as percentage of clients with diminished drug use following entry into the program. An addition that would enhance the value of activity

Table 55

OPEN DOOR

OBJECTIVES AND MEASUREMENT CRITERIA, WITH ADDITIONS

| OBJECTIVES | CRITERIA USED | ADDITIONS TO CRITERIA |
|---|---|---|
| Rehabilitation of drug users | Total number in counseling<br>Number of counseling sessions<br>Number of hot line calls<br>Percent of clients with diminished drug use | Average hours of counseling per week<br>Number of clients reaching treatment goals |
| Interdiction or prevention of drug-related criminal offenses | Decrease in school drug offenses<br>Number of speaking engagements<br>Number of people attending sessions<br>Percent of client involvement with criminal justice system | Percent of client decrease in school offenses |
| Coordination and consolidation of community resources for youth drug-related problems | Number of referrals<br>Number of speakers<br>Number of job placement counseling sessions<br>Number of legal counseling sessions | Number of applicants referred among agencies<br>Number and type of contacts<br>Financial support and services donated<br>New funding sources - coordinated efforts |
| Drug education to the community | | Number of speaking engagements<br>Number of people attending<br>Number of people supporting community drug programs |

measures would include measure of the total hours per week of counseling services provided to the average client. Impact measures would be enhanced by adding the percentage of clients reaching treatment goals set in prior counseling sessions (e.g., reconstitution of family units, return to school, etc.).

The second objective calls for the interdiction or prevention of initial or repeated drug-related criminal offenses. This objective is appropriate for this program. Measures of activity include the number of speaking engagements and the number of people reached in these efforts. Impact measures include estimates of the decrease in drug offenses in elementary and high school. However, Open Door questions the validity of this measure because of possible changes in attitudes of school and police officials toward drug offenses. The percent reduction in criminal justice system involvement of clients and former clients is also mentioned in annual reports. This is a useful measure if adjustments are made for change in attitudes of concerned agencies toward drug offenses. An additional important impact measure for this program would be the "percent decrease in offenses in schools."

The third objective is the coordination and consolidation of local drug-abuse treatment, rehabilitation and law enforcement resources, which include court, educational, medical, social welfare, religious, and commercial resources. This is probably not an appropriate objective for Open Door over the long term, although they have been currently very instrumental in conjunction with other local agencies in performing this function. This objective could be reduced in scope by restating to indicate that the program will "participate"

in coordination activities of the surrounding community. Currently reported measures that are related to this objective measure activities such as number of referrals, speakers, and legal counseling sessions. Better measures of this objective would include a breakdown of the number and source of referrals among local agencies, financial support received, coordinated effort for funding sources development, and the quantity of other services received from, and rendered to, other agencies.

A final objective recently added is to provide drug education to the community. This is an appropriate objective as part of a communitywide effort. Criteria for measurement could include level of activity, and impact measures indicating increasing levels of support for community drug related programs.

3. Client Attributes

a. Client Criteria

The Open Door program is best suited to young adults (16-35 years) not heavily involved with drugs. It is designed to focus on the middle class white high school student surrounded by peers using drugs. These students are often intelligent, bored with school, and frustrated because they cannot control their own lives. They feel that their parents do not understand them, and do not understand their parents. Drug use is not heavy in surrounding communities, and there is little economic stress or oppression. Some of the parents become involved in the treatment program themselves out of concern for their children, and in this regard are clients also.

Open Door's staff members believe that their clients have two main types of problems: problems with family, school, and law; and problems of individuals in need of human contact.

About 25% of the clients are diverted to Open Door by the criminal justice system. After initial resentment at coercion, some of them are able to set their own goals and do as well as the voluntary clients. Other nonvoluntary clients are hard to work with and leave after their court obligation has been satisfied. Some clients come in for non-drug counseling, including pregnancy, abortion, and V.D. counseling, as well as job and legal counseling.

b. Client Demographics

Demographic data are presented in Table 56 based on a sample of current clients. As shown, Open Door clients are young, with an age range of 12-33 years and a median age of 22. A majority (74%) are non-Hispanic white, 24% are Hispanic white, and 2% are black; there are more

Table 56

OPEN DOOR
CLIENT DEMOGRAPHIC CHARACTERISTICS

| | Hispanic White | | Black | | Non-Hispanic White | | Other | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age Group | M | F | M | F | M | F | M | F | M | F | T |
| 10 - 14 | 0 | 2% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2% | 2% |
| 15 - 19 | 4% | 4 | 0 | 0 | 14% | 12% | 0 | 0 | 18% | 16 | 34 |
| 20 - 24 | 0 | 4 | 2% | 0 | 10 | 14 | 0 | 0 | 12 | 18 | 30 |
| 25 - 29 | 4 | 2 | 0 | 0 | 2 | 12 | 0 | 0 | 6 | 14 | 20 |
| 30 - 34 | 2 | 0 | 0 | 0 | 6 | 2 | 0 | 0 | 8 | 2 | 10 |
| 35 - 39 | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 | 2 | 4 |
| Total | 12% | 12% | 2% | 0 | 32% | 42% | 0 | 0 | 46% | 54% | 100% |

females (54%) than males (46%).* However, of another sample of 40 probationers randomly selected to study the project's impact on criminal justice involvement, 94.8% were male. Contributing causes of this very high percentage of males are: (1) criminal justice policy, (2) attitudes of female abusers and their parents, and (3) lower criminal justice involvement of females. Many of the male clients in treatment at Open Door are probationers required to attend, whereas most female clients are referred from other sources not exerting legal pressure, and hence are voluntary clients. Thus, Open Door seems to appeal more to the younger female than to the male.

Table 57 compares the Open Door population with baseline Census statistics for the age range 10-34 years. The table shows that the project's proportion of non-Hispanic whites matches the proportion in the regional population, but that the project's proportion of Hispanic whites and blacks is substantially higher than the proportion in the regional population. Other minority representation at Open Door is not in proportion to the population, which is probably due to the low abuse level among them.

In terms of education, 4.2% of the client population have completed some grammar school, 26.8% have had some high school, 50.7% have completed high school, 15.5% have had some college, and 2.8% have completed college. It should be noted that because of the younger age range served by Open Door, many of the clients are still attending school.

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* These statistics agree closely with those obtained in the second Open Door evaluation (discussed in Section III.D.5) with different (late 1972) sample populations.

Table 57

OPEN DOOR
COMPARISON OF CLIENT DEMOGRAPHICS WITH REGIONAL* POPULATION CENSUS STATISTICS
(Age Range 10-34 Years)

| Sex | Census | Open Door |
|---|---|---|
| Male | 49.2% | 46% |
| Female | 50.8 | 54 |
| Race/Ethnic | | |
| Hispanic white | 18.0 | 24 |
| Black | 0.2 | 2 |
| Non-Hispanic white | 75.6 | 74 |
| Other | 6.2 | 0 |
| Age Group | | |
| 10-14 | 21.0 | 2 |
| 15-19 | 20.6 | 34 |
| 20-24 | 22.9 | 30 |
| 25-29 | 20.5 | 20 |
| 30-34 | 15.0 | 10** |

* West San Gabriel Valley in Los Angeles County.
** This column totals 96% because 4% of the Open Door population is over 34 and is not included.

c. Drug Use

Tables 58 and 59 illustrate the drug use patterns of clients prior to their treatment at Open Door. The major difference in use between the sexes is that all opiate abusers are male, whereas with drugs other than opiates (exclusive of alcohol and marijuana), there is little difference between male and female users. Of note in both tables is the small fraction of clients (exclusively male) who have abused opiates, compared to the large fraction who have used drugs other than opiates, as would be expected for this age group. This phenomenon is also observed in the drug patterns of Walden youth clients, whereas older clients in some of the other projects (e.g., Camarillo) tend to abuse

Table 58

OPEN DOOR
AGE OF FIRST DRUG USE

| | Percent of Age Group (School Level) First Using Drug | | | | | |
|---|---|---|---|---|---|---|
| Drug | Grade School | Jr. High School | Sr. High School | After High School | Non-Users | NR |
| Opiates | 2.6% | 4.9% | 19.9% | 12.4% | 60.2% | 20 |
| Drugs exclusive of alcohol and marijuana | 13.9 | 27.2 | 34.3 | 17.5 | 7.1 | 11 |
| Marijuana | 19.4 | 34.3 | 31.1 | 13.4 | 1.6 | 4 |

N = 50

Table 59

OPEN DOOR
FREQUENCY OF DRUG USE

| | None | Periodic | 2/week | Daily | NR |
|---|---|---|---|---|---|
| Opiates | 60.2% | 31.0% | 4.4% | 4.4% | 19 |
| Hard Drugs (Other drugs-exclusive of alcohol and marijuana) | 7.1 | 53.9 | 13.6 | 25.5 | 11 |
| Marijuana | 1.6 | 38.3 | 30.7 | 29.5 | 4 |

N = 50

opiates. Younger users who indiscriminately use many different drugs without special preference are called polyusers. Most of the Open Door clients belong in this category, as evidenced by the fraction of users (93%) shown in the total drug class (drugs exclusive of alcohol and marijuana). Most of them seem to get involved during their high school years; as shown in Table 58 , nearly 62% are polyusers in junior and senior high school. The table also shows that use of marijuana is quite general (about 85%) by the time the clients are in high school.

With respect to frequency of use, Table 59 shows that of the 40% who use opiates, most (31%) are only occasional users (chippers). There is far more frequent use of other drugs (exclusive of alcohol and marijuana), with 25% using them daily. Of those that use marijuana only, 30% are using it daily. Although Open Door clients are light abusers compared to the hard core clients in treatment at facilities such as Camarillo, a majority of them nevertheless had substantial drug abuse problems when they entered treatment, and many of these problems could lead to hard core addiction.

d. Client Retention

Client retention is difficult to measure at Open Door because client termination dates are not recorded, and because the diversity of treatment services complicates the matter of retention. There are: drop-in clients who attend once or twice; diverted clients, many of whom stay only as long as the courts require; clients who spend substantial periods in individual therapy; parents who take part in therapy with their children or in parent groups; and clients who stay in group therapy for extended periods (two years or more), moving from patient status to that of client participating for personal growth. In this milieu, it is difficult to

describe success, graduation, or retention. However, an estimate can be made on the basis of average number of registered or scheduled individual counselees in treatment and the number of people entering treatment, both of which are given in the project's monthly untilization statistics. This estimate is 5-6 months, average client retention. To arrive at this estimate, we have assumed that the number of clients is an average of 10 per group per week, and that 25% of the clients are concurrently in both group and individual therapy.

The typical Open Door client does not complete uniformly scheduled treatment, but begins with frequent visits and gradually tapers off to a comfortable visit frequency, or tapers off and leaves. This process sometimes happens rapidly and sometimes over a period of years.

4. Staff Attributes

At the time of the site visit, there were 38 staff members at the Open Door Clinic,* of whom 27 were part time volunteers. Of the eleven paid staff, five are full time. The part time staff (paid and volunteer) account for at least another six full time equivalents as estimated from staff schedules, bringing the total full time equivlents to eleven. There is an average of 120 individual counselees in treatment each month, resulting in a staff to client ratio of at least 1:11 based on full time equivalent staff. The staff members conduct about sixty groups per month with a total of about 300 attendees. The average number of hours per staff member is sixteen hours per week.

* The staff was recently expanded by ten paid employees to man two new facilities: a recovery house (small residential treatment facility) and a cooperative for coordination and referral. Both facilities are sponsored by S.B. 714 funds.

Table 60

OPEN DOOR
STAFF DEMOGRAPHICS

| | Race - Ethnic | | | | |
|---|---|---|---|---|---|
| Age | Hispanic | Black | White | Other | Total |
| 15 - 19 | 5% | | | | 5% |
| 20 - 24 | | | 10% | | 10 |
| 25 - 29 | 5 | | 45 | | 50 |
| 30 - 34 | | | 20 | | 20 |
| 35 - 39 | | | 10 | | 10 |
| 40 - 44 | | | 5 | | 5 |
| Total | 10% | | 90% | | 100% |

N = 20

Staff attributes were determined from a sample of twenty members interviewed during the evaluation. About ninety percent of the staff are non-Hispanic white, and ten percent are Hispanic white; this appears to be an appropriate mix for the clients served. There are no black counselors. However, the black population is low in that area (see previous section 3). The staff is about equally divided between male and female, and 65% are under thirty years of age. This emphasis is desirable in view of the preponderance of youth in the program. Staff demographics are described in Table 60.

The majority of the staff are professionals, and some were once clients in the program. The staff education level is as follows: 15% have completed high school, 30% have some college education, 55% have college degrees including some postgraduate work (B.A. or higher),

and 25% have other mental health training. The site visit statistics showed 35% with a history of drug involvement, and 25% with a history of criminal justice involvement.

The project appears to be making excellent use of provider staff. As shown in Table 61, about 49% of staff time is spent in direct counseling, and about 23% is spent in training and program-oriented meetings.

The high quality and extent of the staff's training set the Open Door apart from similar clinics that are not so successful. The staff training program is carefully structured and attendance is mandatory. Training sessions are attended not only by trainees but also (generally) by trained counselors. All activities of trainees are carefully supervised; in particular, counseling sessions by trainees are assisted and monitored by experienced counselors. The training program is a requirement for all voluntary and paid counselors in the project. All of the Open Door's staff interviewed by the site visit team were rated good to excellent.

Employment at Open Door is usually part-time and requires a minimum commitment of six months, of which at least the first three months are volunteer participation and require ten hours of work per week; of this, four hours a week must be spent in training for at least three months, but many are trainees for longer periods. Graduation from training status is based not only on completion of requirements and fulfillment of obligations but also on ability to understand, communicate, and apply acquired skills.

Subjects covered in training sessions include: homosexuality, suicides, teenagers, parents of children with drug problems, anxiety,

Table 61

THE OPEN DOOR CLINIC
DISTRIBUTION OF STAFF TIME*

| TYPE OF SERVICE | PERCENT OF STAFF HOURS |
|---|---|
| Individual counseling | 28.5% |
| Group therapy | 16.9 |
| Family counseling | 3.8 |
| Staff training - trainee | 11.9 |
| Staff training - trainer | 3.9 |
| Clerical, etc. | 7.8 |
| Staff meetings, program-oriented | 6.8 |
| Client intake | 4.0 |
| Supervision of staff | 3.7 |
| Management | 1.6 |
| Outreach | 2.8 |
| Emergency services | 1.8 |
| Maintaining client records | 1.8 |
| Housekeeping, etc. | 1.0 |
| Other** | 3.7 |

* Based on interviews of 20 staff members.
** Research and evaluation 1.0%, client follow-up or aftercare 0.9%, community relations 0.8%, diagnosis 0.6%, job training 0.3%, and medical health care 0.1%.

depression, psychotic episodes, and different counseling approaches. Also, there are 12 one-hour orientations covering community relations, drugs, suicide, drug programs for referrals, first-aid, abortion, and hot line calls.

All staff must attend at least one weekly staff group meeting and one twice-monthly staff meeting. However, attendance at weekend retreats every two to three months is optional. Staff members each have a "big brother" or "big sister" counselor, with whom they are required to discuss all their cases and their own personal problems.

These discussions are transmitted to the rest of the staff via meetings with coordinators and other counselors. Such communications on each case assure that a client will be properly placed or referred, and that a proper regimen of treatment is developed.

The staff is selected on the basis of how well they will fit into that family-like atmosphere of close associations. More specific attributes given include flexibility, creativity, and ability to fit into an unstructured situation, such as the Open Door. They must be drug free, including abstinence from marijuana use. Supervision of the staff is very tight but unobtrusive. A high degree of loyalty is expected from the staff and given by them. Thus, they stay on for a long time, the mean retention for the current staff being over 2 years.

The Open Door staff have a much lower turnover and a much better sense of what they are doing than most ambulatory treatment projects. We believe that most of this is due to Open Door's superior training, as well as other factors such as selection of staff and closeness of supervision.

As in all drug-free clinics, salaries are very low. This attribute is a deterrent to obtaining and keeping some potentially good counselors and, together with indefinite job security, is a threat to the existing staff.

Treatment staff adequacy, as appraised by the evaluation site visit team, shows 90% with a rating of good to excellent.

5. Quality of Self Evaluation Efforts

Open Door's past evaluation efforts are exemplified by two efforts of outside consultants. The first evaluation, published in 1971, was conducted under the guidance of Gilbert Geis, professor of sociology at UC Irvine, with the assistance of his graduate students. The second evaluation, nearly completed, is being conducted by Michael Agopian under the direction of Professor Geis, with the assistance of the Open Door director. The first (Geis) evaluation contains a description of the project and the treatment provided, a survey of the neighborhood's knowledge about the project and drug use, a survey of the attitudes of political leaders and school counselors toward the project, and a comparison of attributes of the Open Door hot line with others in the area. The second (Agopian) evaluation's most relevant portion consists of an extensive 4-month follow-up of 86 clients. It also contains a general description or overview of the project, an examination of factors influencing staff performance, a description and discussion of two therapy groups, and 12 detailed biographic case summaries.

Applying the evaluation classification presented in CCCJ's "Evaluation of Crime Control Programs in California: a Review," the above evaluation studies were "assessments." Assessment is a research design that involves the collection of data through structured surveys and the use of extensive observation. Quantitative data are presented in tabular summaries; little use is made of controls or baseline data for comparison and assessment of variation, and statistical tests are not used for the comparison of data or the evaluation of statistical hypotheses.

a. Data Sources and Validity

Data used in the evaluations have been obtained either by

surveys or through direct observation of the treatment process. During the formative part of the second evaluation, the evaluators considered getting the courts to help structure some control groups, and getting probation to provide some client data. These arrangements could not be economically made and were dropped. Thus, the client data are primarily restricted to the sample of 86 clients in the follow-up survey (the sample originally contained 96 clients, but ten could not be located in the follow-ups).

Aside from the evaluation data described, Open Door maintains little data on its own. Intake data are obtained on an intake form to be filled out for each person entering the clinic for treatment. In actual operation, however, these forms are completely filled out for less than 50% of the clients, and not at all for some. For clients diverted through the probation office, a portion of the intake data describes the problem and identifies the probation officer. These clients can be tracked through CJS files to assess impact if evaluation requires it.

Client flow data are counted by receptionists from visits of clients and others, and by the staff from incoming calls on the hot line phone service. Other utilization data are extracted from client intake forms, staffs' client rosters, and counts of outside activities.

For effective ongoing evaluation, more data (including client, staff, and utilization or client flow data) should be maintained and periodically summarized by the Open Door staff. The client intake form contains minimal information concerning the personal background and drug history of the client. All intake forms should be filled out consistently for all registered clients (all clients other than one-time drop-ins). Additional client data should include date and reason for termination

of treatment; drug history including dates of first use and first regular use for each drug as well as current frequency of use; relationships with others using drugs; criminal justice involvement history, including arrest dates and charges, convictions, dates of incarcerations, and dates of probations; dates and descriptions of previous treatment; and baseline census and criminal justice data for the catchment area.

Additional staff data should include demographic characteristics; education by date and type; prior experience by date and type (drug treatment and other); views on and experience with drug abuse; date of joining the clinic, and date and reason for termination; positions held at the clinic with related dates of status change; specialties and strengths in treatment; detailed time spent in different activities on the job, especially in individual counseling, group counseling, training, and consultation; and salary and hours worked.

Additional utilization data on the monthly summary should include number of clients enrolled in individual therapy only, in group therapy only (by type of group), and in both, with the frequency of attendance and the duration of sessions; number of groups per week by type, with average attendance; and number and average attendance of rap groups.

All Open Door data examined appeared to be valid. The main problem was that intake forms were either incomplete or missing. We tested the validity of client data by comparing (1) the demographic characteristics (age, race/ethnic, sex) of a random sample of 50 clients drawn from current intake forms with (2) the same information for the Geis/Agopian survey sample of earlier clients. The correlation of all factors was almost exact, indicating both validity of data and similarity of clients for the two time periods, December 1972 and December 1973.

b. Use of Data and Methodology

Open Door's approach has been that maintaining and evaluating data are not necessary for good treatment, and that evaluation can be done adequately by outside consultants on a sample basis. Services and operations at the clinic are not diverse or organizationally complicated, enabling rather straightforward management based on general knowledge of day to day events. In this limited environment, the minimum data approach is probably satisfactory with respect to the delivery of quality treatment. The clinic can be managed and good treatment provided without extensive collection and evaluation of client, staff, and operational data. However, this approach neglects research and grant operation needs which are particularly important to community based free clinics such as the Open Door.

Prior evaluations have had little impact on the operation, organization, and treatment at the clinic. The objective of these evaluations seems to have been to describe the clinic to outsiders and provide research for the evaluators. This would suggest a possible reorientation of future evaluations.

For a small well-run clinic, the concept of maintaining minimal ongoing records and using periodic in-depth evaluations by outside consultants using sample data is appealing and easy. However, the concept has serious shortcomings. Outside evaluations are usually restricted by available funds and the objectives of the evaluators, and thereby may not consider some important factors or may not sample data to evaluate other characteristics later. Some staff, client, and utilization data should be consistently collected and monitored on an ongoing basis. Sufficient data and periodic summaries are needed to place or refer clients; detect changes in client types; monitor the staffing patterns in light of client volume

and flow; provide current statistics for reports to regulatory agencies; assess cost-benefits and modify policy on such activities as outreach and referral.

The monthly summaries now produced by Open Door are somewhat unclear or ambiguous and some important data are missing, e.g., number of clients in both group and individual counseling; number of terminations or closed cases. The reporting format should be revised so that all entries are completely defined and easy to read. With proper corrections and additions along the lines suggested above, the monthly summaries would be an excellent management and evaluation tool. A simplified layout of the tables with explicitly defined entries (using footnotes, etc.) would provide an easily understood summary of Open Door activities for use by outside agencies (funding included), evaluators, politicians, and other interested parties. The amount of effort to make these revisions would be minimal since most of the information is already there.

The two outside evaluations (briefly described at the beginning of this section) are good. From the point of view of project description and qualitative assessment, they are very good. Their primary weakness is in quantitative assessment (e.g., analysis, presentation, and inferences related to numerical client data). The following paragraphs discuss the two evaluations in more detail. The second evaluation is current, better planned, and more relevant than the first, which was essentially a collection of independent papers done by different graduate students and edited by Professor Geis.

The first evaluation had four studies that made use of numerical data. One studied the knowledge of people in the neighborhood regarding the Open Door Clinic and drug abuse in general. In this study,

a pamphlet describing the project and discussing drug use was mailed to an experimental group and not to a control group. Then a follow-up survey was administered to both groups to test for changes in knowledge of the topics contained in the pamphlet. There were no differences between the groups in either personal attributes or knowledge.

The results of the hot line survey in the first evaluation are useful in that they give a detailed description and comparison of several hot lines in the area. Information included hours of service, staffing, type of calls, procedures, etc. Other measures that would have been useful are total calls received, and number of crisis calls.

A useful study was made for the first evaluation concerning changes in parents attending parent groups at Open Door. The data in this study came from a 44 item questionnaire administered to the study group before and after the group therapy series. The same questionnaire was given to a nontreatment control group randomly selected from the community. This study used statistical tests for the differences between means among the various samples. The results were largely inconclusive, although the parents in treatment tended to show a higher sensitivity to drug abuse and its treatment than did the control group. The experimental and control groups were, for the most part, very similar. However, there was a substantial difference in the income distributions for the two samples. This may imply some differences between them.

The second evaluation (in preparation) was reviewed in draft manuscript by the SSI evaluation team. For the purpose of client and project evaluation, our focus is on the follow-up study, which presented and compared two sets of data--responses of clients to questionnaires before (pre-test) and after (post-test) a 4-month period. While much valuable

data were collected, the comparisons presented in the draft document could be revised to provide a better basis for drawing conclusions.

Following are examples of problems relating to the numerical treatment in the second evaluation follow-up study. Table 62 is a summary of the pre-test and post-test drug use frequency comparisons given in the draft evaluation. Their pre-test and post-test data were compared as though they were different random samples. The sample sizes are too small for this type of comparison. Also, as shown, there were several no-responses (NR's) in the post-test results for each drug shown and it is not known which frequency of use category they would fall into. Also small sample comparison between pre-test and post-test data should compare status on a client by client basis (e.g., the percent of clients who had stopped using or decreased using).

The presentation of the drug data showed the number of clients who were not using specific drugs, but there was no total or combined summary that showed how many people were drug free.

Table 63 is an exerpt from the draft manuscript, which contains the only arrest breakdowns in the evaluation. It shows total arrests by crime type for the sample. The two columns are not directly comparable because they do not cover the same time periods. The pre-test time periods are unknown and arrest rate comparisons cannot be made. The "no response" or "not reporting" category has been included in the calculation of percentages so that inferences cannot be made from the sample relative to the total population. This is true of all of the tables in the follow-up study and can be easily corrected. Another approximate method that can be used for comparing the pre-test and post-test data used for this table would be to calculate the percent of people who had no arrests subsequent

CONTINUED

3 OF 4

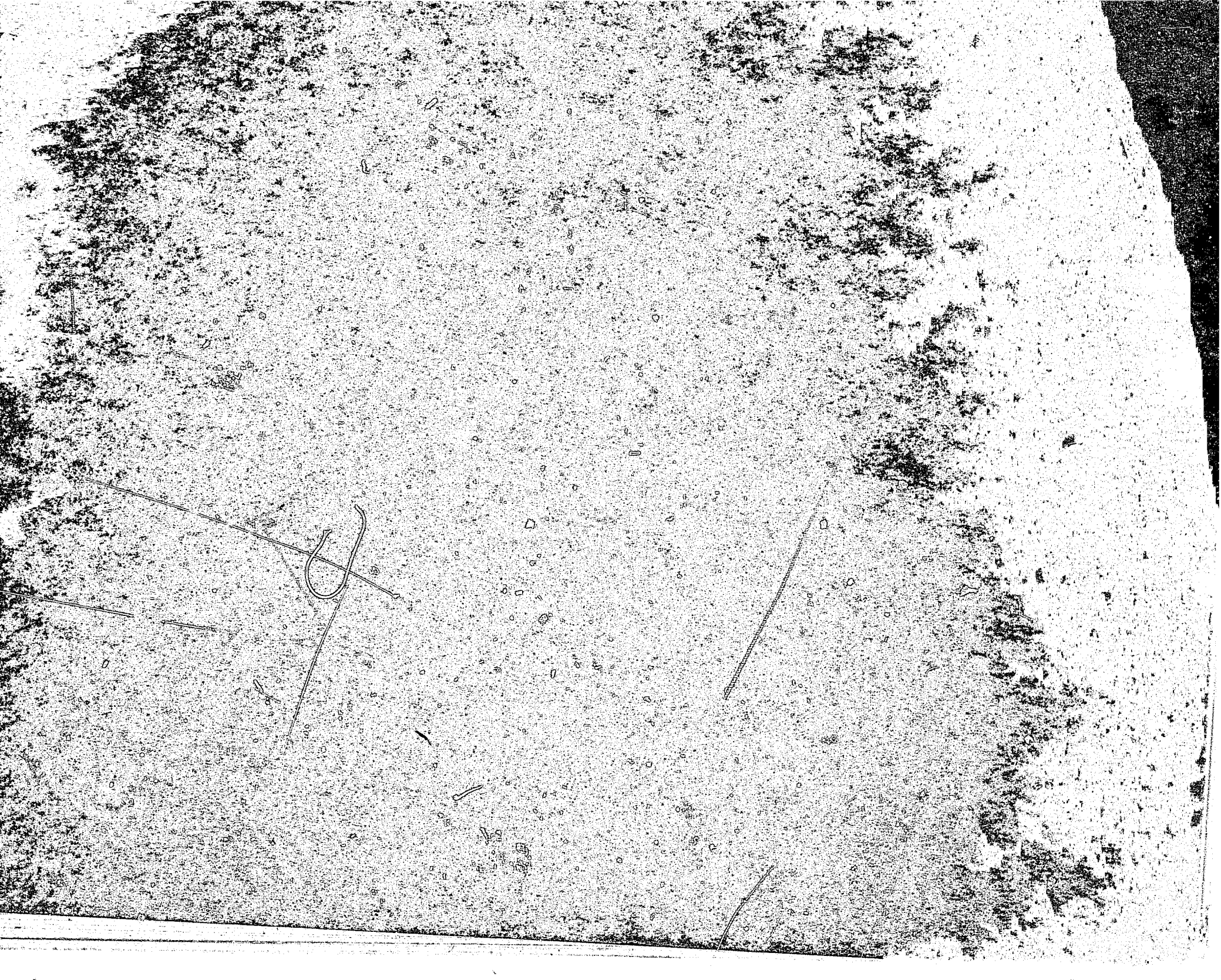


Table 62

OPEN DOOR
FREQUENCY OF DRUG USE

| TYPE OF DRUG | FREQUENCY OF USE | | | | SAMPLE CLIENTS |
|---|---|---|---|---|---|
| | None | Periodic | 2 times/week | Daily | |
| Marijuana | | | | | |
| Pre-Test* | 22.6% | 36.1% | 20.9% | 17.4% | 86 |
| Post-Test** | 41.5 | 42.9 | 10.4 | 5.2 | 77, NR=9+ |
| Opiates | | | | | |
| Pre-Test | 81.4 | 11.8 | 3.4 | 3.4 | 86 |
| Post-Test | 90.7 | 9.3 | 0.0 | 0.0 | 75, NR=11 |
| Post-Test (worst)++ | 79.1 | 14.1 | 3.4 | 3.4 | N=86 |
| Post-Test (best) | 91.9 | 8.1 | 0.0 | 0.0 | N=86 |
| Hallucinogens | | | | | |
| Pre-Test | 48.8 | 44.4 | 4.6 | 1.2 | 86 |
| Post-Test | 79.2 | 18.2 | 2.6 | 0.0 | 77, NR=9 |
| Amphetamines | | | | | |
| Pre-Test | 43.0 | 32.6 | 12.8 | 11.6 | N=86 |
| Post-Test | 73.3 | 21.3 | 4.0 | 1.3 | N=75, NR=11 |
| Barbiturates | | | | | |
| Pre-Test | 46.5 | 36.1 | 14.0 | 3.4 | N=86 |
| Post-Test | 77.3 | 18.7 | 2.7 | 1.3 | N=75, NR=11 |

* Pre-test refers to client problems on entry into treatment.
** Post-test relates to client problems at the time of post-test, 4 months after pre-test.
+ There were some no-responses in the post-test who were not taken out of the pre-test. Improvement was not shown on a person by person comparison but in general by treating post-test and pre-tests as different samples and comparing proportions independently.
++ Problems in this approach are shown by distributing NRs in worst and best likely ways for opiates. The same can be done for others.

EXCERPT FROM SECOND EVALUATION

Table 63

30(A). HAVE YOU EVER BEEN ARRESTED?

| SITUATION | Pre-test | Post-test |
|---|---|---|
| Never | 33.1*<br>(44) | 68.8<br>(64) |
| Moving traffic violations | 15.0<br>(20) | 11.8<br>(11) |
| Disturbing the peace | 5.4<br>(7) | 1.1<br>(1) |
| Loitering | 3.0<br>(4) | 2.1<br>(2) |
| Malicious mischief | 7.5<br>(10) | 1.1<br>(1) |
| Demonstrating or other form of civil disobedience | .8<br>(1) | —— |
| Drug violation | 17.3<br>(23) | 6.5<br>(6) |
| For an act of violence | 2.2<br>(3) | 1.1<br>(1) |
| Other arrests | 13.5<br>(18) | 3.2<br>(3) |
| delete → [No answer | 2.2<br>(3) | 4.3<br>(4)] ** |
| | 100.0%<br>N=133 | 100.0%<br>N=93 |
| | (Sample Size M=130)**<br>(No answer or NR=3)** | (M=89)**<br>(NR=4)** |

* Recalculate percentages based on (M).
** Recommended changes.

to the pre-test interview for the people in each crime type. Also, the number of clients who had ever been arrested was not given in the evaluation. Data not shown but of interest is the number of clients who had been arrested for more serious crimes (other than moving traffic violations), and there was no way to determine this from the data presented. As a lower estimate, we used the number who had ever been on probation, which was given in the manuscript.

The other sections of the second evaluation are qualitative. These were well planned, executed, and written up, and they give some insight into the clinic's operation. A brief description of them follows:

- o A description and assessment of two therapy groups by two evaluators, Agopian and another sociologist. Each became a member of a separate therapy group for over three months, compared notes, and described his observations.
- o Staff descriptions, made by tracing the steps that a new staff member would have to go through in order to become a counselor.
- o Twelve case summaries for clients who had heavy involvement with the clinic.

In summary, the evaluation efforts at Open Door have been good, but more emphasis should be given to: proper data collection, presentation, and use; limited tracking of clients known to probation, as a means of helping to assess outcome; and use of evaluative material in modifying treatment, outreach, referral, etc.

c. Adequacy of Funding Allocated for Evaluation

Evaluation funds for the second evaluation were $13,000. According to the researcher, the minimal funds precluded use of additional people or services. With additional funds, he would have extracted criminal

justice data, and obtained more part time help to sit in on groups, for comparison in his follow-up study. The product is well worth the money, especially if the statistical problems in the client follow-up section are corrected.

## 6. Project Impact

### a. Impact Measures and Samples Used

Open Door carries on an active schedule directed toward the rehabilitation of drug users and the prevention of crime. The project believes that these efforts have resulted in a significant improvement in the behavior of the youth it serves. Since the clinic keeps few records, most information on impact comes from the evaluations made by consultants who interview samples of the clients.

Reduction in criminal activity of Open Door clients was assessed on the basis of a random sample, drawn from the client rosters, of 40 clients who were probationers. Statistics concerning reduction in drug use patterns of clients in treatment were taken from the second evaluation of Open Door by Agopian et al.* A subsample of 50 clients from their follow-up study of 86 clients was used to describe some client attributes and backgrounds. Another sample of 50 fairly current clients was also used, primarily for demographic descriptions since they were selected from clinic intake forms with very little control.

* M. Agopian et al., "The Second Evaluation of the Open Door Clinic," in preparation.

Table 64 presents the demographics of individuals diverted to Open Door by the criminal justice system, on the basis of the above-mentioned sample of 40 known probationers. Notable here is that most (94.8%) of those diverted were male. These clients were tracked through Los Angeles probation files to assess criminal justice involvement for the upper limit or "worst case" Open Door clients. The data items extracted from the probation files were those listed in Section III.D.5.

Table 64

OPEN DOOR
CLIENT DEMOGRAPHICS FOR PROBATION REFERRAL SAMPLE

| Age | Race/Ethnic/Sex: Hispanic M | Hispanic F | Black M | Black F | White M | White F | Other M | Other F | Total M | Total F | Total T |
|---|---|---|---|---|---|---|---|---|---|---|---|
| < 15 | | | | | 2.6% | | | | 2.6% | | 2.6% |
| 15 - 19 | 2.6% | | | | 23.0 | | 2.6% | | 28.2 | | 28.2 |
| 20 - 24 | 10.3 | 2.6% | 2.6% | | 28.1 | | | | 41.0 | 2.6% | 43.6 |
| 25 - 29 | | | | | 15.3 | 2.6% | | | 15.3 | 2.6 | 17.9 |
| 30 - 34 | | | | | 5.1 | | | | 5.1 | | 5.1 |
| 35 - 39 | | | 2.6 | | | | | | 2.6 | | 2.6 |
| Total | 12.9% | 2.6% | 5.2% | | 74.8% | 2.6% | | | 94.8% | 5.2% | 100.0% |

N = 39 NR = 1

b. Criminal Justice Involvement

Client arrest records, based on the investigation of the subsample described above, are given in Table 65. The total arrest rate of 79 arrests per 100 client years is above the statewide range for juveniles with prior arrest records -- i.e., 42 arrests per 100 client years.* However, the total client population of Open Door contains both those with prior records and those without. On the basis of the Agopian

* Five Year Follow-up of 1966 Juvenile Burglary Involved Arrestees, Research Report #13, Bureau of Criminal Statistics, Sacaramento, California. Based on 2,832 juvenile arrests in 1966, with re-arrests during subsequent 5 year period.

Table 65

OPEN DOOR
PROBATION SAMPLE--ARREST RATES BEFORE ENTRY
(Arrests per 100 Client Years)

Arrests Before Entry per 100 Client Years, by Race/Ethnic Group #1

| Crime Type | Hispanic White | Black | Non-Hispanic White | Other | Total (by Crime Type) |
|---|---|---|---|---|---|
| Personal | 5 | 0/4** | 0/12* | 0/2+ | 4 |
| Property | 20 | 0/4** | 20 | 0/2+ | 19 |
| Nonvictim drug | 42 | 25 | 50 | 50 | 42 |
| Nonvictim other | 5 | 0/4** | 10 | 0/2+ | 5 |
| Miscellaneous | 5 | 0/4** | 40 | 0/2+ | 9 |
| Total | 77 | 25 | 120 | 50 | 79 |

* Zero arrests per 12 client years.
** Zero arrests per 4 client years.
\+ Zero arrests per 2 client years.

sample, 30% of the clients had arrest histories serious enough that they were on probation. Arrest rates of Hispanic whites were about 50% higher than the rates for non-Hispanic whites. The low arrest rates of blacks cannot be considered significant because the number of blacks in the sample was too small--i.e., four. Drug arrests make up 53% of total arrests, so that total arrest rate for other crimes is only 37 arrests per 100 client years. Thus, the sample appears to contain few individuals with confirmed criminal life styles.

Table 66 compares arrest rates for the Open Door sample with those of the population in the region. The sample shows a much higher arrest rate for property and nonvictim drug crimes than occurs in the general population. In proportion to their respective arrest rates in the general population, non-Hispanic white clients at Open Door have an arrest rate that is twice as high as that of Hispanic white clients. However, the arrest rate among blacks in treatment, as mentioned before, cannot be considered significant because of the small size of the sample.

A comparison of arrest records before and after start of treatment is shown in Table 67 for various age groups. For the total

Table 66

OPEN DOOR

COMPARISON OF BASELINE POPULATION ARREST TATES WITH THOSE OF PROBATIONER CLIENTS PRIOR TO TREATMENT

| | Baseline Population* Arrests/100 Population (Man Years) | Open Door Clients Prior Arrests/100 Client Years |
|---|---|---|
| Crime Type | | |
| Personal | 1.69 | 4 |
| Property | 4.00 | 19 |
| Nonvictim drug | 1.61 | 42 |
| Nonvictim other | 4.00 | 5 |
| Miscellaneous | 2.43 | 9 |
| Total | 13.73 | 79 |
| Race/Ethnic | | |
| Hispanic white | 29.33 | 120 |
| Black | 1.42 | 25 |
| Non-Hispanic white | 8.04 | 77 |
| Other | 2.01 | 50 |
| Total | 13.73 | 79 |

Table 67

OPEN DOOR

CLIENT ARREST RATES BEFORE AND AFTER START OF TREATMENT, BY AGE GROUP

| | Arrests per 100 Client Years Before and After Start of Treatment, by Age Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 10-19 Years | | 20-24 Years | | 25-39 Years | | Total by Crime Type | |
| Crime Type | Before | After | Before | After | Before | After | Before | After |
| Personal | 4 | 0 | 0 | 0 | 10 | 29 | 4 | 5 |
| Property | 17 | 19 | 28 | 10 | 5 | 0 | 19 | 11 |
| Nonvictim drug | 38 | 0 | 53 | 20 | 30 | 0 | 42 | 11 |
| Nonvictim other | 8 | 0 | 3 | 0 | 5 | 0 | 5 | 0 |
| Miscellaneous | 17 | 0 | 0 | 10 | 15 | 0 | 9 | 5 |
| Total by age group | 84 | 19 | 84 | 40 | 65 | 29 | 79 | 32 |
| % clients with decreased arrest rate since entry | 92% | | 81% | | 90% | | 87% | |
| % clients without arrests since entry | 92% | | 69% | | 90% | | 82% | |

* From contiguous cities of Alhambra, El Monte, Monterey Park, Rosemead, and San Gabriel (West San Gabriel Valley) in Los Angeles County.

sample, arrest rates were reduced from 79 to 32 arrests per 100 client years. This result is for clients over a period of two years prior to treatment and over a period of 1 to 18 months after start of treatment. Arrest rates decreased in all age groups. The fourfold reduction of arrest rate of the 10-19 year group by a factor of 4 is particularly notable in view of the difficulty that many clinics experience in treating juveniles.

The other measures, given at the bottom of Table 67, also show very good results of treatment, with clients in all age groups showing decrease in arrest rate from 81% to 92% (average 87%). The proportion of clients without additional arrests since entry into treatment ranged from 69% to 92%, with an average of 82%. These results tend to be more favorable than those reported by Open Door. The earlier Geis/Agopian study indicated that more than 50% of those with prior arrest histories were without arrest during the 4 months after the study began. This difference is consistent with the findings of J. Newmeyer, epidemiologist at Haight-Ashbury Free Clinic, that criminal justice clients should show a greater improvement.* Other supporting statements are in the third year grant request indicating that over 70% of those with arrest records were without arrests in the period July 1970 to September 1971.

c. Drug Usage

Changes in client drug use patterns are shown by statistics

* Personal communication.

derived from the second Open Door evaluation, in which 86 clients were interviewed in a follow-up study. We were provided basic drug use frequency for clients who answered questionnaires both before and after the four-month follow-up period. Many of the clients interviewed were not new clients at the time of the first interview but had been in treatment for some time before the start of the follow-up study. Thus, the results do not necessarily reflect changes over only the four month study period but also over arbitrary periods that were different for many clients.

As shown in Table 68,there was a substantial reduction in use of all drugs listed, except marijuana, for which the reduction was less pronounced.* Two important factors should be noted: (1) some of the clients were still in treatment at the time of the follow-up interview, and therefore their drug use would be expected to be lower than if they were not in treatment; and (2) the total Agopian sample was divided equally between male and female clients, as is typical of Open Door clientele, but the subsample used in Table 68 was heavily biased toward male clients, with 75% male and 25% female. This should show improvement to be less than actual because males are typically more excessive (most of the probationers diverted to Open Door are males).

The project also indicated that treatment appeared to be resulting in a general decrease in drug use. The third year grant request indicates that in 1972, 62% of all clients counseled had diminished their use of drugs while in treatment; 31% had diminished or eliminated their use of drugs for at least 6 months; and 16% had diminished or

* These data were provided by clients and are subject to unreliability, as noted in Section III.D.5.

Table 68

OPEN DOOR
FREQUENCY OF DRUG USE BY SAMPLE CLIENTS BEFORE AND THROUGHOUT FOUR-MONTH STUDY PERIOD
(Percent of Sample with Given Level of Use)

| | Non-users Before and After | Reduced Use During Period | Use Remained Constant During Period | Increased Use During Period |
|---|---|---|---|---|
| Opiates (N=50; NR=26) | 5.8% | 52.2% | 0.0% | 0.0% |
| Barbiturates (N=50; NR=20) | 13.3 | 80.0 | 6.7 | 0.0 |
| Amphetamines (N=50; NR=19) | 12.9 | 71.0 | 9.7 | 6.5 |
| Hallucinogens (N=50; NR=18) | 15.6 | 65.6 | 12.5 | 6.5 |
| Marijuana (N=50; NR=8) | 0.0 | 69.0 | 12.4 | 9.5 |

eliminated use for a year or more. These results are consistent with the sample results showing a 75% decline in client drug related arrests during this period.

d. Other Impacts

The other two impact related achievements include community resources coordination and community drug education. These efforts take the form of cooperation with other agencies, and outreach programs. Open Door recently joined several agencies in forming the West San Gabriel Valley Drug Coalition. This affiliation has been designed to work with the State Interagency Drug Task Force in developing a comprehensive statewide drug treatment and rehabilitation plan, and in locating sources of funding. As part of this effort, Open Door helped to start and staff a

small residential treatment facility, and is working with a large community diversion program sponsored by OCJP.

The outreach programs have included newsletters, provisions of speakers at schools and colleges, and counseling assistance in local high schools. School administrators are impressed with Open Door's work and feel that the project is making a definite contribution.

In summary, impact in a free clinic for young people such as Open Door is hard to determine, no matter what client interviews and probation records imply. Clients are generally light users with low criminal involvement potential. Many treated have little or no drug use history. Many are in treatment at the time they are interviewed about their level of drug use, and in that environment with its nondrug emphasis, the frequency and intensity of use are bound to be down. The point to be made here is that when the problem is small, a great improvement does not amount to much change. The drug abuse and criminal involve- problems for the majority of the clients at Open Door are small compared to the problems of clients in maintenance or in therapeutic communities. Thus, major impact intended is that treatment such as is provided by Open Door will reduce the number of potential clients for the heavy treatment modalities.

7. Project Potential

a. Cost-Benefit Measures

Funding of the Open Door Clinic has come principally from the OCJP Grant funds with incremental funds (27% of total) from the Alhambra High School District and the Cities of Alhambra, Monterey Park, and San Gabriel. The funding breakdown for fiscal year 1972 is as follows:

| | |
|---|---|
| OCJP | $ 73,803 |
| Alhambra High School District | 7,600 |
| City of Alhambra | 7,600 |
| City of Monterey Park | 7,695 |
| City of San Gabriel | 4,275 |
| | $100,973 |

The above funding data were used, together with estimates of impact discussed in Section III.D.6, to derive cost-benefit measures for treatment at the Open Door Clinic. Definitions of terms used in the derivation of these estimates are presented below:

- o Cost per client year - the cost to support one client in treatment for a year.
- o Cost per graduate - total budgeted treatment funds divided by the total reported number of graduates.
- o "Improved client" - a client whose arrest rate after start of treatment is lower than the average arrest rate in the two years prior to treatment.
- o "Arrest free client" - a client without arrests after start of treatment

Table 69 shows several cost-benefit measures applied to the Open Door data. Since Open Door keeps poor records of clients and

Table 69

OPEN DOOR
COST-BENEFIT MEASURES

| | |
|---|---|
| Total Funds | $100,973 |
| Daily attendance | 30 |
| Client/year | 380 |
| % with reduced arrests* | 87% |
| % arrest free* | 82% |
| $ per client year | $3,400 |
| $ per improved client (arrests) | 305 |
| $ per arrest free client | 324 |
| $ per attendance day | 13 |
| % improved client (drug) | 62% |
| # improved clients (drug) in treatment | 373 |
| $ per improved client (drug) | 429 |
| % improved client (for 1 year) | 16% |
| $ improved client (for 1 year) | $1,660 |

* % of the probation sample.

does not record some required aggregate statistics (such as client retention), it has been necessary to use a variety of approximations to arrive at representative cost-benefit values.

Cost per client year was based on an approximation of average daily attendance which was derived from data on number of visits per month (group and individual) and approximate number of registered clients (drop-ins were not considered). The value so derived was $3,400 per client year. This value may be compared with the range of values for ambulatory treatment centers in the New York study ($1,764 - $3,864) and with the average of these centers of $2,740 per client year.

Data obtained from the client sample in this project indicated a significant reduction in arrests after start of treatment. Values cited in the previous section were 82% for arrest free clients and 87% for clients with reduced arrest frequencies. As indicated previously, the sample included only clients on probation that were diverted by the criminal justice system to Open Door. As a result, the improvement and the unit costs for improvement apply directly to this client group rather than to the total client population. It is possible that for some time after entry into the program, those on probation would exhibit a lower criminal involvement than the total client population.

Based on the sample, cost per arrest free client or per improved client is low ($ 324 per arrest free client, and $305 per improved client). These unit costs apply to the probation sample (assuming that they receive a proportionate share of the project efforts) or to the entire client population (assuming that arrest rates for the population are proportionate to the probation sample).

The Third Year Grant Request of the Clinic indicates that 62% of tne clients were estimated to have diminished drug use while in treatment. This result tends to be corroborated by the reduction in drug arrests among clients after initiation of treatment (74%). This percentage of diminished drug use yields a cost per improved client (drug) of $429. The same source indicates that 16% of the clients reported a diminished drug use for a year or more. On this basis the cost per improved client would be $1,660.

b. Suggested Project Modifications

Open Door needs to be embedded in an appropriately coordinated regional group of agencies under the guidance of a regional drug abuse coordinator. It does what it is set up to do with excellence, and rather than losing funding, which seems to be the case, it should have more funding, so that it can expand its efforts and enlarge its space. All staff past the training stage should be given salaries.

The agency is in need of stable funding, and the energies of the director should be turned toward this end, as well as to continuing the clinical excellence that he has developed. With the energetic help of his board, he should develop a more active community relations campaign to increase community support and create broader based community funding.

Appropriate areas of development, which would be better implemented with the help of a county coordinator, would be (1) accessible, cost free, emergency medical care for overdoses, without fear of arrest; (2) a closely linked detoxification unit where staff could work with clients; and (3) a minority oriented satellite, with equally well-trained staff of an appropriate ethnic mix.

E. Walden House, Inc.

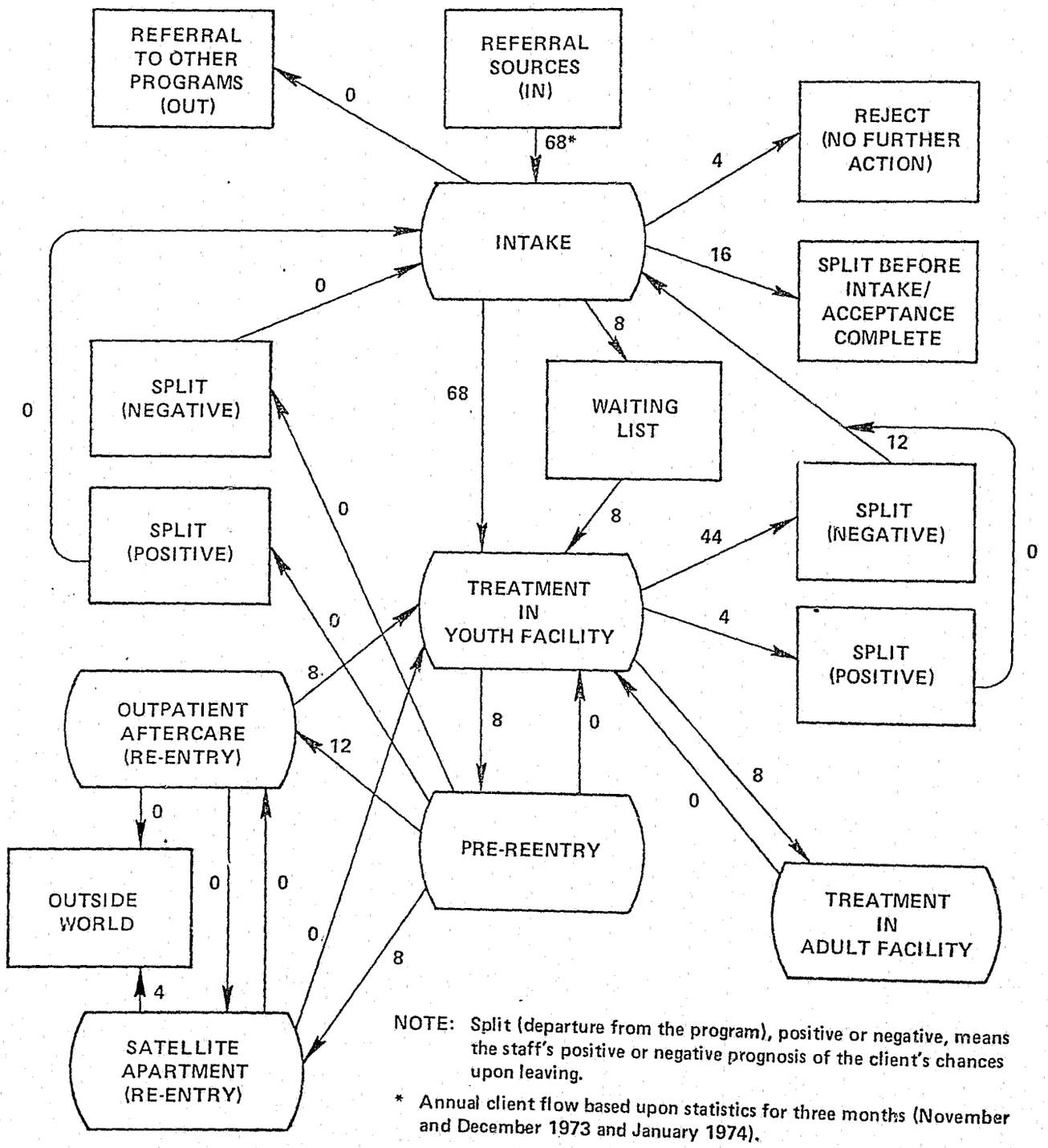
1. Services Provided

Walden House, Inc. operates a voluntary residential treatment program (therapeutic community) with aftercare for drug abusers in the Haight-Ashbury and Pacific Heights districts of San Francisco. The program has two large Victorian houses: one in the Haight-Ashbury is the youth residence, with a capacity of 32 (Figure 9 ); and the other in Pacific Heights is the adult residence, also with a capacity of 32 (Figure 10 ). Aftercare facilities are located in a storefront several miles down Sacramento Street from the adult facility. The outpatient/aftercare program provides outpatient counseling and guidance for Walden residents who are reentering society, ex-residents of Walden, and other people in the community with drug-related problems. The satellite apartment (providing living quarters for residents who are in the process of reentry) is located above the outpatient program and can accommodate up to seven occupants.

The Walden programs are therapeutic communities (TCs) which, over a three-year period, have moved steadily away from the traditional pattern of the classical TC (Synanon, Mendocino) for drug treatment. The fluidity of the programs is due in part to "process workshops," which are intensive annual or semiannual reevaluations of treatment policy, in which both staff members and clients participate. Any one of these workshops can result in drastic changes of treatment policy and philosophy. This ability to change rapidly in order to meet the changing needs of clients and the drug abuser community is a hallmark of the Walden approach. The youth facility is even more fluid than the adult facility in moving further from the classical pattern. Efforts

Figure 9

WALDEN HOUSE
CLIENT FLOW FOR YOUTH FACILITY

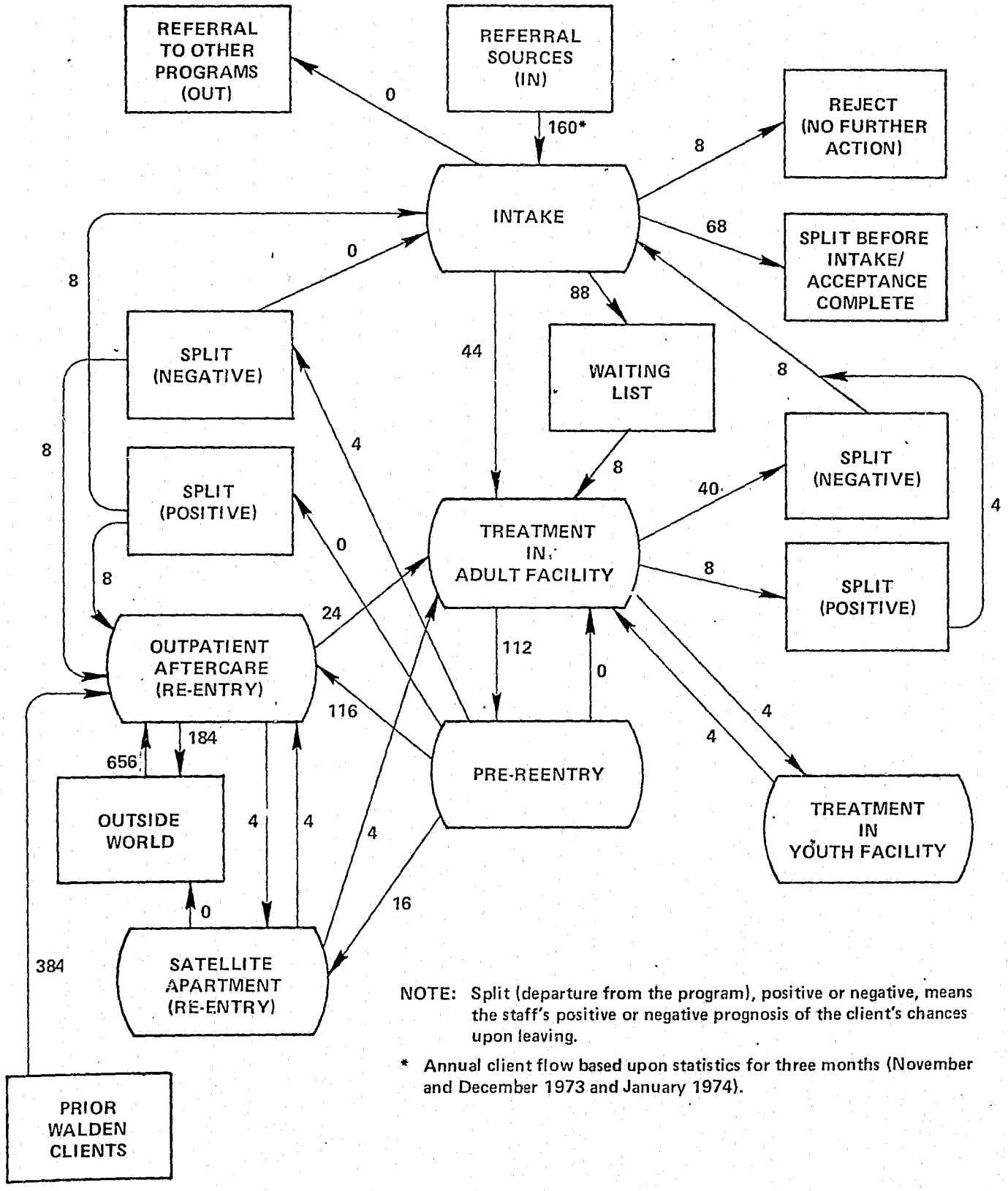



NOTE: Split (departure from the program), positive or negative, means the staff's positive or negative prognosis of the client's chances upon leaving.

* Annual client flow based upon statistics for three months (November and December 1973 and January 1974).

Figure 10

WALDEN HOUSE
CLIENT FLOW FOR ADULT FACILITY




NOTE: Split (departure from the program), positive or negative, means the staff's positive or negative prognosis of the client's chances upon leaving.

* Annual client flow based upon statistics for three months (November and December 1973 and January 1974).

like these and the short term program at Camarillo might ultimately broaden the range of clients of the TC or create a new type of program for clients as yet unserved.

Walden's current approach is to reduce the residential phase of treatment (six months maximum, three months desirable) and to extend and emphasize the reentry phase. The final phase of residence is preparation for reentry, and is called pre-reentry. After a month or more in pre-reentry, a client is weaned from residence in the TC to the reentry program, sometimes through the outpatient program and sometimes through the satellite apartment. In this approach, Walden tries to make the addict employable in the practical sense--for example, teaching him to follow instructions. Upon entering the residential program, client writes and signs a mutually agreed upon contract or regimen for treatment, and revises it after 30 days.

The major differences between the Walden approach and the classical TC are illustrated in the following facets of the Walden approach:

- Classical rhetoric, such as "dope fiend behavior," is not used.
- Social differences are respected.
- Clients can question directions given them.
- Evenings are not heavily structured.
- Groups are not attack oriented, although house meetings and groups may vary with program needs.
- Clients are permitted solitude.

On the other hand, if a problem develops, such as when clients are reinforcing each other's negative behavior, controls are tightened, and groups and house meetings become more confrontative. But as the

situation eases, confrontation decreases again. Walden believes that if behavior is less strictly controlled, client's symptoms are more clearly demonstrated in their behavior and can be dealt with.

a. Adult Facility

In the adult facility, services are distributed as follows: group therapy 40%, individual counseling 30%, and 30% divided among several services such as job counseling, medical health care, and education. The features of the therapeutic program are:

- Seminars. These are conducted by an outside instructor or resident on educational topics (e.g., Eastern Philosophy or Corporate Structure).
- Sensitivity workshops.
- Dissipations, which are marathons.
- Parents groups, conducted by a marriage and family counselor.
- Family counseling as needed.
- Individual counseling by staff two or three times a week per client.
- In-house graduated scale of privileges and job responsibilities.
- Disciplines used as learning experience--for example, washing dishes.
- Communication table. A client who has been communicating poorly must talk to each person in the house for at least an hour.
- The pond or fish bowl. This is the only group where all residents in the house can get together. The activity lasts all of each Wednesday.

- o Slip group, used for social control and solutions of in-house problems. This group meets once a week for two hours or longer, to discuss problems between clients.
- o Static group, or stable therapy groups of 8-9 people with two therapists.

An innovative feature of the Walden program is to give patients over the age of 21 the privilege of drinking (under supervision) at the end of 90-120 days. This feature is a response to the discovery, in the formal program evaluation, that many patients developed a serious alcohol abuse probelm after discharge. The Walden staff hope that by introducing alcohol at an early stage, they can help the client to handle it without going to excess. They do not yet know the effect of this program modification, but feel that it could not make the alcohol problem any worse.

b. Youth Facility

Placement in this facility is not based solely on age (15-22 years) but also on case history and life style. For example, most naive users are placed here, while hard-core users are always placed in the adult unit. Most of the juveniles in treatment were referred as wards of the court. The staff works with the client's family on a group and individual basis, and there is a weekly parents' group, with about 25% attendance.

The youth program has moved fairly far from the classical TC, which emphasizes status and "hostile" peer pressure, in the direction of a family structure. There are no severe punishments, but only "minor ego deflations". In view of the difficulty of involving this age group, and the relative success of Open Door, the direction taken by the Walden youth facility seems appropriate. However, because these

changes were instituted only a few months ago, they will need to be evaluated over time.

The youth facility conducts the same types of groups as the adult facility. After 60 days or more in residence, clients may return to community schools. Counselors work on family problems with the clients, trying to work at the client's level, not from a superior position. Treatment is more individualized than in the adult facility. Clients are given passes twice a month to try out their relationships with their families. These passes are evaluated with the family or the probation officer. A teacher from the school district spends two hours a day, five days a week here. There are classes, field trips, films, and other constructive activities.

c. Satellite Apartment and Outpatient/Aftercare Clinic

The satellite apartment provides housing for seven clients in the reentry phase for up to six months. A manager also lives there. Each occupant pays $75 a month rent.

In the outpatient/aftercare clinic, satellite apartment occupants and other clients in the reentry phase receive group therapy and individual counseling. Outpatient/aftercare service is also extended to ex-clients of Walden and to drug abusers from the community who were not previously associated with Walden.

Immediately after leaving residence, a client receives more intensive counseling, perhaps three times a week. Then he tapers off to once a week. Appropriate criteria for leaving Walden are: the client should have a job, should be partly resocialized, and must have relationships beyond Walden House at the time of leaving.

c. Client Flow and Referral

Figures 9 and 10 show gross client flow for the youth and adult facilities, respectively. The outpatient and satellite units are incorporated in both figures at the lower left portion. The numbers next to the connecting lines represent annual client flow based on three months' data (November, December 1973 and January 1974). Zero client flow indicates potential client flow that did not occur during the sample period and should therefore be considered rare. The figures do not depict steady state flows (e.g., the numbers going into a box do not equal the numbers going out, since the sample was drawn from a fixed period of time, leaving some numbers in the boxes).

Table 70 shows client referrals to Walden House by source, as determined from client screening forms for random samples of clients selected for this evaluation. This table shows the close relationship of the youth facility with municipal and other community agencies; 80% of the clients were referred from these sources.

Table 70 also shows that 53% of the clients were probation and parole referrals. Walden's youth facility will accept any suitable applicant. It is considered an institution to which wards of the courts can be referred by most Bay Area counties, and it receives many referrals from counties other than San Francisco.

The adult facility's policy is to take most clients from San Francisco but often accepts from other counties clients who are considered suitable for treatment. This facility has about 63% referrals from probation, parole, and other community agencies, again illustrating strong community relationships and a dependence on them. Only 11% were referred by self* or family.

* Self referral is not strictly correct, but means that although the individual was not referred by any person or agency, he may have learned of the program through newspapers and other media or through word of mouth (person unnamed).

Table 70

WALDEN HOUSE
CLIENT REFERRAL BY SOURCE

| REFERRAL SOURCE | YOUTH | ADULT |
|---|---|---|
| Probation | 44.44% | 24.53% |
| Community | 33.33 | 24.53 |
| Medical | 2.22 | 22.64 |
| Parole | 4.44 | 0.00 |
| Family | 4.44 | 5.66 |
| Client | 6.67 | 1.89 |
| Other | 4.44 | 1.89 |
| Self | 0.00 | 15.09 |
| Court | 0.00 | 3.77 |
| | N = 45 | N = 53 |

In the outpatient unit, 50% were referred by probation, parole, and other community agencies, with 20% self referred or family referred. The number of self referrals in the outpatient facility should increase as it becomes known that abusers off the street will be treated, in addition to clients associated with Walden House.

Figures 9 and 10 indicate that for applicants not yet admitted into the program, Walden House has no effective arrangements to refer them to other agencies. In the adult facility, Figure 10 shows a substantial number of people lost during intake or from the waiting list. This situation could be alleviated by adding more beds or making arrangements to refer some of these applicants to alternative treatment programs.

Screening of applicants for entry is not highly structured, and takes into account the individual's drug history, behavior (violent or nonviolent), intellectual compatibility with other clients, and the needs of the referring agency.

## 2. Treatment Philosophy, Objectives, and Criteria

### a. Treatment Philosophy

Walden House aims to reduce residents' drug use significantly and to motivate residents to seek education and employment as alternatives to street life. The project's expectations of the addict are not rigid. On entering the program, the client makes a contract for 30 days. At the end of this time, the contract is renegotiated so that the client can set his own goals.

As indicated in the preceding section, the project's change from the traditional TC pattern has also involved a change in treatment philosophy. With the greatest emphasis placed on the re-entry phase, there are no other clearly discernible phases. Much of the daily program is lightly structured, and discipline is also light. Clients have considerable freedom in choosing activities, and are encouraged to contribute ideas during the workshops.

### b. Impact-Oriented Objectives and Criteria for Measurement

Walden House has established a range of objectives as indicated in Table 71. Criteria for the most part are directly related to impact of treatment on graduates. No information is given on progress of clients now in treatment nor on measures of activity level in the program.

The first objective calls for the elimination or reduction of criminal behavior and life style. Progress toward this objective is measured by a series of appropriate criteria directly indicating treatment impact over a period of 1 to 2 years after graduation. The reported data on incarcerations give an indication of the fraction of graduates with some criminal justice involvement before and after treatment. This aspect of the problem could be further

Table 71

WALDEN HOUSE

OBJECTIVES AND MEASUREMENT CRITERIA, WITH ADDITIONS

| OBJECTIVES | CRITERIA USED | ADDITIONS TO CRITERIA |
|---|---|---|
| Elimination or reduction of criminal behavior and life style | Percent of graduates incarcerated (before and after)<br>Percent of graduates on probation (before and after)<br>Percent of graduates on parole (before and after) | Percent of incarcerations by type of offense<br>Percent of convictions<br>Frequency of arrest per man year |
| Reduction in tax consumptive behavior | Percent of graduates on public assistance (before and after)<br>Percent of graduates employed by type of employment (before and after) | Percent of full-time and part-time employment<br>Percent with salary above subsistence level<br>Job turnover rate<br>Number and type of relationships with job sources<br>Number of job placements per year |
| Decrease in illegal drug use | Percent of graduates using drugs by type of drug (before and after)<br>Intensity of drug use by graduates (before and after)<br>Frequency of drug use by graduates (before and after) | Number of current clients on drugs (observation or urinalysis) |
| Increase productive behavior | Percent of graduates in educational activities | Percent of clients reaching educational/training goals<br>Percent of clients achieving other treatment goals |
| Increase internal growth | | |

clarified by adding criteria related to severity and frequency of offenses, and to dispositions by the criminal justice system.

The second objective is the reduction of tax consumptive behavior. As stated, this objective appears to overlap with the first objective. It might therefore be desirable to restate the objective in a manner such as the following: "to reduce unemployment and welfare dependence." The criteria for measurement currently used are appropriate (e.g., salary, job turnover rate, etc.). Others of interest include criteria examining the performance of the project in helping clients obtain jobs (e.g., relations with employers, job placements per year, etc.).

The third objective calls for a decrease in illegal drug use. Currently used criteria are appropriate, including measurement of percentage of graduates using various drugs as well as intensity and frequency of use of drugs. Application of these measures to current clients would be of interest.

The fourth objective calls for an increase in productive behavior. This objective appears to overlap with Objective 2. It might be combined with Objective 2 or reoriented toward specific types of productive behavior not covered by the other objectives. Such behavior might include social functioning, educational activities, support of other constructive community activities, etc. The present criterion for this objective is given in terms of the percentage of graduates currently engaged in obtaining an education. This criterion might be supplemented by criteria indicating the percentage of graduates reaching educational, training, and other treatment goals.

The fifth objective is to increase internal growth.

This consideration underlies all successful treatment in drug-free modalities; however, it is not in itself an impact-oriented objective. No observable criteria for measurement can be suggested. Internal growth should be reflected in the progress toward the other objectives; therefore, it is suggested that this consideration be deleted as an impact-oriented objective.

3. Client Attributes

a. Client Criteria

Attributes of an ideal client of the adult facility (as described by the staff) are: white or nonpolitically motivated black, middle class, heroin addict, not highly independent, with no strong sex drives. Attributes of an ideal client for the youth facility are: white, middle class, naive in regard to street knowledge compared to the knowledge of adult facility clients, experimenter or early abuser of drugs, or incorrigible.

In screening a client, the Walden staff look at his drug problem and its relation to other problems; positive peer relationships; school work (attendance, grades, quality of work); family environment; and type of pressure or motivation for treatment. Clients who are not accepted are:

a. Those considered not to need a therapeutic community.

b. Those with a recent history of violence.

c. Patients with strong emotional disturbances and suicidal tendencies.

d. Patients chronically involved with psychedelics or amphetamines (adult facility).

People with a combined alcohol and drug problem will be accepted. If an

applicant is employed and doing well but is a chipper,* Walden will try to support him in the community through the outpatient/aftercare clinic.

There are few disciplinary discharges because clients usually leave the program rather than being discharged. Infractions for which a client can be discharged or pressured to leave are violence or threat of violence, criminal behavior such as using drugs or stealing, and consistent nonconformity with the rules.

Placement in the youth facility is not based strictly on age. Although all juveniles are placed in the youth facility, young adults who are experimenters or naive users are also placed there. The youth facility accepts some juveniles who have used PCP,* or who have been taking amphetamines or hallucinogens.

b. Client Demographics

To describe the client population in detail, the site visit evaluation team selected random samples of clients in each facility. From the adult facility, descriptive data were collected for 69 clients in two subsamples: an early sample (May-June 1973) of 43, and a current sample (December 1973-January 1974) of 28. From the youth facility, 65 clients were sampled -- an early sample of 37 and a current sample of 19. From the outpatient/aftercare facility, a current sample of 31 was selected but an early sample could not be obtained because the facility was not in operation then.

Client demographics for the three facilities are shown in Tables 72, 73, 74. The youth and adult facilities show a smaller majority of

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* Occasional user.

* PCP (1-phenyl-1-piperidinocyclohexane) is a strong animal tranquillizer that is suspected of causing some organic brain damage through abuse. The youth facility is attempting to build a specialty in treating abuse of PCP. The facility is being advised in this effort by Dr. David Schwartz of the San Mateo County mental health department.

Table 72

WALDEN HOUSE
YOUTH CLIENT DEMOGRAPHICS

| Age | Race/Ethnic/Sex: Hispanic White M | Hispanic White F | Black M | Black F | Non-Hispanic White M | Non-Hispanic White F | Other M | Other F | Total M | Total F | Total T |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 - 19 | 3.6% | 5.4% | 3.6% | 3.6% | 23.1% | 28.5% | 1.8% | 1.8% | 32.1% | 39.3% | 71.4% |
| 20 - 24 | 1.8 | | 1.8 | | 16.0 | 3.6 | 5.4 | | 25.0 | 3.6 | 28.6 |
| Total | 5.4% | 5.4% | 3.6% | 3.6% | 39.1% | 32.1% | 7.2% | 1.8% | 57.1% | 42.9% | 100.0% |

N = 56

Table 73

WALDEN HOUSE
ADULT CLIENT DEMOGRAPHICS

| Age | Race/Ethnic/Sex: Hispanic White M | Hispanic White F | Black M | Black F | Non-Hispanic White M | Non-Hispanic White F | Other M | Other F | Total M | Total F | Total T |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 - 19 | | | | | 1.4% | | | | 1.4% | | 1.4% |
| 20 - 24 | 2.8% | | 4.2% | 2.8% | 22.7 | 19.9% | 4.2% | 4.2% | 33.9 | 26.9% | 60.8 |
| 25 - 29 | | | 1.4 | | 5.6 | 8.4 | 2.8 | | 9.8 | 8.4 | 18.2 |
| 30 - 34 | | | 2.8 | | 4.2 | 1.4 | 1.4 | | 8.4 | 1.4 | 9.8 |
| 35 - 39 | | 1.4% | | | 1.4 | 1.4 | | | 1.4 | 2.8 | 4.2 |
| 40 - 44 | | | 1.4 | | 2.8 | | | | 4.2 | | 4.2 |
| > 44 | 1.4 | | | | | | | | 1.4 | | 1.4 |
| Total | 4.2% | 1.4% | 9.8% | 2.8% | 38.1% | 31.1% | 8.4% | 4.2% | 60.5% | 39.5% | 100.0% |

N = 71

Table 74

WALDEN HOUSE
OUTPATIENT CLIENT DEMOGRAPHICS

| Age | Race/Ethnic/Sex: Hispanic White M | Hispanic White F | Black M | Black F | Non-Hispanic White M | Non-Hispanic White F | Other M | Other F | Total M | Total F | Total T |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 - 19 | | | | | | 9.7% | | | | 9.7% | 9.7% |
| 20 - 24 | 3.2% | | 12.9% | 3.2% | 19.5% | 6.5 | 3.2% | | 38.8% | 9.7 | 48.5 |
| 25 - 29 | | | 3.2 | | 16.2 | 3.2 | | | 19.4 | 3.2 | 22.6 |
| 30 - 34 | | | 3.2 | | 3.2 | | | | 6.4 | | 6.4 |
| 35 - 39 | | | | | 3.2 | 3.2 | | | 3.2 | 3.2 | 6.4 |
| 40 - 44 | | | | 3.2 | | | 3.2 | | 3.2 | 3.2 | 6.4 |
| Total | 3.2% | | 19.3% | 6.4% | 42.1% | 22.6% | 6.4% | | 71.0% | 29.0% | 100.0% |

N = 31

males than is usual in other treatment programs, such as the Walden outpatient facility. Reasons for this smaller majority of males were given previously in Section III. A.3. Walden also has a higher proportion of females than is generally observed in therapeutic communities. The youth facility contains a higher fraction of female clients than the adult facility, partly because the increased pressure of outside relationships experienced by the adult female militate against her entry into a therapeutic community. The female fraction of the adult facility is, in turn, higher than that of the outpatient facility, reflecting the lack of child care help and transportation for the outpatient female.

There is no detectable difference in the age distributions of the adult and the outpatient facilities, both ranging from 18 to 44, with a mean age of 26. The youth facility age is naturally younger, with a mean age of 18.3 years.

Walden demographics were compared with baseline Census data on populations aged 15 - 44 for San Francisco-Oakland SMSA and San Francisco County.* This comparison is presented in Table 75. In particular, a comparison of Walden client data with baseline data shows a better representation of all demographic groups than is normally found in these projects. Walden appears to be appealing equally to all segments of the population when characterized in these terms.

c. Drug Use

Table 76 shows opiate use history for the youth sample. It indicates a high percentage (49%) of non-heroin users. This fact tends to

* San Francisco-Oakland SMSA (Standard Metropolitan Statistical Area) includes San Francisco County (which is the same as the city of San Francisco), its contiguous counties, and Contra Costa County.

Table 75

WALDEN HOUSE
COMPARISON OF DEMOGRAPHIC STATISTICS
WITH REGIONAL POPULATION CENSUS
(AGES 19 - 44)

| | San Francisco-Oakland SMSA | San Francisco County | Walden | | |
|---|---|---|---|---|---|
| Sex | | | Adult | Youth | Outpatient |
| Male | 50% | 49.7% | 60.5% | 57.1% | 71.0% |
| Female | 50 | 50.3 | 39.5 | 42.9 | 29.0 |
| Race-Ethnics | | | | | |
| Hispanic | 6.9 | 7.7 | 5.6 | 10.8 | 3.2 |
| White | | | | | |
| Black | 10.7 | 13.9 | 12.6 | 9.0 | 15.7 |
| Non-Hispanic White | 74.7 | 61.7 | 69.2 | 71.2 | 64.7 |
| Other | 7.7 | 16.7 | 12.6 | 9.0 | 6.4 |
| Age | | | | | |
| 15 - 19 | 19.6 | 15.9 | 1.4 | 71.4 | 9.7 |
| 20 - 24 | 20.8 | 24.0 | 60.8 | 28.6 | 48.5 |
| 25 - 29 | 18.0 | 20.0 | 18.2 | | 22.6 |
| 30 - 34 | 14.3 | 14.4 | 9.8 | | 6.4 |
| 35 - 39 | 13.0 | 12.4 | 4.2 | | 6.4 |
| 40 - 44 | 14.3 | 13.3 | 4.2* | | 6.4 |

* One person older than 44 years was excluded so that the column total is less than 100%.

Table 76

WALDEN HOUSE
YOUTH FACILITY OPIATE DRUG HISTORY

| CURRENT AGE | OPIATE NON USERS | AGE AT FIRST USE OF OPIATES | | | | | | TOTAL USERS |
|---|---|---|---|---|---|---|---|---|
| | | < 12 | 12-13 | 14-15 | 16-17 | 18-19 | 20-21 | |
| < 16 | 33.3%* | 0 | 33.3% | 33.3% | 0 | 0 | 0 | 11.3%** ( 6) |
| 16 - 17 | 75.0 | 0 | 12.5 | 6.3 | 6.3% | 0 | 0 | 30.2 (16) |
| 18 - 19 | 46.7 | 0 | 6.7 | 13.3 | 20.0 | 13.3% | 0 | 28.3 (15) |
| 20 - 21 | 44.4 | 11.2% | 0 | 0 | 22.2 | 22.2 | 0 | 17.0 ( 9) |
| 22 - 23 | 16.7 | 0 | 0 | 0 | 0 | 50.0 | 33.3% | 11.3 ( 6) |
| 24 - 25 | 0 | 0 | 0 | 0 | 0 | 0 | 100.0 | 1.9 ( 1) |
| Total | 49.0% | 2.0%** | 9.4% | 9.4% | 11.3% | 13.2% | 5.7% | 100.0% (53) |

N = 56
NR = 3

* Percentage of age group using opiates.
** Percentage of total.

corroborate the Walden policy of placing hard-core heroin addicts in the adult facility and treating the younger experimental users of many drugs as a separate group. Most clients in the youth facility have a drug abuse history (see Table76 ) many using anything available at a given time, including amphetamines, barbiturates and hallucinogens as well as the opiates.

Table 77 shows that for clients using any drugs except alcohol and marijuana there is a substantial time lag (5-7 years) from first use

Table 77

WALDEN HOUSE
YOUTH FACILITY DRUG HISTORY
EXCLUSIVE OF ALCOHOL AND MARIJUANA

| CURRENT AGE | OPIATE NON USERS | AGE AT FIRST USE OF OPIATES | | | | | | TOTAL USERS |
|---|---|---|---|---|---|---|---|---|
| | | < 12 | 12-13 | 14-15 | 16-17 | 18-19 | 20-21 | |
| < 16 | | | 100.0% | | | | | 12.0%** ( 6) |
| 16 - 17 | 20.0% | 13.3% | 26.7 | 40.0% | 0 | 0 | 0 | 30.0 (15) |
| 18 - 19 | 0 | 7.1 | 35.7 | 21.5 | 35.7% | 0 | 0 | 28.0 (14) |
| 20 - 21 | 0 | 12.5 | 25.0 | 25.0 | 12.5 | 25.0% | 0 | 16.0 ( 8) |
| 22 - 23 | 0 | 0 | 0 | 49.9 | 16.7 | 16.7 | 16.7% | 12.0 ( 6) |
| 24 - 25 | 0 | 0 | 0 | 0 | 0 | 100.0 | 0 | 2.0 ( 1) |
| Total | 6.0% | 8.0%** | 34.0% | 28.0% | 14.0% | 8.0% | 2.0% | 100.0% (50) |

N = 56
NR = 6

* Percentage of age group using drugs daily.
** Percentage of total.

to treatment at the Walden youth facility. Table 78 shows the use pattern of marijuana for youth facility clients; this pattern is a better indication of when the clients became involved in substance abuse. A substantial number claimed to have started before the age of 12, and most started before the age of 15. This table does not show the age/treatment trend that is evident for the other drugs, with the older people in treatment starting

Table 78

WALDEN HOUSE
YOUTH FACILITY MARIJUANA DRUG HISTORY

| CURRENT AGE | OPIATE NON USERS | AGE AT FIRST USE | | | | | | TOTAL USERS | |
|---|---|---|---|---|---|---|---|---|---|
| | | < 12 | 12-13 | 14-15 | 16-17 | 18-19 | 20-21 | | |
| < 16 | 0 | 83.3%* | 16.7% | 0 | 0 | 0 | 0 | 10.7%** | ( 6) |
| 16 - 17 | 6.7% | 33.3 | 13.3 | 40.0% | 6.7% | 0 | 0 | 26.8 | (15) |
| 18 - 19 | 0 | 21.1 | 31.6 | 36.8 | 10.5 | 0 | 0 | 33.9 | (19) |
| 20 - 21 | 0 | 22.2 | 22.2 | 22.2 | 22.2 | 11.1% | 0 | 16.1 | ( 9) |
| 22 - 23 | 0 | 0 | 0 | 66.6 | 16.7 | 0 | 16.7% | 10.7 | ( 6) |
| 24 - 25 | 0 | 0 | 0 | 100.0 | 0 | 0 | 0 | 1.8 | ( 1) |
| Total | 1.8% | 28.6%** | 19.6% | 35.7% | 10.7% | 1.8% | 1.8% | 100.0% | (56) |

N = 56

* Percentage of current age group (percent of total in row).
** Percentage of total.

Table 79

WALDEN HOUSE
ADULT FACILITY OPIATE DRUG HISTORY

| CURRENT AGE | OPIATE NON USERS | AGE AT FIRST USE OF OPIATES | | | | | TOTAL USERS | |
|---|---|---|---|---|---|---|---|---|
| | | < 15 | 15-19 | 20-24 | 25-29 | 30-34 | | |
| 20 - 24 | 15.0% | 2.5%* | 62.5% | 20.0% | 0 | 0 | 62.5%** | (40) |
| 25 - 29 | 9.0 | 9.0 | 27.3 | 27.3 | 27.3% | 0 | 17.2 | (11) |
| 30 - 34 | 0 | 14.3 | 14.3 | 14.3 | 28.6 | 28.5% | 10.9 | ( 7) |
| 35 - 39 | 0 | 0 | 75.0 | 0 | 0 | 25.0 | 6.2 | ( 4) |
| 40 - 44 | 0 | 0 | 100.0 | 0 | 0 | 0 | 1.6 | ( 1) |
| > 44 | 0 | 100.0 | 0 | 0 | 0 | 0 | 1.6 | ( 1) |
| Total | 10.9% | 6.3%** | 51.6% | 18.8% | 7.8% | 4.6% | 100.0% | (64) |

N = 71
NR = 7

* Percentage of age group using opiates.
** Percentage of total.

at a later age. Thus, no relationship can be established between marijuana abuse and entry into treatment.

The Walden adult facility treats heroin addicts primarily. Most clients also have extensive histories of abuse of other drugs. Table 79 shows the opiate abuse history for the adult facility. Most clients started using drugs before they were 20 years old, and many have long histories of heroin abuse with its associated criminal justice involvement. At present, four clients in the adult facility are on methadone maintenance, and are being encouraged to enter detoxification.

Table 80 presents the abuse histories described by the clients of the outpatient/aftercare facility during their intake interviews. Most of the clients are in the 20 - 29 age group and began abusing drugs during their teens and early twenties. The clients of the outpatient/aftercare facility are Walden reentry clients, ex-Walden clients, and abusers not otherwise associated with Walden. The facility is new and has a mix of

Table 80

WALDEN HOUSE
OUTPATIENT DRUG HISTORY
EXCLUSIVE OF ALCOHOL AND MARIJUANA

| CURRENT AGE | NON USERS | AGE AT FIRST USE | | | | | TOTAL USERS |
|---|---|---|---|---|---|---|---|
| | | 15 | 15-19 | 20-24 | 25-29 | 30-34 | |
| 15 - 19 | 0 | 100.0%* | 0 | 0 | 0 | 0 | 8.7%** ( 2) |
| 20 - 24 | 8.4% | 0 | 83.4% | 8.4% | 0 | 0 | 47.8 (12) |
| 25 - 29 | 20.0 | 0 | 40.0 | 40.0 | 0 | 0 | 17.4 ( 5) |
| 30 - 34 | 0 | 50.0 | 0 | 0 | 0 | 50.0% | 8.7 ( 2) |
| 35 - 39 | 0 | 0 | 50.0 | 0 | 50.0% | 0 | 8.7 ( 2) |
| 40 - 44 | 0 | 0 | 50.0 | 50.0 | 0 | 0 | 8.7 ( 2) |
| Total | 8.0% | 12.0%** | 58.0% | 16.0% | 4.0% | 4.0% | 100.0% (25) |

N = 29
NR = 4

* Percentage of age group using drugs.
** Percentage of total.

client types. As it develops its own character and treatment philosophy, the client population will likely become more homogeneous.

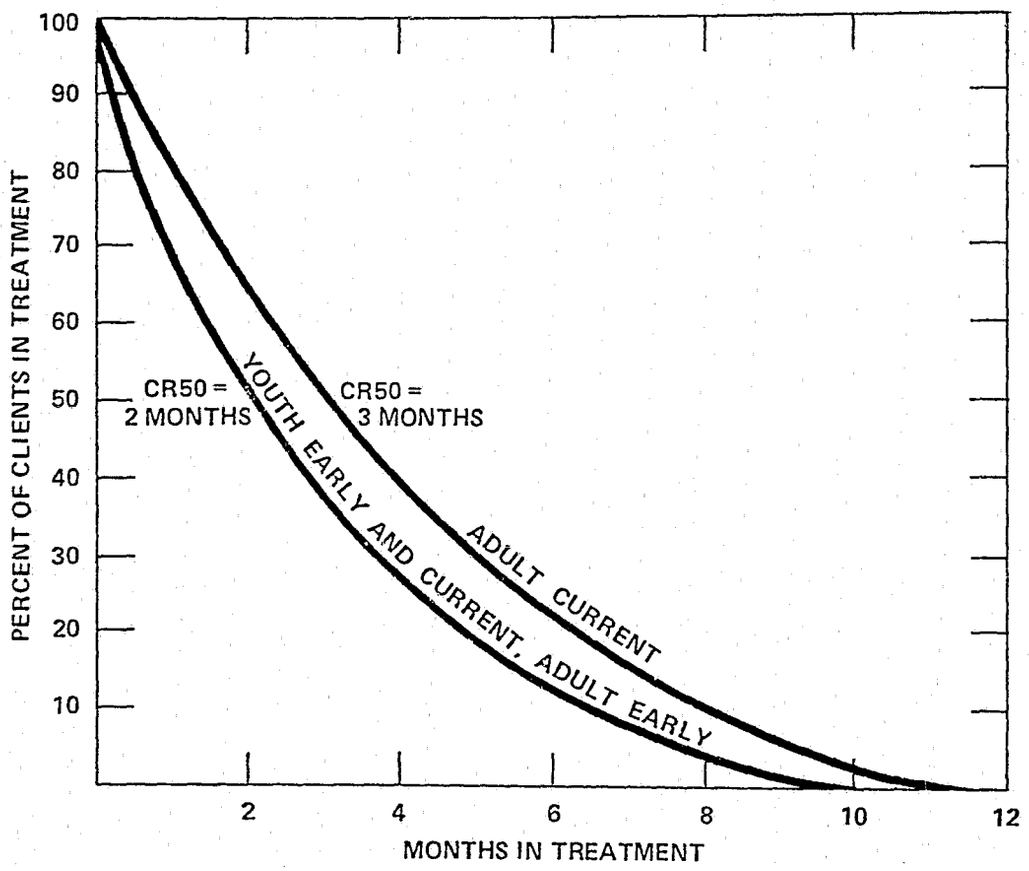
d. Client Retention

Client retention for the Walden youth and adult facilities was estimated using the early and current client samples of both clinics. Results are shown in the client retention curves of Figure 11. Practically all of the clients in the early samples had terminated treatment, so that the curves are an estimate of true retention at that time. For early and current youth and early adult, 50% of the clients terminated the program within two months (CR50 = 2 months on the curve). The median retention for the current adult sample is three months, which is the residential treatment duration specified at present by Walden policy. Since all of the clients in the current sample were in treatment at the time the sample was taken, the curve represents a lower bound on retention at that time (i.e., the true retention curve would lie above the one shown). Also, the change in termination rate is shown in the first few months of treatment. These factors show a significant reduction in the rate of early terminations at Walden during the six months between the two samples.

One of the reasons why Walden loses so many clients early in treatment is its policy that a client should stay only if he is motivated, and his termination is not discouraged if he wants to leave. Younger clients are especially prone to leave when they become dissatisfied or bored. This tendency to leave creates a problem with juveniles. As wards of the court, they should be formally placed, upon termination, in a court-approved institution or home, and it is difficult to coordinate such placement through the probation officer in a timely fashion.

Figure 11

WALDEN HOUSE — CLIENT RETENTION



4. Staff Attributes

Walden House, Inc. is a community based nonprofit corporation governed by a board of directors with policy making powers (Figure 12 ). Under the conditions of its federal funding (NIMH via a contract with the city of San Francisco), staff members cannot hold voting positions on the board, but the administrator, the clinical director, and the deputy clinical director are ex officio members of the board and are accountable to it.

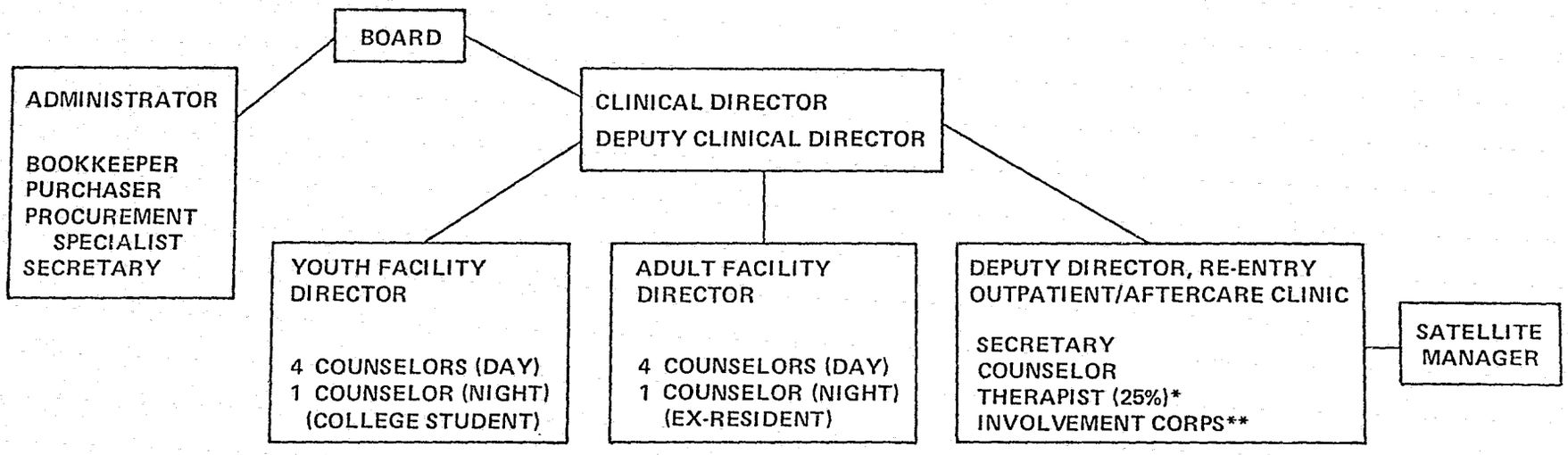
As shown, the number of paid staff is 25, including administrative support. The site visit evaluation team interviewed the 15 professionals and paraprofessionals, such as facility directors, counselors, and therapists who are primarily involved in treatment. Staff statistics quoted here relate to this sample. In addition, there are some volunteers who are working as part of their college training.

Of the 15 members, four are black, ten are non-Hispanic white, and one is other; one third are female; and most of the staff are between 25 and 35 years of age. Although Hispanic whites are not represented, Walden's clients are primarily non-Hispanic white, and that majority has been increasing (see preceding section 3).

The staff of the Walden House have a variety of experience in drugs and drug treatment. Of the 15 members interviewed, 60% have prior drug treatment experience, 80 percent have either prior drug treatment or mental health experience, and at least four people are graduates of therapeutic communities. One member has six years of prior drug treatment experience and four others have more than a year. The on-site evaluation team was unable to obtain answers to questions regarding prior drug use or criminal justice involvement of the staff.

Figure 12

ORGANIZATION OF WALDEN HOUSE, INC.




* Sponsored by MediCal.

** Ongoing community program with a nearby corporation. The Corps generates funds for the program and helps to place clients in jobs. The Corps includes 60-70% of the time of a representative from the Bank of California.

Six of the staff have college degrees; five of these have done postgraduate work. Of the remaining nine staff members, five have completed some college, three have completed high school, and one has had some high school. Fifty-three percent of the staff have had therapy training.

Walden House has established effective working relationships with the city of San Francisco and other organizations. The city pays for a part time psychiatric social worker, and the Bank of California provides a representative to work with the Walden aftercare clinic (Figure 12).

Table 81 presents the distribution of Walden staff time. As shown, individual counseling occupies 22% of staff time while 15% is devoted to group counseling. Group counseling is generally considered to be an efficient use of staff time in a therapeutic community unless advanced clients have developed to conduct their own groups. About 57% of staff time is spent in training, etc. This is an acceptable distribution of effort by current standards. The site visit team rated 87% of the Walden counseling staff as good, and the remainder as adequate.

The staff to client ratios for the adult and the youth facilities are 1:4.3 and 1:2.7, respectively, based on full time equivalents to average beds filled (30 in adult and 20 in youth). These are both less than the ratios of the somewhat comparable Camarillo short term and adolescent programs (1:2.9 and 1:1.2, respectively).

The staff to client ratio for the outpatient/aftercare clinic is 1:10, based on full time equivalents and average active

Table 81

WALDEN HOUSE
DISTRIBUTION OF STAFF TIME*

| Type of Service | Percent of Staff Hours |
|---|---|
| Individual counseling | 21.7% |
| Group therapy | 14.7 |
| Staff meetings - program-oriented | 11.5 |
| Management | 9.0 |
| Maintaining client records | 6.1 |
| Client intake | 5.4 |
| Housekeeping, etc. | 5.1 |
| Staff training - trainer | 3.2 |
| Clerical, etc. | 3.1 |
| Educational services | 3.0 |
| Legal services | 2.8 |
| Staff training - trainee | 2.7 |
| Emergency services | 1.7 |
| Client follow-up or aftercare | 1.6 |
| Outreach | 1.5 |
| Supervision of staff | 1.2 |
| Diagnosis | 1.1 |
| Job training | 1.0 |
| Community relations | 1.0 |
| Other** | 2.6 |
| Total | 100.0% |

* Estimated on the basis of sample clients interviewed.

** Family counseling 0.7%, job development 0.1% medical health care 0.5%, research and evaluation 0.6%, and social services 0.7%.

clients (40) in individual counseling. This ratio is comparable to the 1:11 of both Open Door and Aquarian counseling.

The Walden project does not have a large enough staff to provide wholly staff dominated treatment. The project is neither client run nor client governed in the sense of the Camarillo project. As a consequence, the Walden programs are less structured, with less control over the clients than in the comparable Camarillo units. This problem is more evident in the youth facility where clients have less incentive to stay in treatment. Also, many of the youth are wards of the court, which implies more accountability than for adults. Graduates of the Walden program are no longer used as staff because relapse of some former graduate staff into the use of drugs has had damaging effects on the program (e.g., clients using graduate staff as role models tend to be set back).

The outpatient/aftercare unit is also short on staff. Although the unit is limiting its scheduled case load, it still has difficulty in finding time for groups and many unscheduled clients.

Staff training includes a monthly 5-hour meeting of all staff to discuss program philosophy, current problems, and long and short term program goals. Qualities looked for in staff selection are experience, and subjective attitudes that are compatible with the program (e.g., accepting the idea of social control, working with others, and being willing to document data as needed).

Orientation of a new staff member consists of three steps. First, the new member becomes a resident eight hours per day for two weeks and becomes familiar with all departments. Second, the new member works at identifying his own deficiencies. Third, after a

ninety day probationary period, he can request a one year commitment.

Several highly trained and experienced clinicians and researchers consult with Walden House concerning treatment policy, evaluation, and staff training. They are often involved in the treatment itself. They include a clinical psychologist, an M.S. in psychology, an M.S.W., and a social worker. In addition, a member of the San Mateo County mental health department (whose specialty is child psychiatry and who is also a member of the Walden board) participates in the implementation and evolution of treatment policy in the youth facility.

The administrator and the clinical director are co-directors of Walden House. The administrator is responsible for fiscal, facility, and support functions including community relations and evaluation of utilization. He also has prime responsibility for grant and contract preparation and negotiation. Walden is administered on sound management principles and uses standard, accepted methods of bookkeeping, other record keeping, and budgeting. The administration has developed good systems techniques for monitoring and projecting utilization, cash flow, income, and other indexes that reflect the operational status and potential of the treatment program.

The clinical director and his deputy have the responsibility to determine treatment and training policy, and operating procedures. They direct operations, hire and discharge staff members, assign staff functions, etc. However, even though each executive is responsible for specific areas, the administrator and the clinical director cooperate in each other's efforts. That is, both are therapists, work on the budgets and contracts, dispense discipline

in special cases, and participate in community relations.

This project has a serious problem of maintaining staff at planned levels, turnover being estimated at about 50% per year. For the current staff, average retention is 6.9 months (only four had been at Walden more than a year).

A major problem confronting the Walden organization is the interruption in continuity caused by the high staff turnover. With the high turnover, many staff members may not be integrated with the Walden structure, causing problems of consistency in their approaches to discipline, substance abuse, and other important factors that depend on close association of team members over a longer period of time.

Treatment staff adequacy, as appraised by the evaluation site visit team, shows 66% with a rating of good.

5. Quality of Self Evaluation Efforts

The self evaluation efforts of Walden House consist of two published evaluations (Report No. 1 and Report No. 2).* The first evaluation report covered the period June 1, 1971 to May 15, 1972 and the second evaluation report, June 1972 to May 1973. Both evaluations examined client characteristics for samples of clients to detect changes in client behavior as reflected primarily by drug use and criminal activity. These evaluations are assessments ** since they definitely have a research-like approach and tone. However, they do not employ

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* Report No. 1 - Walden House Evaluation Project, June 1, 1971 to May 15, 1972, Leonard G. Epstein, MSW, and Rebecca A. Hazlewood (Walden House, Inc., May 1972). Report No. 2 - Walden House Evaluation Project, June 1972 to May 1973, Leonard G. Epstein, MSW, principal investigator (John F. Kennedy University, August 1972).

** CCCJ, op. cit., p. 8.

experimental design features, such as control groups, baseline data, and other methodological devices that tend to reduce the influence of unexplained error.

A third evaluation, employing outside consultants, is in the formative stage. Plans call for direct assessment of treatment methods, using ongoing client interviews and observation. The result will be fed back frequently to the Walden House staff so that they can in turn use them to modify ongoing treatment. It appears that this evaluation will be more qualitative than the others, which used a quantitative approach to assess systematically the outcomes of treatment.

Currently, Walden House has decided that future quantitative evaluation of treatment outcome and program impact will be done in-house by the administrative staff rather than by outside consultants. This in-house evaluation, as described by the administrative director, will be at the monitoring level. However, the same degree of detail as before will be maintained on clients and activities, with some additions so that a prospective evaluation at a higher level can be made on demand. In addition to client intake and other data maintained previously, Walden has implemented the NIMH CODAP system required by federal agencies funding treatment. Walden is also monitoring utilization and fiscal data on an ongoing basis, using graphs and tabular displays that highlight problem areas in a timely fashion. Some of the utilization statistics being employed are: total population, admissions, terminations and their prognoses, transfers to different stages in treatment, and the number of clients in school, employed, in vocational rehabilitation, on welfare, or on restriction. These data are kept on a daily basis.

a. Data Sources, Validity, and Use

Data sources in the Walden House evaluations have consisted of direct observation by the evaluators, and client survey using structured questionnaires. The principal investigator worked at Walden House for an extended period and became very familiar with the staff and clients who were in treatment at that time. His observations and personal assessments of client change were therefore especially insightful.

Data elements used in the evaluations included demographic descriptions of clients, such as age and sex; and client background data, such as place of residence, drug history, employment history, and criminal justice involvement. These same factors were then collected by follow-up survey of ex-clients at least six months after treatment, and the data were compared with pre-treatment data in an attempt to assess treatment outcome. The clients sampled in the first evaluation were followed up twice (Follow-up 1 and Follow-up 2), and results were compared for the two follow-up periods.

Data that would have strengthened these evaluations include: client data from other sources to compare with and augment their survey data, baseline data describing the clients' environments, and baseline data and comparative literature describing other treatment programs and modalities.

The validity of data is difficult to assess. There has been a traditional opinion that client-provided data can be unreliable, especially with regard to arrest and drug history. Our evaluation has corroborated this opinion in some instances. However, this problem may have been reduced by the evaluator's intimate familiarity with the clients. This latter approach may be quite useful for treatment but

cannot form a standardized basis for reporting of many projects to a higher governmental agency.

For corroborative purposes, Table 82 shows a comparison of Walden drug history data (pre-screening data) with client response data obtained during the current evaluation. The table compares the first cohort data from the prescreening of the first Walden evaluation with the youth and adult data from the current evaluation. The parameter of comparison is the percent of the samples who have used the listed drugs. Values are comparable for most drugs but differ for barbiturates, alcohol, cocaine, and methadone. These differences may be accounted for by (a) differences in the type of clients admitted during the different time periods (there were apparently no methadone maintenance clients in

Table 82

WALDEN HOUSE

PERCENT OF CLIENTS WHO EVER USED DRUGS BY TYPE OF DRUG

(A Comparison of Early Walden Evaluation Results with Those of SSI Walden Evaluation)

| Type of Drug | First Cohort* Pre-Screening | Youth | Adult |
|---|---|---|---|
| Marijuana | 86.36 | 98.21 | 88.89 |
| Hallucinogens | 67.26 | 76.79 | 59.72 |
| Amphetamines | 59.09 | 57.14 | 55.56 |
| Barbiturates | 45.45 | 75.00 | 61.11 |
| Cocaine | 9.09 | 48.21 | 52.78 |
| Alcohol | 18.18 | 78.57 | 69.44 |
| Heroin | 54.54 | 53.57 | 87.50 |
| Methadone | 0.00 | 12.50 | 51.39 |
| Drug Free | 0.00 | 0.00 | 1.39 |
| Other | | 58.93 | 54.17 |
| | n=22 | n=56 | n=72 |

* From Report No. 2, op. cit.

the first cohort), or (b) differences in drug type classifications. Second cohort data from the second evaluation data from follow-ups of both cohorts were not included in the comparison because of errors that could not be resolved.

b. Methodology

The two published evaluations each used a different, randomly selected client sample. The method of approach was to describe the effect of treatment by testing for changes in client attributes as determined in pre-screening and follow-up interviews. For the first cohort (client sample for first evaluation), in addition to prescreening interviews, there were two follow-up interviews, one during the first evaluation, and one during the second evaluation. For the second cohort (client sample for the second evaluation), in addition to the pre-screening interviews, there was one follow-up interview at least six months after the termination of treatment.

The statistical test used throughout both evaluations to test for before and after differences between pre-screening and follow-up results was Pearson's Chi-square test for consistency between samples.* That is, the test was used to determine whether before and after responses were consistent (statistically similar enough to say that there had been no change). If the responses were different or not sufficiently similar, then a change was said to have taken place, and probably because of treatment. In the calculations, the Chi-square approximation was improved by the Yates Continuity Correction.**

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* M. Fisz, Probability Theory and Mathematical Statistics, 3rd Ed., New York, 1963, pp. 436-440.

** E.L. Crow, et al., Statistics Manual, Dover, New York, 1960.

The criterion for assigning sample subjects to different qualitative levels (e.g., high, low) of some of the factors (e.g., drug use intensity) was not specific or objective. In the case of high-low frequency and intensity of drug use, the criterion appears to have been subjective and related to the investigator's personal knowledge of the clients rather than to a measured frequency of use and amount of drugs used. This is not necessarily invalid with respect to showing a change in factors such as frequency of drug use. But it is difficult to communicate what is high and what is low to others when a specific criterion has not been established (e.g., different people relate differently to "high" and "low" if these qualitative levels are not specifically defined).

The Chi-square approximation is not recommended for statistical tests of consistency or independence in which the frequencies or counts of sample subjects described by some factor combinations are small (less than 5).* An example of this would be a test in which the number of first cohort clients who are frequent heroin users is zero. Many of the factor continuations (contingency tables) in the first two evaluations contain frequencies that are too small. In these cases, it may be more desirable to use an exact test.**

Also, we have been unable to match results for some of their calculations. For example, a conclusion in Walden's second evaluation was that "there was an expected increase at the .001 level of confidence in the frequency of heroin use between the first and second follow-up of the first cohort." It is assumed that this conclusion

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* E. L. Crow, et al., Statistics Manual, Dover, New York, 1960.

** R. A. Fisher, Statistical Methods for Research Workers, 10th Ed., Edinburgh, Scotland, Oliver & Boyd, Ltd. , 1946, Sec. 21.02.

was drawn from Table 11 in Report No. 2 (page 29) concerning the frequency of heroin as first choice drug. A portion of that table is as follows:

| | Follow-up 1 | Follow-up 2 |
|---|---|---|
| None - low | 22 | 14* |
| Medium - high | 0 | 4 |
| (No response) | (0) | (4)+ |

Our calculations resulted in a Chi-square of 3.24 for the questionnaire respondents using the Yates correction. This is significant at the .1 level rather than the .001 level and is highly questionable since the lower left cell frequency is zero. In other words, this test is not sufficient to statistically reject the null hypothesis that the frequency of heroin as drug of first choice for the cohort is the same for both of the follow-up interviews.

Two other sources of error in methodology were (1) description of the statistics presented, and (2) computations in presenting the statistics. (Computational errors are often made in any statistical reporting.) Both of these types of error tend to cause mistakes in the interpretation of data and therefore in the conclusions made. Mistakes such as these argue for the presentation of well-defined and direct (simple) statistics for in-house evaluations. Such statistics should seldom be more than tabular displays of frequencies or counts of clients who meet specified conditions. Even conversion to percentages can usually be left to the reader or the person using the statistics. Statistical tests should be attempted only when statistical expertise is available to check and interpret results. Tables 83 and 84 contain examples of the

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* It should be noted that Table 11 of Report No. 2 erroneously had a zero instead of 14. If the calculations were made from t table with its error, differences noted in the level of confidence would be accounted for.

\+ Parenthetical items added by SSI; not shown in Table 11 of Report No. 2

Table 83

EXAMPLES OF ERRORS - FIRST COHORT

(Table 5: Total Drug Use Pattern: First Cohort)*

| | Pre-screening | | Follow-up 1 | | Follow-up 2 | |
|---|---|---|---|---|---|---|
| | Number | Per Cent | Number | Per Cent | Number | Per Cent |
| Marijuana | 19 | 86.36 | 18 | 81.81 | 14 | (77.7)** |
| LSD | 12 | 54.54 | 5 | 22.72 | 1 | ( 5.5) |
| Other Psychedelics | 5 | 22.72 | 1 | 4.54 | 1 | ( 5.5) |
| Amphetamines | 13 | 59.05 | 4 | 18.18 | 0 | |
| Barbituates | 10 | 45.45 | 1 | 4.54 | 0 | |
| Cocaine | 2 | 9.09 | 2 | 9.09 | 3 | (16.7) |
| Alcohol | 4 | 18.18 | 9 | 40.90 | 8 | (44.4) |
| Heroin | 12 | 54.54 | 3 | 13.63 | 4 | (22.2) |
| Methadone | 0 | 0 | 1 | 4.54 | 0 | |
| Drug Free | 0 | 0 | 4 | 18.18 | 1(0) | ( 5.5) |
| | (N=22) | | (N=22) | | (N=18) | |

* This table is on page 27 of Report No. 2, op. cit.

** Items in parentheses are SSI's corrections or additions.

Table 84

EXAMPLES OF ERRORS - SECOND COHORT

(Table 5A: Total Drug Use Pattern: Second Cohort)*

| | Pre-Screening | | Follow-Up | |
|---|---|---|---|---|
| | Number** | Per Cent | Number** | Per Cent |
| Marijuana | 8 | 27 (53.3) + | 11 | 37 (73.3) |
| LSD | 1 | 3 ( 6.7) | 1 | 4 ( 6.6) |
| Other Psychedelics | 0 | 0 ( 0 ) | 2 | 7 (13.3) |
| Amphetamines | 4 | 13 (26.6) | 1 | 4 ( 6.6) |
| Barbituates | 5 | 17 (33.3) | 2 | 7 (13.3) |
| Cocaine | 0 | 0 ( 0 ) | 0 | 0 ( 0 ) |
| Alcohol | 2 | 7 (13.3) | 7 | 24 (46.6) |
| Heroin | 9 | 30 (60 ) | 3 | 10 (20 ) |
| Methadone | 1 | 3 ( 6.6) | 0 | 0 ( 0 ) |
| Drug Free | 0 | 0 ( 0 ) | 0 | 7 ( 0 ) |
| Total | 30 (15) | | 27 (15) | |

* This table is on page 39, Appendix C of Report No. 2, op. cit.

** Based on primary and secondary drugs only. Should be based on all drugs.

\+ Numbers in parentheses are SSI's corrections and ...

errors described on the previous page.

With respect to computational errors, the percentages in the last column of Table 83 should be based on a sample population of 18. They were based on a sample population of 32 and are therefore about 50% low. In Table 84 the percentages were calculated on the number of drugs reported rather than on the number of clients in the sample (i.e., 15 clients times two drugs, primary and secondary, is 30). The percent was then calculated by dividing the eight clients whose primary or secondary drug was marijuana, for example, by 30 to get the 27% result which they show. The correct result should have been 8 by 15 times 100 or 53.3% The third computational error was to count one client as drug free on Table 83 when in fact he had a primary drug and no secondary drug.

With respect to definition and interpretation errors, the frequency counts from Table 84 are based on primary and secondary drugs only. That is, the number of clients shown is the number of clients whose primary or secondary drug was the one shown rather than the number of clients who had ever used the drug. Typically, clients who have been associated with illegal drug use to the extent of being in a therapeutic community for treatment have been involved with more than two drugs. Most of the clients in our site visit Walden samples had experience with at least five. Therefore, the frequencies in Table 84 would be low and not comparable to those in the first column of Table 83.

c. Value of Evaluative Efforts

These two evaluations provided valuable feedback to the administrative and treatment staff. They were used for program planning, were read by all of the staff to provide a better understanding of their

efforts, and were presented to clients in the form of seminars and were felt to be helpful there.

The principal investigator felt that if more funds had been available, he would have been able to provide additional methodological consultants, statistical consultation, and bigger samples to round out the effort.

Despite some of the problems noted, these evaluations contain valuable, interesting, and helpful information. They are commendable because they have attempted to go beyond the purely descriptive and employ the testing of statistical hypotheses to show the impact of treatment at Walden House on both its clients and the community.

6. Project Impact

a. Impact Measures and Samples Used

Walden House has measured impact of services on client behavior in terms of reductions in criminal behavior, illegal drug use, and tax consumptive behavior. The measures were in the form of two evaluations by follow-up survey, and have been described in Section II.E.5. The first evaluation was conducted in 1972 by the Walden staff and surveyed a random sample of 22 residents. The second evaluation was conducted in 1973 by the Institute for Drug Abuse Education and Research, John F. Kennedy University, on two samples: (1) a sample of 22 former 1971 residents (the same sample as that used in the first evaluation), and (2) a sample of 18 former 1972 residents.*

The SSI evaluation team selected a random sample of clients known to be on probation or parole, and collected criminal jus-

* Walden Reports No. 1 and No. 2, op. cit.

tice involvement data using the following procedures. On the intake questionnaire at Walden, each client had given his current probation or parole status, but the county or state parole area was not given, so that the total list of intake clients contained probationers and parolees from outside the sampling counties of San Francisco and San Mateo (e.g., Contra Costa County). Using this total list, the evaluation team searched the probation/parole files in San Francisco and San Mateo Counties for records of clients who were both on the list and on probation in one of those two counties. Eleven additional client files which were not in the Walden list were provided by the San Mateo County probation office.

Table 85 shows the distribution of the final probation/parole sample obtained for Walden House. None of the five client files

Table 85

WALDEN HOUSE
DISTRIBUTION OF CRIMINAL JUSTICE
FOLLOW-UP SAMPLE
(San Mateo County)

| Agency | Number of Clients |
|---|---|
| Parole | 0 |
| San Mateo adult probation | |
| Youth facility | 2 |
| Adult facility | 10 |
| San Mateo juvenile probation | |
| Youth facility | 5 |
| San Francisco adult probation | |
| Adult facility | 7 |
| San Francisco juvenile probation | |
| Youth facility | 6 |
| Adult facility | 1 |
| Total | 31 |
| Unusable records | 6 |

Table 86

WALDEN HOUSE
COMPARISON OF BASELINE AND PROBATION CLIENT ARREST RATES

| Crime Type | Baseline Population* Annual Arrests/100 population (People Years) | Walden Probation Before Treatment Arrests/ 100 Client Years |
|---|---|---|
| Personal | .72 | 10 |
| Property | .98 | 40 |
| Nonvictim drug | .60 | 32 |
| Nonvictim other | 2.21 | 39 |
| Miscellaneous | 1.77 | 27 |
| Total | 6.28 | 148 |

* San Mateo and San Francisco Counties.

purported to be in the San Francisco area parole archives could be located, and apparently those clients were not parolees from that area. Data collection in San Francisco required visits to the Hall of Justice, Juvenile Hall, and the parole archives; and in San Mateo, visits to five different probation offices. Data collected included: date and reason for arrest, for each arrest from two years prior to entry into Walden up to the present; start and termination dates of treatment at Walden and at other programs; periods of probation; periods of incarceration; etc.

b. Criminal Justice Involvement

Table 86 compares arrest rates for the Walden sample with those of the baseline population, and shows a pretreatment total arrest rate of 148 per 100 client years, which is fairly typical for drug abusers with criminal life styles. This rate can be compared to the rate in the BCS follow-up study,* which gives a rate of 42 arrests per 100 man years, for juveniles with prior drug arrest records.

*Five Year Follow-up, op. cit.

The arrest rate for all minority groups was 100 arrests per 100 client years, compared to 169 per 100 client years for non-Hispanic white clients. This is the opposite of the trend normally seen in crime statistics, but is not a high-confidence inference because of sample anomalies. The trend may be a result of agency referral practices, attitudes of referred addicts, or screening procedures at Walden House.

The comparison in Table 86 between the general population and the Walden pretreatment arrest rates shows the Walden rates to be much higher in all categories, as would be expected because of the clients' typically high criminal justice involvement. The Walden rates are comparable to those of other facilities whose clients have a long history of abuse and criminal activity in the personal, property, and nonvictim drug categories (e.g., Sacramento Methadone with 8, 68, and 42, respectively). However, Walden is high in the nonvictim other category (compared to Sacramento Methadone with 3). This is possibly due to the younger clientele at Walden.

Table 87 compares arrest records prior to and after the start of treatment for various age groups.* In terms of total arrests for all age groups, the decrease in arrest rate following start of treatment was about a factor of 2 (53%): i.e., from 148 arrests per 100 client years to 70 arrests per 100 client years. Comparable reductions are seen in age groups 15-19 years and 20-24 years. In terms of other measures, 73-77% of the clients in varying age groups showed a decrease in arrest rate after beginning treatment. From 54% to 60% of

* Walden residential clients are free to leave the facilities on pass after the first 30 days of treatment, and a significant number of those on pass were involved in criminal justice activity, as also occurs with clients in methadone maintenance.

the clients were without arrests after entry into treatment, with an average of 58% without arrests since entry (a period of 1 to 21 months). These results may be compared with the results of the first and second Walden evaluations. In the first sample, Walden reported 73% without a record of arrest in the year following treatment. Of the 27% arrested, none had been arrested for personal or property crimes. Over a two year period, 67% were not arrested. The second sample shows much less favorable results--60% were arrested in the year following treatment.

These inconsistent treatment outcomes and other considerations have caused a shift in the program emphasis of Walden House. It was recently decided to focus on the reentry phase by shortening the

Table 87

WALDEN HOUSE
CLIENT ARREST RATES BEFORE AND AFTER TREATMENT
BY AGE GROUP
(Arrests per 100 Client Years)

| | Arrests per 100 Client Years Before and After Treatment by Age Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 15-19 Years | | 20-24 Years | | 25-29 Years* | | Total by Crime Type | |
| Crime Type | Before | After | Before | After | Before | After | Before | After |
| Personal | 7 | 13 | 15 | 0 | | | 10 | 7 |
| Property | 20 | 7 | 65 | 24 | | | 40 | 13 |
| Nonvictim Drug | 27 | 31 | 42 | 32 | | | 32 | 30 |
| Nonvictim Other | 66 | 7 | 12 | 0 | | | 39 | 3 |
| Miscellaneous | 13 | 7 | 46 | 9 | | | 27 | 17 |
| Total | 133 | 65 | 180 | 65 | | | 148 | 70 |
| % clients with decreased arrest rates since entry | 73%** | | 77%+ | | | | 74% | |
| % clients without arrests since entry | 60% | | 54% | | | | 58% | |

* Insufficient sample size.
** Two clients included with no prior and no subsequent arrests.
\+ One client included with no prior and no subsequent arrests.

time spent by the client in residence at the therapeutic community, and by maximizing the time spent in reentry. However, the feasibility of this shortened time for in-house treatment has yet to be proven.

The impact of services on the youth facility at Walden may be difficult to measure henceforth, since this facility recently shifted its policy, and is in a state of transition.

Table 88 presents arrest trend data for Walden House juveniles and adults from 1968 to 1973. There was a slight increase in total arrests (13%) in the first half of this six-year period, and a slight decrease (14%) in the second half. These are not sufficient to account for the large decrease (54%) in arrest rate shown in Table 87 for Walden House clients.

c. Drug Usage

According to the first Walden evaluation, the number of clients using drugs (other than alcohol and marijuana) in the first year after start of treatment was reduced by a factor of 2 to 10. The number using alcohol increased threefold, and the number using marijuana was very high (82% of the sample). Four individuals (18%) remained drug free. In the second year after treatment, there continued to be a substantial reduction in the number of individuals using most hard drugs. However, use of cocaine and alcohol increased, and use of marijuana remained almost as high (78% of the sample). One person remained drug free. In the second sample, a decrease was noted in the use of hard drugs, but an increase in the use of alcohol and marijuana. The only person remaining drug free was in jail.

Table 88

WALDEN HOUSE

ARREST TREND DATA BY CRIME TYPE FOR SAN MATEO AND SAN FRANCISCO COUNTIES
Percent of Arrests for Given Years (Juvenile and Adult)

| Crime Type | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 |
|---|---|---|---|---|---|---|
| Personal | 7.34% | 6.34% | 6.49% | 6.77% | 7.95% | 9.64% |
| Property | 17.11 | 16.99 | 16.61 | 17.14 | 15.33 | 21.55 |
| Nonvictim drug | 7.75 | 7.84 | 8.39 | 8.22 | 9.64 | 8.79 |
| Nonvictim other | 44.49 | 42.71 | 42.69 | 41.15 | 28.57 | 34.01 |
| Miscellaneous | 23.31 | 25.64 | 25.82 | 26.72 | 28.51 | 26.02 |
| Total number of arrests | 72,886 | 81,099 | 83.403 | 83,636 | 79,217 | 72,074 |

d. Other Measures of Impact

Regarding tax consumptive behavior (unemployment), the first Walden evaluation found no significant change between before and after treatment; 9 were unemployed before, and 10, after. A complicating factor in measuring employment/unemployment is that in the past, reentry for certain graduates was provided in the form of employment on the Walden House staff. A few months ago, three graduates relapsed into the use of drugs, with the result that graduates are no longer being assigned to the staff, and hence, an employment opportunity has been lost for some clients.

7. Project Potential

a. Cost-Benefit Measures

This section examines the unit costs to achieve the impact discussed in the preceding section. Funding figures are based on corporate budget and financial statements of Walden House and information from an interview with the Walden staff. The total corporate budget was $430,090 for the fiscal year September 1, 1973 to August 31, 1974. This budget included $50,000 for facility improvements. A breakdown of treatment programs is as follows:

| | |
|---|---|
| Youth facility | $128,148 |
| Adult facility | 131,707 |
| Outpatient/reentry | 82,487 |

Walden receives support from several sources, the primary sources being NIMH ($146,800), with supplemental funds from OCJP ($49,000), the county probation departments, and Short-Doyle. Walden has also recently received a grant of $29,280 from a private group, The San Francisco Foundation (outpatient/reentry).

Table 89 shows the cost-benefit measures based on the given budget figures and the impact measures discussed in the preceding section. Cost per client year is based on the assumption of full utilization of the capacity of the facilities (32 in each residence). The outpatient/reentry clinic is new and has not yet developed enough operating experience to reach a steady state of activity. As a result cost-benefit values are likely to be highly variable for a period of time. Definitions of terms

Table 89

WALDEN HOUSE
COST-BENEFIT MEASURES

| | Adult Facility | Youth Facility | Outpatient Facility |
|---|---|---|---|
| Total funds, $ | $131,707 | $128,148 | $82,487 |
| Average attendance, no. clients | 32[a] | 32[a] | 20[e] |
| Graduates/year, no. | 120[b] | 12[d] | 184 |
| % clients improved (decreased arrest rate) | 74 | 73 | 0 |
| % clients arrest free | 58 | 60 | 0 |
| $ per client year | $4,116 | $4,005 | $4,124 |
| $ per graduate | $1,096 | $10,680 | 0 |
| $ per improved client (decreased arrest rate) | $1,006 | $2,210 | 0 |
| $ per arrest free client | $1,291 | $2,670 | 0 |
| $ per attendance day | $11.68 | $11.36 | 0 |
| % drug free clients | 18[c] | -- | 0 |
| # of drug free clients | 22 | -- | 0 |
| $ per drug free client | $5,986 | -- | 0 |
| Total # clients | 176 | 80 | 0 |
| # arrest free | 102 | 48 | 0 |
| # improved | 131 | 58 | 0 |

a. Actually, this is capacity.
b. Number moving from pre-reentry to outpatient/aftercare and satellite apartment (appears high in view of capacity of 32, and 2-3 month retention).
c. Drug free after 1 year (from early evaluations of Walden House). Dr. John Newmeyer of the Haight-Ashbury Free clinic stated that, on the basis of more current observations, he feels that this number is closer to 50%.
d. In their review of the draft of this evaluation, Walden House questioned the use of this figure for the number of graduates. Their staff rated only 12 people as completing the treatment cycle, partially because a clear definition of "successful completion of treatment" was lacking. This was caused by major changes in treatment philosophy and terminology during the year -- e.g., the term "graduate" was officially dropped from their treatment terminology since it "was not supposed to be used to describe successful treatment".
e. Approximate daily attendance based on a weekly attendance of 55 clients per week.

and measures used in Table 89 are as follows:

- Cost per client year - the cost to support one client in treatment for a year.
- Cost per graduate - total budgeted treatment funds divided by the total reported number of graduates.
- "Improved client" - a client whose arrest rate after start of treatment is lower than the average arrest rate in the two years prior to treatment.
- "Arrest free client" - a client without arrests after start of treatment.

Unit costs are $4,116 for the adult facility and $4,005 for the youth facility. These costs are considerably below the costs of the residence facilities at Camarillo. However, Camarillo is a hospital complex with the higher overhead associated with that type of operation. Differences in cost cannot be explained by staff costs and are primarily due to institutional overhead factors. For instance, Walden youth and adult facilities have staff to client ratios of 1:2.7 and 1:4.3, respectively, as compared with Camarillo short term and family of 1:2.9 and 1:7.5, respectively. These results may also be compared with unit costs in therapeutic communities examined in New York.* The cost range per client year in these projects was $2,102-$8,257.

Cost per graduate for Walden House adult facility is generally lower than that of the classical therapeutic communities, partly because of the shorter client retention time (averaging 2 to 3 months). For the adult facility, the cost per graduate is $1,096. Costs per graduate at the youth facility are high because only a small fraction of clients complete the treatment cycle. The estimated cost per graduate for the youth facility is $10,680.

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* Romm, op. cit.

In regard to changes in criminal justice involvement, the random sample from client files indicates that 58% remained arrest free and 74% had a decrease in arrest rate after entry into treatment. This result, when applied to the total client population of the adult facility for the period, yields a cost of $1,291 per arrest free client and $1,006 per improved client. In this instance, the value of the cost per graduate in the adult facility is close to the arrest cost benefit measures given above. But it should be clear that the relationship between cost per graduate and unit cost based on arrest data could vary greatly from project to project.

The comparable values for the youth facility are $2,210 per arrest free client and $2,670 per client with decreased arrest rate. In this particular instance, cost per graduate ($10,680) is probably a more meaningful indicator of performance, since juveniles in the facility not completing the treatment cycle are still kept under close supervision as wards of the court.

With respect to the outpatient clinic, there are 40 registered clients receiving counseling and 60 to 70 irregular and drop-in clients. The unit has capacity for at least 40 more regular clients but would need additional funding. The given staff to client ratio (1:10) would indicate 1-2 visits per week by regular clients. On this basis the cost per client year not counting drop-ins would be approximately $4,000. With the inclusion of drop-ins and transients, the value per client year would be approximately $2,000.

With respect to changes in drug usage, the Walden project reports present a mixed picture. As described in previous sections, one sample showed substantial reduction in drug usage while the second sample

did not. On the assumption that treatment methods are now as effective as those covered in the first sample, the project data would indicate that about 18% of previous clients would be drug free at the end of one year; the percentage drug free would continue to decrease until at most a few percent of clients would be drug free after two years. It is hoped that the reentry efforts and the outpatient clinic will improve the long term results of treatment at Walden. Using the 18% figure at the end of the first year would give a cost of approximately $5,850 per drug free client.

Clients are for the most part drug free while in treatment so that cost per attendance day is a reasonably estimate of the cost per drug free day. The costs achieved in the adult facility ($11.68/day) and in the youth facility ($11.36/day) are much lower than the probable cost of the drug habit on the street (i.e., variously estimated at $30 to $300 per day).

b. Suggested Project Modifications

Walden House should be encouraged in its expansion of its reentry phase. This needs a better facility and more staff, but it is undoubtedly a good direction to move in. Whether the concomitant shortening of the inpatient phase is feasible is more doubtful, and needs careful evaluation over time.

The program needs more funding for a larger residence and more stable staff. Money is needed for better salaries for staff, fringe benefits and an enrichment of the training program. The adult facility could be enlarged by 8-13 beds to eliminate the waiting list and thereby serve the clients who were lost from that list

It is questionable whether the youth residence should be enlarged. It is not full and has been recently reorganized. It should

be re-evaluate in its new form. Walden House has noted that on April 30, 1974, subsequent to the evaluation, this facility was overfilled with 35 patients and had a waiting list of 15 people. In light of the need thus demonstrated, expansion could be considered after re-evaluation.

# Appendix

## QUESTIONNAIRES USED AS A GUIDE TO INTERVIEWING PROJECT DIRECTORS AND TREATMENT STAFF

STAFF QUESTIONNAIRE

Age _____ Sex _____ Race _____ Job Title _____

1. Length of experience:
   a) In this drug treatment program? _____ Years _____ Months
   b) In other drug treatment programs? _____Years _____ Months
   c) Type of program
   d) Please describe other related experience and its length
      _____ Years _____Months

2. Education and training (professional, paraparofessional)
   a) Number of years of school completed _____ Years
   b) Degrees held and major field (e.g., M.A. in psychology)
   c) Please describe any other formal or informal training.

3. How many hours per week do you work?

4. Which of the following activities did you perform during the past week? Please check as many as are applicable. How many hours per week do you spend at each?

| | |
|---|---|
| Client intake | Supervision of staff |
| Diagnosis | Management |
| Individual counseling | Clerical, secretarial, bookkeeping, etc. |
| Family counseling | Housekeeping, maintenance, security, etc. |
| Group therapy | Maintaining client records |
| Job training | Research and evaluation |
| Job development | Staff training - trainer |
| Education services | Staff training - trainee |
| Medical health care | Community relations |
| Legal services | Staff meeting - program oriented |
| Emergency services | Social services (housing, welfare, etc.) |
| Outreach | Client follow-up or aftercare |

5. Please give the number and average duration of client contacts each week in the recent past.

6. Do you have a drug history? Please describe.

7. If you have an arrest or incarceration history, describe it briefly.

Additional comments on your work, problems, needs:

# DIRECTOR'S INTERVIEW

Project Goals

1. What modality is effective for what client?
2. What measures best monitor each of these functions?

1. What are your program goals?

2. What is your treatment philosphy? Your treatment goals?
   a) What is your view of the causes of addiction that your program can deal with?
   b) What are your criteria of the success or failure of a client?
   c) What types of clients succeed or fail?
   d) What is your attitude toward, and treatment of, returnees?

3. What is your therapeutic approach?
   a) The attitude and atmosphere of the program - permissiveness, etc.
   b) The program structure - stages, etc.
   c) Criteria for graduation.

4. What do you consider the most serious problems you have to deal with in meeting the objectives of your overall treatment program?

5. Do you measure client retention (that is, do you keep aggregate records of the length of time clients remain in your program)?
   _____ Yes _____ No

6a. Do you conduct urinalysis tests? ____ Yes ____ No
   For what drugs?
   How often?

6b. What percent of your unrinalysis tests (over a period of several months) are positive for heroin?
   _____ %
   For other drugs _____%

7. What is your treatment capacity? Outpatient ____ Residential ____

8. How many clients are now being treated in your program?
   Scheduled ____ Post-Graduate ____
   Non-Scheduled ____ Other _____

9a. Average number of visits per week by clients ____

9b. What is the average duration of these visits?
   How much time is spent each week?

10. What percent of your clients are in the following treatment modalities:
   Maintenance. . . . . _____ %
   Detoxification . . . _____ %
   Drug free. . . . . _____ %
   Other_____ _____ %
   TOTAL 100 %

11. There are presently _____ clients in treatment.
    a) Their average age is _____.
       Their ages range from _____ to _____.
    b) Approximate racial/ethnic breakdown is:

| | | |
|---|---|---|
| Black. . . . . | _____ | % |
| White. . . . . | _____ | % |
| Oriental . . . . | _____ | % |
| Chicano. . . . . | _____ | % |
| Other _____ | _____ | % |
| TOTAL | 100 | % |

    c) The percent of clients primarily abusing heroin is _____ %.
       Abusing other drugs _____ %
    d) The percent referred from the criminal justice system is _____ %.
       Do you record arrest history of each client (prior, during, after)?
       _____ Yes _____ No
    e) The average length of time clients have been in treatment is _____ months.
    f) What is the source of your information (e.g., recent analysis of client characteristics, estimate based on familiarity with clients, etc.)?

## PROVIDER SERVICES

12a. Please describe services provided.* 12b. What fraction of staff time was spent on that service?

Individual counseling
Family counseling
Group therapy
Job counseling, training and placement
Education services
Medical helath care
Legal services
Social services (welfare, housing assistance, etc.)
Emergency services
Social/Recreational programs
Intake
Outreach
Administration
Staff training
Community relations
Follow-up

## SERVICES PROVIDED TO CLIENTS

13a. % of clients receiving this service. 13b. Number of encounters per week.
13c. Average duration of encounter.

Individual counseling
Family counseling
Group therapy
Job counseling, training and placement
Education services
Medical health care
Legal services
Social services (welfare, housing assistance, etc.)
Emergency services
Social/Recreational programs

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* D = Direct, R = Referral

14a. What services would you like to provide that you are currently unable to provide?

14b. Why are you unable to provide these services?

15a. Describe your outreach effort (type, magnitude)

15b. What are your referral sources?

15c. What arrangements with outside agencies do you have - social welfare, police, probation, etc. (Get names.)

16. Do any of the following characteristics affect admission to your program and, if so, in what way?

| Characteristic |
|---|
| Age |
| Sex |
| Residence |
| Duration of drug use |
| Type of drug used |
| History of emotional illness |
| Alcoholism |
| Economic status |
| Employment status |
| Other |

17. What are your specific intake procedures? (Get copy of forms.)

18. Under what conditions would a client leave your treatment program? (Include program completions as well as dismissals for cause.)

19. What sort of follow-up activities, if any, do you conduct for clients who have graduated, dropped out or otherwise left treatment?

20. Discuss staff training, use of volunteers, clients, etc.

21. Approximately how many people are requesting treatment who cannot be admitted to your program? _____ Why?

22. Discuss major events (such as financial) that have caused major changes in capacity to treat clients.

23. What are your days and hours of operation?

24. Description of facility.

25. What is your staff turnover rate?
Average length of employment with you?

26. What are staff salaries?

27a. What client records do you maintain? (Ask for sample.)

27b. What is your philosophy about client records, their confidentiality, etc.?

28a. What funds were authorized for treatment last year? (CODAP definition)

28b. Do you charge clients for services?

29. What is your administrative structure?

30. How did you get started? Felt need? What assistance did you get? What more did you need?

Interviewee _____

Title _____

Interviewer _____ Date _____

END