QUICK EVALUATION METHODOLOGY

SPECIAL ACTION OFFICE FOR
DRUG ABUSE PREVENTION

October 1973

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INTRODUCTORY NOTE

This monograph was designed to serve several audiences, ranging from policy makers interested in a fast way of obtaining evaluative information to the field team actually conducting a quick evaluation. As a result, everyone may not wish (or need) to read the entire text. Perusal of the "Highlights" and "Appendix A" (sample quick evaluation report) should be sufficient to determine whether the rest of the monograph will be of interest.

The following guide may help people locate those parts of the monograph which are of greatest use to them:

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PREFACE

In early 1973 it became evident that the Special Action Office needed a short, systematic framework for assessing a variety of drug abuse treatment programs. The "Quick Evaluation" methodology was developed to meet that need. This approach enables an average treatment program to be evaluated by two people in two days, including one day spent on-site.

Although the approach encompasses only program operations and excludes client outcome analysis, quick evaluations have proved a useful way of making rough initial assessments of treatment programs. These assessments can then be further refined by additional analysis, if needed.

Since we found the quick evaluation approach a valuable one, we decided to document our procedures and make them available to other people who need evaluative information but have little time to collect it. We hope that our efforts may at least provide a useful analytical starting point, which other people can modify to meet their own needs.

A variety of people provided helpful comments during the conceptualization, development, pilot test and revision of the quick evaluation system. Of particular assistance were Jerome H. Jaffe, Robert L. DuPont, James M. H. Gregg, Raymond H. Milkman, Howard L. Walton and C. James Sample. In addition, Judy Manning, Helen Wills and Ruth Duba patiently typed and retyped the different drafts of this report.

Numerous other people within the Special Action Office, at other Federal agencies and in local treatment programs also provided assistance and encouragement. We greatly appreciate all the help received. Any remaining errors of fact or judgment are, of course, solely the responsibility of the authors.

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October 1973

HIGHLIGHTS

Introduction

As Federally funded drug abuse treatment programs multiplied, the need for evaluation systems became increasingly critical. Efforts are currently underway to develop comprehensive evaluative systems. However, while these systems are being developed, procedures are needed for conducting the more limited analyses required for making funding decisions and assessing technical assistance needs. Consequently, a "quick evaluation" system was developed.

Objectives of Quick Evaluation System

Quick evaluations are designed to be of use to decision-makers facing the following problems:

- whether to continue funding a particular treatment program and, if so, at what level;
- whether technical assistance should be provided to a particular program and, if so, what type; and
- if an entire city's programs are analyzed, whether funding of a proposed new program appears warranted.

Quick evaluations facilitate rapid determinations of whether programs are in serious trouble, are doing all right, or are in need of technical assistance and likely to benefit from it. They are *not* designed to be in-depth analyses of programs, to consider the effectiveness of treatment (as indicated by client outcomes) or to assess *quality* of care delivered. However, the quick evaluation approach is well suited to serve as the "core" of more detailed studies, which might include some or all of these considerations.

Important Features

The quick evaluation approach presented in this report is a complete system, ready to implement. All the required data collection and reporting forms are included, as well as an example of a completed report.

Using this system, an evaluation can be done rapidly. Two people require approximately two days to complete a quick evaluation. This includes one day on-site, when the program staff are interviewed and provide various data about costs, clients and staff. The quick evaluation approach minimizes the burden on the program staff. A quick evaluation usually requires about eight hours of program staff time, spread among several different people (e.g., director, financial officer, chief of personnel, etc.).

The quick evaluation approach identifies a few areas of critical interest and focuses major efforts on getting reliable data for those areas. Data validation procedures, particularly in the area of determining actual client loads, were developed as part of the quick evaluation system. Moreover, all the data collected are *used* in the quick evaluation report.

Analytical Approach

The quick evaluation methodology is largely built around ten analytical criteria. However, descriptive data are also considered, since such characteristics as the age of a treatment program will affect the interpretation of the analytical criteria. The evaluator's subjective assessment, including impressions and observations made on-site, also assist in the interpretation of more quantitative data.

Analytical Criteria

Ten analytical criteria, six quantitative and four qualitative, were selected as the major program performance measures. The quantitative measures are:

- cost per client-year;
- ratio of actual to standard budget;
- staff-client ratio;
- counselor-client ratio;
- staff turnover rate; and
- percent of positive urinalysis tests.

The qualitative criteria included are:

- level of services provided to clients;
- scope of record-keeping systems;
- quality of records; and
- validity of reported data.

All criteria are specifically defined and capable of independent verification.

Descriptive Information

Descriptive information about each program is summarized under four categories:

- background (e.g., program name, location, director, number of facilities, capacity and date of first client treatment);
- funding (e.g., Federal funds, total funds and amount spent);
- clients (e.g., number currently in treatment, client characteristics and client loads); and
- staff (e.g., authorized and filled positions and person-years of effort).

Subjective Assessment

A subjective assessment is provided for each program. The evaluation team's impressions and observations are presented for fourteen areas of interest: facility, director, staff, admission and intake, discharge and follow-up, client services, financial procedures and records, client records, validity of reported data, adequacy of resources, utilization of resources, other problems or comments, technical assistance needs and recommendations. Comments are usually brief and focus on providing a short overall assessment and identifying specific problems.

Conclusion

In general, quick evaluations are designed to be short, decision- and problem-oriented assessments of treatment programs. Data are collected systematically, highlighted in the quick evaluation report and arrayed in a consistent format to facilitate further analysis by people so inclined. Quick evaluations deliberately exclude a number of important areas, such as client outcome and quality of care. However, despite their limitations, quick evaluations appear to provide useful and rapid assessments of treatment programs.

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I. INTRODUCTION

A. *Background*

In January 1973, approximately 400 drug treatment programs were being funded by various Federal agencies. Each agency had its own funding standards, monitoring procedures and evaluation techniques. These were fairly well developed at some agencies but virtually nonexistent at others. It was likely that some agencies were funding programs which would have been rejected by other agencies. Moreover, no one knew how much treatment was being delivered by the various types of programs around the country. Anecdotal information was plentiful, including:

- horror stories about programs reporting large client loads but in fact serving only a few people;
- success stories about well-run programs effectively rehabilitating addicts; and
- other stories of programs muddling along, somewhere between those extremes.

The extent to which any (or all) of these anecdotes reflected the true national treatment picture was unknown.

Systematic evaluation studies were clearly needed, and several were in progress. For example, work was underway to develop techniques for evaluating treatment programs by measuring changes in client behavior, assessing the characteristics of the various delivery system variables and relating those variables to client outcomes. These techniques were to be used to evaluate a sample of treatment programs, located around the country.

Although such efforts were expected to provide considerable insight concerning the nature and impact of treatment programs, even preliminary study results would not be available before late 1973. In the meantime, any program evaluation was likely to consist of short site visits to various programs by Federal and/or contractor personnel. Such site visits would assist in refunding decisions, grant transfers among agencies, and identification of technical assistance needs. It seemed desirable to have these site visits be as systematic as possible. This required development of a conceptual framework for organizing and analyzing the data as well as systematic procedures for collecting it. The "Quick Evaluation" methodology was developed to meet these needs.

The methodology was pretested on five programs, and numerous revisions were made as a result. A preliminary methodology report was then drafted and circulated to a variety of people, having programmatic as well as evaluative experience. Their comments led to further revisions, which are reflected in this report.

Since the quick evaluation approach seems to be useful in some circumstances, we decided to document the procedures, so that people working on related problems could benefit from our experience. It is important, however, that people who consider implementing this approach clearly understand what it should and should not be used to do. The approach has a number of limitations as well as a number of useful features.

The methodology was designed so that two people could evaluate an average program in two days. In addition, approximately one person-day of total staff time is required from the drug treatment program.

The methodology relies exclusively on data available at the treatment program. No attempt is made to conduct follow-up interviews of clients or to contact other community organizations which might have knowledge of the treatment program's operations. The methodology does, however, include procedures for on-site verification of data provided by the treatment program.

Based on a five-program pretest, the methodology seems to be:

- relatively simple and straightforward to implement;
- sensitive to the vast differences in operating performance among treatment programs; and
- able to produce useful, analyzable data.

The methodology is also well suited to serve as the "core" of more ambitious studies. Additional evaluation modules can easily be added to this core to provide more detailed information on special areas of

interest. Some possible additions to the core methodology are discussed in Chapter IV of this report. In addition, the quick evaluation approach could become an integral part of a more comprehensive monitoring/evaluation system.

B. *Possible Uses of Quick Evaluation*

Quick evaluations were designed to be of use to decision-makers facing the following problems:

- whether to continue funding a particular treatment program, and if so, whether the program appears to need more, less or the same amount of money;
- whether technical assistance should be provided to a particular program , and if so, what type; and
- if an entire city's programs are analyzed, whether funding of a proposed new program appears warranted.

C. *Limitations of Quick Evaluation*

There are several limitations of quick evaluations. One is that they are not in-depth analyses of treatment programs. Quick evaluations can group projects into similar categories, but they cannot provide reliable project-by-project rankings. Such rankings would require more detailed analysis.

Quick evaluations can be considered as a rough first cut evaluation effort. The presumption is that projects will fall into clusters and that those at the extremes can be quickly identified. This information can then provide a basis for structuring:

- corrective action for those programs which seem worst;
- detailed evaluative studies of the best projects to assess the reasons for their success; and
- technical assistance for projects falling between those extremes.

Of course, if only a few programs are evaluated (e.g., all the programs within a small area), there may be little variation among them. However, knowing that no extremes exist within a group of projects is itself useful information. Moreover, comparison of the group results with national norms would provide insight concerning the relative standing of the entire group. For example, in a larger sample, the small project group might be included in a cluster at one extreme.

An additional limitation of quick evaluations is that they identify problem areas which require technical assistance but do not specify the exact nature of that assistance. For example, a quick evaluation can indicate that management procedures need to be improved but cannot further state that this problem could be resolved through a two-day site visit by a management consulting team, focusing on improving the flow of client traffic and helping the director establish program performance measures.

Another limitation of quick evaluations is their exclusion of follow-up client interviewing. The implicit assumption is made that there is a correlation between program effectiveness in terms of client outcome and program efficiency as assessed through a quick evaluation. However, it may be that programs which are 20% more expensive than the norm are 50% more effective. If so, decisions based on quick efficiency evaluations alone would be poor decisions.

Finally, a quick evaluation does not address the question of whether a community *needs* that particular treatment program; a quick evaluation only assesses the performance of that program. The implications of not funding a mediocre methadone maintenance program are quite different for a community where that is the only such program than for a community where there are several others.

II. ANALYTICAL APPROACH

A. *Important Features*

In general, the evaluation approach was to identify a few areas of critical interest and focus major efforts on getting reliable data for those areas. Data validation procedures, particularly in the area of determining actual client loads, were developed as part of this effort. Moreover, all the data collected are used in the quick evaluation report. This study is not designed to build a data bank for possible analysis at a later date but rather to collect information which is currently needed for analysis.

Considerable attention was given to the question of the most appropriate time periods. One possibility was to use the grant year of the Federal grant agency. However, since different agencies use different grant years and, in addition, state, local and private funding sources use still different grant periods, this did not seem feasible. Instead, the Federal government's fiscal year, July 1 through June 30, was selected. This is also the time period used for reporting requirements under the Client-Oriented Data Acquisition Program (CODAP). Although some programs maintain their financial records primarily by grant, a periodic (often monthly) financial statement is usually prepared, and fiscal year data can be developed from those records. Actually, three time periods are considered within the analysis: current (i.e., the most recent month or week), current fiscal year to date, and past fiscal year. A time period longer than one year seemed necessary for certain data elements; however, it did not seem essential to analyze any program's operations for the period prior to the preceding fiscal year. Such data would be primarily of historical, not analytical, interest, since most programs change so rapidly.

Attention was also given to the best way of categorizing types of treatment. The matrix in the Federal PROMIS data collection system was selected. This matrix provides a two-way classification of treatment: by residence category and by modality. There are three residence categories: outpatient, residential (live-in) and inpatient (hospitalized). The residence category is a major variable affecting treatment costs, and most treatment cost "norms" have been derived on this basis. There are four modalities for each of these residence categories. The modalities are: maintenance (e.g., methadone or LAAM), detoxification, drug free and other (e.g., antagonists, such as cyclazocine). Analysts interested in more detail could add a third level of classification to this system. Then, for example, outpatient maintenance programs would be further subdivided. Such detail is not needed for a quick evaluation, however.

The quick evaluation methodology is largely built around ten analytical criteria. However, descriptive data are also considered, since such characteristics as the age of a treatment program will affect the interpretation of the analytical criteria. The evaluator's subjective assessment, including impressions and observations made on-site, also assist in the interpretation of more quantitative data.

B. *Analytical Criteria*

Ten analytical criteria, six quantitative and four qualitative, were selected as the major program performance indicators. Table 1 shows the reporting format developed for these criteria, which are described below.

(1) *Quantitative Measures*

Six quantitative measures were selected:

- cost per client-year;
- ratio of actual to standard budget;
- staff-client ratio;
- counselor-client ratio;
- staff turnover rate; and
- percent of positive urinalysis tests.

(a) *Cost per client-year*

This measure is computed for three different time periods: the most recent month, current fiscal year to date and past fiscal year. This enables cost trends to be considered, as well as the levels for particular time periods. Costs are calculated separately for the three different residence categories of treatment: outpatient, residential and inpatient. The current cost rate is computed from the most recent month's costs (annualized) and the verified current client load for the week before the site visit. A client is defined as someone who is being seen at least twice per week. Current fiscal year costs to date and past fiscal year costs are computed from program records.

Costs, incidentally, are total financial costs, considering all funding sources. No attempt is made to develop an accurate "economic" cost (for example, by imputing the fair market value of donated goods and services). The cost estimates are obviously crude ones. Detailed cost analysis would separate fixed from variable costs and include a variety of other considerations. However, a crude cost estimate is often sufficient to provide useful information on program operations. More detailed cost estimates can always be developed for those programs which require them.

As a first cut, costs should be neither too high nor too low. Very high costs would indicate either a very inefficient program or one delivering very high quality, high cost service. Very low costs would indicate either a very efficient program or one delivering very low service to its clients. Rough estimates for the standard costs per client-year of outpatient, residential and inpatient treatment are $1,500, $4,500 and $30,000, respectively. Some programs now provide various forms of "daycare" treatment. These programs usually have an eight-hour-a-day "residential" component; clients live outside the treatment program the rest of the time. A rough estimate of the standard cost for daycare treatment is $2,000 per client-year. If actual values deviate substantially (e.g., 25% or more) from the standard costs, the reason should be explored.

(b) *Ratio of Actual to Standard Budget*

This ratio compares the funds available for treatment with the funds expected to be required, based on current (verified) client loads and the standard costs for outpatient, residential and inpatient treatment. The time period considered is the current fiscal year. Usually, the ratio should be close to 1.0. Higher ratios indicate more expensive care than anticipated. Whether this resulted from inefficiency, from provision of better care, or from some other factor is an important issue to address. Ratios lower than one indicate cheaper care than anticipated. Again, there could be a variety of reasons for this outcome, and these should be considered.

(c) *Staff-Client Ratio*

This ratio is the total number of current staff members divided by the current, verified client load. The staff is measured in terms of full-time equivalent positions (e.g., two half-time staff members would represent one full-time equivalent). More complex measures were considered, such as excluding clerical and other support staff. However, any improved insight derived from using more complex measures did not seem to warrant the increased data collection difficulty. The calculation of a total staff-client ratio can be done easily, even for programs with very rudimentary record-keeping procedures. For outpatient programs the staff-client ratio can be expected to be approximately 1 to 15. Residential and inpatient programs have more staff per client, since approximately five people are required to cover one position on a 24-hour-day, seven-day-week basis.

(d) *Counselor-Client Ratio*

This ratio is the current number of counselors dividied by the current, verified client load. For programs based largely on counselor-client relationships, this ratio roughly indicates the attention individual clients may receive. One full-time counselor can probably serve 20 to 25 clients. Ratios outside this range require further consideration and explanation.

Table 1. ANALYTICAL SUMMARY

	Outpatient	Residential	Inpatient
A. Cost per client-year:			
(1) Current rate			
(2) Current FY through _____			
(3) Past FY			
B. Other Quantitative Indices:			
1. Ratio of actual to standard budget			
2. Staff-client ratio			
3. Counselor-client ratio			
4. Staff turnover rate			
5. Percent of positive urinalysis tests			
C. Qualitative Indices:			
1. Level of services provided to clients			
2. Scope of record-keeping systems			
3. Quality of records			
4. Validity of reported data			

DEFINITIONS:

A.1: [(Costs for most recent month) X (12)] ÷ (number of clients seen at least twice last week).

A.2: (Costs for current FY to date) ÷ (current FY client-years of treatment to date).

A.3: (Costs for past FY) ÷ (past FY client-years of treatment).

B.1: [Actual budget] ÷ [number of clients seen at least twice last week) X (standard cost per client)]. Standard cost per client is $1,500 for outpatient care, $4,500 for residential care and $30,000 for inpatient care.

B.2: (Number of staff-members) ÷ (number of clients seen at least twice last week).

B.3: (Number of counselors) ÷ (number of clients seen at least twice last week).

B.4: [Number of people employed during past and current FY) – (number of positions filled at least half the time during past and current FY)] ÷ [number of positions filled at least half the time during past and current FY].

B.5: (Number of positive urinalysis tests) ÷ (total number of urinalysis tests).

C.1: "Medium" consists of individual counseling at least once a week; vocational rehabilitation (i.e., job counseling, training or placement); and two of the following: legal, social or health services. "High" consists of more services and "low" of less.

C.2: "Medium" means the program (a) was able to complete the data forms easily; (b) keeps a formal budget, prepares authorizing documents before disbursing funds, records all expenditures and receipts, and makes periodic financial statements; (c) keeps individual client records, including admission forms and counselors' notes. "High" consists of more records and "low" of less.

C.3: "Medium" means that 70-80% of the records are relatively complete, up-to-date, and consistent. Client records include weekly counselors' notes which seem relevant and useful. "High" indicates that more than 80% meet these conditions and "low" less than 70%.

C.4: "Medium" indicates that data verified by the evaluation team and data reported by the program differ by 10-20%. "High" indicates differences of less than 10% and "low" of more than 20%.

(e) *Staff Turnover Rate*

Very high turnover rates are sometimes an indication that a program is experiencing difficulties. Care must be taken with the interpretation of this number, however, since high turnover could mean that the program generates very capable staff members, who are in demand at other programs. The time period selected for measuring turnover is the combined past and current fiscal years. Such a long time period was selected, since there would be little opportunity for turnover during a short time period. Turnover is calculated by subtracting the number of positions filled at least half the time from the total number of unique individuals who were employed over that time period and dividing by the number of positions filled at least half the time. Again, more complex measures were considered, such as looking at turnover rates for different staff levels (e.g., top staff, professionals, paraprofessionals and support staff), but the more complex measures did not seem to merit the extra effort.

(f) *Percent of Positive Urinalysis Tests*

Care must be used in interpreting this number, since such factors as the procedures for urinalysis testing and the quality of the lab will affect the usefulness and meaning of the measure. However, a very high percent positive is probably a good indicator that something is wrong with program operations, whatever the testing procedures and lab quality. Except in such an extreme case, it would probably be a mistake to place much emphasis on this measure without further consideration of the factors which influence it.

(2) *Qualitative Indicators*

It is always difficult to decide how to handle the variety of information which critically affects program operations but cannot be readily quantified. Often qualitative considerations are compietely ignored, with the implicit hope that "all other things will be equal" and therefore quantitative measures will provide accurate program assessments. The quick evaluation methodology rejects this approach and includes qualitative and subjective considerations. This approach reflects a bias that it is better to include qualitative considerations, even in an imperfect fashion, than to ignore them altogether. Starting to assess qualitative indicators in a systematic way provides a basis for continually improving the procedures for making that assessment. It also provides a basis for determining whether qualitative measures do, in fact, affect the interpretation of quantitative results.

In addition to a narrative subjective assessment of the program by the quick evaluation team, the analytical summary includes four qualitative criteria:

- level of services provided to clients;
- scope of record-keeping systems;
- quality of records; and
- validity of reported data.

These areas are rated as "high," "medium," or "low." The "medium" level is defined very specifically, and the other two levels are defined relative to that standard.

(a) *Level of Services Provided to Clients*

A "medium" level of services consists of:

- individual counseling at least once per week;
- some vocational rehabilitation service (job counseling, job training *or* job placement); and
- two of the following: legal, social or health services.

These services may be provided either by the program itself or through referral to other organizations. A "high" level of service consists of more services than the medium level (e.g., family counseling or group therapy may also be done), while a "low" level consists of less.

(b) *Scope of Record-Keeping Systems*

"Medium" means the program:

- was able to complete the required data forms relatively easily;
- maintains the following financial records: a formal budget, documents authorizing fund disbursements, records of all expenditures and receipts and periodic financial statements; and
- maintains individual client records, which include admission forms and counselors' notes.

"High" consists of more records and "low" of less.

(c) *Quality of Records*

"Medium" means that 70-80% of the records are relatively complete, up-to-date and consistent. In addition, client records include weekly counselors' notes which seem relevant and useful. In general, the records are of such quality that a third party would find them of use in treating the client. "High" indicates that more than 80% of the records meet these conditions and "low" that fewer than 70% do.

(d) *Validity of Reported Data*

"Medium" indicates that data verified by the evaluation team and data reported by the program differ by 10-20%. "High" indicates differences of less than 10% and "low" of more than 20%.

(3) *Possible Additional Criteria*

Although additional criteria were considered, these were rejected for various reasons. Some of these criteria are discussed below, along with the reasons for their ultimate exclusion from the quick evaluation methodology:

(a) *Deaths*

Program-related deaths may be an indicator of poor program operations. However, there are major problems in defining program-related deaths. For example, if a child of a methadone maintenance client accidentally overdoses on the client's take-home medication, should that death be considered program-related? The answer might be yes if the program failed to provide take-home medication in a form that minimized the likelihood of a non-addict taking it by accident or if it failed to instruct the client on proper precautions to be taken with take-home medication. If, however, the program took all possible precautions, should the death still be considered program-related, since it was methadone distributed by the program which was the cause of death? This example is only one of many dealing with the problem of adequately defining a program-related death. Another example is: what time period should be considered? For example, if a client drops out of drug free treatment one week and overdoses the next, is that program-related? It may be, if the addict lost his earlier tolerance during treatment and overdosed because he did not realize this fact.

Another problem with this measure is that it does not seem appropriate to get that data from the treatment program, which is the data collection approach used for quick evaluations. In some cases programs may not know that a former client died; they may only know that he stopped coming to the treatment program.

Finally, it would be difficult to verify easily whatever the program said. If a program did not want to admit any program-related deaths, it would be a great deal of work for the evaluation team to find that out.

This is contrary to a major tenet of the quick evaluation methodology, i.e., that data should be easily verifiable. Therefore, deaths were not included as an analytical criterion, although deaths are obviously an important area of consideration for program operations.

(b) *Staff Characteristics*

The staff's experience, education and training may be good indicators of the quality of care. However, this data would have to be collected for each individual staff member, aggregated and systematically categorized. This would greatly increase the time required for data collection and analysis. For quick evaluation purposes, we decided this amount of effort was not warranted. However, consideration of staff characteristics could easily be added to the core methodology. This is discussed in greater detail under Chapter IV, "Possible Additions to Quick Evaluation."

(c) *Staffing Pattern*

Another important staff consideration is the staffing pattern (e.g., the percent of medical personnel, counselors, etc.). Theoretically, it would be possible to compare a program's staffing pattern with "ideal" staffing patterns and identify those which were very different. Those would then receive closer analysis. Although this approach is theoretically possible, no simple way of implementing it was developed. Therefore, the measure was dropped.

(d) *Client Retention*

A question is included in the director's interview about client retention. However, we decided to make the response one of the items to be considered as part of the subjective assessment rather than an evaluative criterion. The reason for this is that programs assess and estimate their client retention rates in such different ways. Ideally, we would make the client retention question very specific (e.g., of the clients who entered your treatment program six months ago, what percent are still in the program, by modality?) However, many programs might be unable to answer such a specific question, although they would have a rough idea of the client retention rate. Moreover, it would probably be difficult for the evaluation team to verify the answer to a very specific client retention question without a time-consuming record search. Therefore, we opted to accept the director's estimate of client retention as a rough indicator of possible program performance and to include that information in the subjective assessment, instead of trying to verify it and include it in the analytical criteria. Anyone interested in accurately measuring client retention could, however, add a section to the core evaluation which would deal with this issue. This is discussed further in Chapter IV.

(e) *Relationship Between Rate of Spending and Rate of Treatment*

Some measure of the relationship between the rate of spending and the rate of treatment would be useful. It means something very different when a program is treating half its expected client load and is also spending at a rate half of that expected than when the program is treating half its expected client load and spending at a full rate. However, we were unable to develop any quick, simple measure which adequately reflected this relationship. One possibility was the ratio of the percent of funds spent to the percent of the estimated total client-years of treatment which had actually been provided to date. However, this would not work for relatively new programs, since start-up costs would be included in the expenses. In addition, in many cases it would probably be difficult to obtain a good estimate of the total client-years of treatment expected to be provided under a given grant. Frequently, the grant indicates the funded treatment capacity but does not include a timetable for building up to that capacity.

A second measure considered was the ratio of percent of funds spent to percent of capacity utilized. This measure, however, is a static one which would only be useful for programs with a relatively stable client load. The measure would change significantly over one month for programs either building up or declining.

Other measures were considered but none seemed "right." Therefore, we decided merely to report in the descriptive summary the data on capacity, client-years of treatment, budgeted funds and costs. Anyone interested in developing ratios from these data can do so. Care should be taken to develop an appropriate ratio, however.

(f) *Client Outcome*

Although the quick evaluation methodology does not provide for follow-up client interviewing, we considered the possibility that some programs might maintain client performance data, particularly in terms of changes in employment and criminal activity. In such cases, it would be useful to include this outcome data in our analysis. Therefore, we considered defining employment and criminality variables and including these measures in the analytical summary, for those programs which kept such data. However, this created problems similar to those of trying to define client retention very specifically. Therefore, we decided to delete employment and criminality as analytical measures but to ask for copies of any evaluation or client follow-up studies which may have been done. These studies would be considered in the subjective assessment of the program; they would also become part of the quick evaluation file for that program.

(g) *Quality of Client Care*

There are a number of qualitative indicators which were considered for inclusion in the analytical criteria. One of the most important of these is quality of client care, which is a crucial element of program operations and an important factor to consider when interpreting cost data. However, it is extremely difficult at present to identify the exact elements which constitute a high quality of client care. This is much more difficult, for example, than to define a high level of client services or high quality records precisely. Moreover, even if agreement were reached on the exact components of high quality care, determining the extent to which these components were present at a particular program would require that program operations be observed by a skilled clinician, probably for several days. Use of resources at this level was outside the constraints set for quick evaluations. Therefore, quality of client care is not included as an analytical criterion, although impressions about client care should be incorporated into the subjective assessment.

(4) *Summary*

After consideration of a number of possible analytical criteria, ten were selected for use. These ten can be easily verified by the evaluation team, if verification seems needed. In addition, a range of values can be hypothesized for each criterion, within which the assumption would be made that the program's performance is acceptable. Values outside those ranges may also be acceptable, due to special program conditions, but that determination requires further information and consideration. Although the quick evaluation methodology places considerable emphasis on analytical criteria, we recognize that the interpretation of these criteria depends to some extent on the characteristics of the program—e.g., its age, growth history, clientele, etc. Therefore, descriptive characteristics and a subjective assessment are included for each program.

C. *Descriptive Information*

Table 2 shows the descriptive information presented for each program. This information is of four types:

(1) *Background*

This includes the program's name, location, director, number of facilities, capacity, and date of first client treatment.

(2) *Funding*

The Federal funds, total funds and amount spent for the past fiscal year and the current fiscal year to date are presented. This information comes from the financial data forms completed by the program.

(3) *Clients*

This consists of three sections:

(a) *Number of clients currently being treated*

This presents the number of clients by residence category (outpatient, residential or inpatient) and modality (maintenance, detoxification, drug free or other). These numbers are those derived from the evaluation team's independent verification of client loads, based on determining the number of clients seen at least twice per week.

(b) *Characteristics of clients currently in treatment*

Characteristics include the average age, percent male, percent black, percent primarily abusing heroin, percent referred from the criminal justice system and average length of time in treatment. This information comes from the director's interview.

(c) *Client loads*

This section includes the client-years of treatment for the past fiscal year and the current fiscal year to date and the percent change in client load from July of the current fiscal year to the present. Information, presented by residence category, is derived from the client data form completed by the program.

(4) *Staff*

The currently authorized positions and currently filled positions for the total staff are indicated, as well as the past fiscal year and current fiscal year (to date) person-years for professional and paraprofessional staff.

The descriptive information presented is a brief summary of some of the major characteristics affecting the interpretation of the analytical criteria. The age of a program, its client growth rate and whether it is fully staffed, are among the descriptive items presented. There are, of course, many other descriptive characteristics which could be reported for a given program. While these characteristics were not considered crucial for our purposes, other evaluators might need to add additional descriptive data elements to our approach. For example, no information is presented on methadone dosages, since we do not categorize treatment programs except by residence category and modality. Someone who further classified the modalities might use dosage as a major distinguishing characteristic of maintenance programs. For our purposes, however, dosage information is not needed. We are assuming that programs are adhering to the FDA guidelines or, if they are not, that FDA inspection teams will find that out and take appropriate action.

D. *Subjective Assessment*

A subjective assessment is provided for each program. The evaluation team's impressions and observations are presented under fourteen headings. Comments are usually brief for each topic and are focused on

Table 2. DESCRIPTIVE SUMMARY

I. Background

Program Name: _____

Location: _____

Number of Facilities: _____ Capacity: _____

Date First Client was Treated: _____

Director: _____ Telephone: _____

II. Funding

Item	Past Fiscal Year	Current Fiscal Year
Federal Funds*		
Total Funds		
Amount Spent		**

*Federal Agency: _____

**As of: _____

III. Clients

A. Number of clients being treated as of _____.

Modality	Outpatient	Residential	Inpatient	Total
Maintenance				
Detoxification				
Drug Free				
Other				
TOTAL				

B. Characteristics of clients currently in treatment

Average age	
Percent male	
Percent black	
Percent primarily abusing heroin	
Percent referred from criminal justice system	
Average length of time in treatment	

C. Client Loads

Item	Outpatient	Residential	Inpatient
Client-years of treatment:			
Past fiscal year			
Current fiscal year through _____			
Percent change in client load from July of current fiscal year to present			

IV. Staff

Currently authorized positions	
Currently filled positions	
Professional and paraprofessional person-years	
Past fiscal year	
Current fiscal year through _____	

a short overall assessment or identification of specific problem areas. The subjective assessment checklist completed on-site is used in the preparation of the subjective assessment. The specific topics addressed are:

(1) *Facility*

Any problems with space, lay-out, condition, location, etc., are noted.

(2) *Director*

The evaluation team assesses both the director's responses to questions and the general level of management ability, as reflected in the program's operations.

(3) *Staff*

This includes comments on overall impressions of the staff's capabilities, motivation and workload, as well as discussion of any problems concerning staff organization, salary levels, vacancies, etc. This requires consideration of information from the staff data forms as well as on-site impressions.

(4) *Admission and Intake*

These procedures should be assessed to see if the program is being very selective and restrictive in terms of the clients it accepts. These topics are covered in the director's interview.

(5) *Discharge and Follow-Up*

Conditions for program completion and for dismissal before completion are sometimes good indicators of a program's treatment philosophy, as are their follow-up procedures (if any follow-up is done). These topics are covered in the director's interview.

(6) *Client Services*

The types and amounts of client services are areas addressed in the director's interview. In addition, perusal of client records and on-site observations should help verify the director's comments.

(7) *Financial Procedures and Records*

One of the financial data forms completed by the program indicates the records maintained. In addition, ability to complete the other financial data forms relatively easily is an indication of the quality of the record-keeping system. On-site observations could also supplement those items.

(8) *Client Records*

This assessment should be based on on-site review of client records and should consider both scope and quality.

(9) *Validity of Reported Data*

The evaluators should comment on the extent to which the data they verified agreed with the data reported by the program.

(10) *Adequacy of Resources*

Inadequate resources could be indicated by the existence of a waiting list (which the evaluators have reason to believe is a "real" one), or by the program's inability to provide certain services it believes would

improve its effectiveness. On the other hand, a program might have more resources than it needs, given its client load. This could be indicated by low rates of spending and treatment.

(11) *Utilization of Resources*

Resources may be adequate but poorly utilized. For example, the program may have excess capacity, poor hours of operation, poor allocation of staff among the various occupational skills required, etc. Any such problems should be noted.

(12) *Other Problems or Comments*

Other items which seem important for that program should be discussed. This could include community relations problems, special grant conditions, etc.

(13) *Technical Assistance Needs*

Areas of needed technical assistance should be identified and commented upon. The evaluators should, however, remember that technical assistance is itself a scarce resource and that some programs might require so much help that the investment is simply not worthwhile.

(14) *Recommendations*

Recommendations concerning future Federal involvement, in terms of funding and possible technical assistance, should be succinctly summarized.

E. *Final Report*

The final report on each program should be short, focused on the major features of the program, and organized as follows:

- Highlights;
- Descriptive Summary;
- Analytical Summary; and
- Subjective Assessment.

The highlights section should be a one- or two-page summary of the major features of the analytical summary, descriptive summary and subjective assessment. Sub-sections should include:

Background: The program's name, location, number of facilities, capacity, client load by modality, costs of treatment, Federal funding agency, and other important points should be presented.

Program Strengths: This should summarize the program's strong points and cite relevant data to support the judgments made.

Program Weaknesses: The program's weak points should be summarized, along with any extenuating circumstances or other explanations.

Technical Assistance Needs: The technical assistance needs of the program should be discussed.

Recommendations: The funding and technical assistance recommendations of the evaluation team should be presented, along with the rationale underlying those recommendations.

Appendix A is an example of a project report. The final report should not include lengthy narrative descriptions of particular aspects of the program's operations. Instead, the report should be short, decision- and problem-oriented, with data arrayed in a consistent format for each program to facilitate further analysis by anyone so inclined. Also, the completed interview and data forms will be kept on file for anyone interested in more detailed information.

III. IMPLEMENTATION

A. *Procedures*

Implementation procedures for quick evaluations can be considered in terms of activities performed before, during and after the site visit. Before the site visit, the evaluation team should review the project file, particularly the grant application and quarterly reports, and discuss the project with the Federal monitor. In addition, the evaluation team should call the program director to arrange the site visit. At that time, the team should indicate that:

(1) approximately 60 to 90 minutes of the director's time will be required;
(2) several data forms will need to be completed by program staff members *on the day of the visit*:

  (a) financial data forms (estimated time requirement: 3 hours);
  (b) staff data forms (estimated time requirement: 2 hours); and
  (c) client data form (estimated time requirement: 1 hour); and

(3) program records, including client records, should be available to the evaluation team.

On site, the evaluation team:

- interviews the director;
- distributes the data forms on financial, staff and client data, collects them at the end of the day and checks them for completeness;
- tours the facility;
- verifies the number of clients being treated; and
- reviews various records, including several randomly selected files on individual clients.

Figure 1 indicates the flow of activities during the site visit.

After the visit, the evaluation team analyzes the data collected, reflects on the observations made, and prepares its report in the format described earlier. The on-site materials are designed to facilitate the writing of the final report. Most of that report should be able to be written in a few hours time and could, in fact, be done on-site or in transit. Feedback to the program should also occur after the site visit. This could consist of sending the program a copy of the quick evaluation report or a letter abstracting the major findings.

Appendix B presents a complete set of the various forms used on-site. These are briefly described below.

B. *Director's Interview*

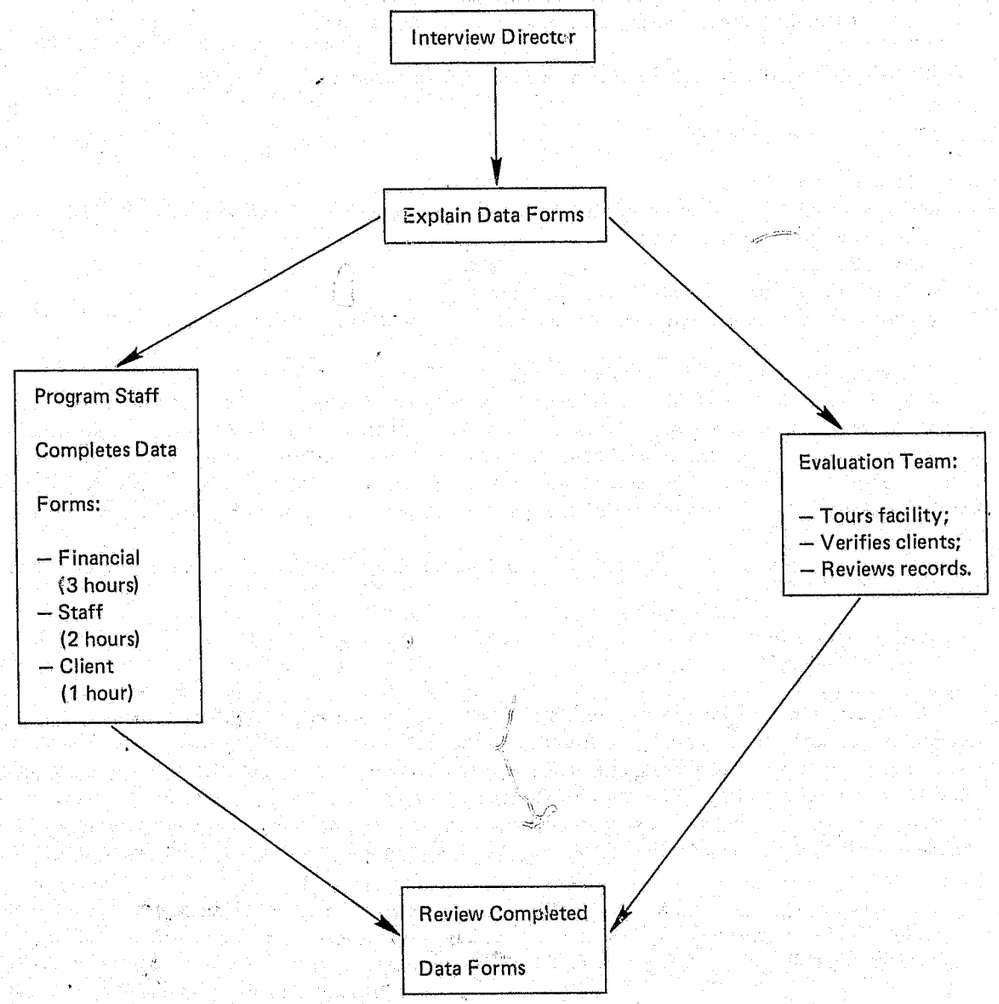
The director's interview covers such topics as the program's objectives, its efforts to assess its progress, its problems and thoughts on additional resources which might help resolve them, and overall information on the number of clients being treated, their characteristics, the types of treatment and ancillary services provided, admission and discharge criteria, intake procedures, unmet demands for treatment, organizational structure, and days and hours of operation. This interview takes approximately 40 to 60 minutes to complete. At the end of the interview, the director is asked to provide copies of the following materials, if they exist:

- the most recent organization chart;
- written treatment guidelines or policy statements;

- the most recent financial statement; and
- studies of treatment effectiveness, including analyses of urinalysis results, employment, criminal activity, retention rates, etc.

In addition, the data forms (explained below) which the program must complete are discussed with the director, who channels the evaluation team to the appropriate staff members. A "materials checklist" has been developed to help the evaluation team keep track of the items which need to be collected on-site; a copy of this checklist is given to the director as well.

Figure 1. QUICK EVALUATION SITE VISIT



The evaluation team's other planned activities should also be discussed with the director. These include verifying the number of clients in treatment, reviewing several individual client files and touring the facility. Once the discussion with the director has been completed, the evaluation team should insure that the data forms are understood by the people who will complete them and that they can be finished by the end of the day.

C. *Data Forms*

Seven data forms have been developed, which summarize the major financial, client and staff information of the program. Each form was designed to be as self-contained and self-explanatory as possible. Therefore, these forms could simply be given to the appropriate people to complete (or could be mailed to the program ahead of the site visit and simply picked up and reviewed by the evaluation team). However, we believe it is better, whenever possible, to explain the forms personally to the people completing them. Since the time needed to complete them is relatively short, it is not an unreasonable requirement to have the forms done on the day of the site visit.

(1) *Funding by Source of Funds*

This form is completed for the total program (i.e., not for specific facilities) and presents total funding information and the date of first funding by source (Federal agency, state, local or private sources). Information includes the funds available (budget) for the past fiscal year and current fiscal year and the amount expended for the past fiscal year and the current fiscal year to date. All budget and cost amounts are presented as totals for the program and as totals for staff. The data on staff costs are included because most programs can identify those costs, even if they have difficulty tracking and allocating total costs. At least a crude estimate of total costs can, therefore, be derived from staff cost data. If the program cannot estimate the percent of its total costs which are for staff, an estimate of 75-80% can be used and is probably reasonable for most programs.

(2) *Allocation of Funds to Facilities and Residence Categories*

This form allocates the funding totals from the preceding form to the various facilities and residence categories (outpatient, residential, and inpatient). This form does not, of course, have to be completed for programs with a single facility and a single residence category (e.g., a program consisting solely of one outpatient clinic).

(3) *Grant Information*

Since we are collecting information by fiscal year but many grants are awarded for different time periods, this table summarizes relevant data needed on a grant-by-grant basis. This information consists of the grant amount, starting and ending date, amount spent to date, and the date funds are expected to be exhausted.

(4) *Financial Procedures*

This checklist indicates:

- the types of financial records maintained by the program (e.g., a regularly prepared budget, sequential record of commitments, record of all expenditures and receipts, accounting statement, etc.);
- the nature of financial procedures (e.g., whether authorizing documents must be generated before funds can be disbursed, procedures for signing and clearing checks, etc.); and
- whether an audit has been performed and, if so, by whom and when.

This form also indicates the location of the financial records, in case the evaluation team decides to check any of them or to verify financial data provided by the program.

(5) *Client Data*

This form is completed for each facility. It indicates the client loads for the past fiscal year and by month for the current fiscal year for each residence category and modality. It also indicates the date the first client was treated for each residence/modality combination and the number of clients currently being seen twice per week. Whenever possible, we define a client as someone being seen by the program at least twice per week. However, historical data must rely on program records and use whatever definition of client upon which the records are maintained. The client data form provides space for indicating what that definition is, so that we will have a better indication of how to interpret the numbers.

(6) *Staff Data*

This form is completed for each facility and provides information on each person employed by the program during the period from the beginning of the past fiscal year to the present.

This information consists of the position title, date hired, date left (if applicable); annual salary and hours worked per week. The information is needed so that such figures as staff man-years, turnover rates, and staff-client ratios can be calculated. It seemed simpler to ask the program to provide data on a person-by-person basis and require the evaluation team to make the necessary calculations than to ask the program to make those calculations. Moreover, detailed information sometimes provides greater insight into what is occurring at a program than the summary calculations do. For example, turnover may be concentrated at the top of the organization, among the counselors, or evenly spread throughout the organization. The interpretation of the total turnover rate would be different in each case.

(7) *Vacant Staff Positions*

This form, completed for each facility, indicates the length of time each vacant position has been unfilled, the annual salary, the hours per week and the position title. Vacant positions plus people currently on board should constitute the total authorized staffing plan. Vacancies, and the level in the organization at which they occur, are sometimes good indicators of specific problem areas. This is particularly true when that information is correlated with the data from the previous form on turnover for those positions.

D. *Checklists and Worksheets for Evaluation Team*

In addition to the director's interview and the data forms, three other forms were developed for use in quick evaluations. These forms consist of:

- a checklist to assist the evaluation team in systematically recording subjective impressions of a site;
- a worksheet to be used while conducting the independent verification of the current client load; and
- a checklist for use while individual client records are reviewed.

(1) *Subjective Assessment Checklist*

This checklist includes:

- areas of interest which might be observed during the facility tour (e.g., the condition of the facility, general impressions of the staff, etc.);
- items covered in the director's interview which might otherwise not be adequately noted (e.g., program objectives, client retention rates, etc.);

- elements from the data forms which are not specifically included in the format for the final report (e.g., salary structure, staff vacancies, etc.); and
- the evaluator's judgments about the program's adequacy and effective utilization of resources.

Each item is checked "problem," "not a problem" or "don't know." Space is provided at the end of the checklist to discuss each item noted as a "problem." These problems should be discussed in the final report.

(2) *Independent Verification of Client Load*

This worksheet should be used to explain the procedure for verifying the client load, summarize the results and comment upon the level of agreement between reported and verified data. The verification procedure will vary with the nature of the program and the type of records maintained. For inpatient and residential programs, the maximum number of clients possible at a given time could be estimated by counting the number of beds. However, this is not a reliable estimate of the current client load, because many beds may be unfilled.

One way to make an inconspicuous load count of current clients in a residential facility is to count the number of people present at dinner; the staff can usually be identified and excluded from the count. A count could also be made during any other activity in which all clients usually participate. The program director should be able to help identify such activities.

It should usually not be difficult to verify the client load at an inpatient facility. A count of patients present on the ward can usually be easily made.

For outpatient programs, we have defined a client as someone being seen at least twice per week. For a program which dispenses medication, the medication records can be reviewed for the week before the site visit to determine the number of clients seen different numbers of times. The evaulation team will, of course, have to make arrangements to use these records at a time when they will not interfere with program operations. In some cases this may require review of the records after the normal operating hours of the clinic. Usually, however, these records can be reviewed when the clinic is open, but either medication is not being dispensed or it is a "slow" time and clinic operations would be only slightly disturbed.

Client loads will probably be hardest to verify for outpatient, drug free programs. In some cases counselors' notes or other records will be maintained of contacts with clients. In an extreme case, where *no* records are kept, there will be no alternative to counting the number of clients who are seen on the day of the site visit. This is a time-consuming process for the evaluation team, but the importance of the data warrants it. The first requirement of a treatment program is that it must have clients. Without some reason to believe that it does so, and that it reports them accurately, the rest of the data on the program will be irrelevant. In cases where an on-site count is required, the evaluation team should try to determine whether the day of the visit is a typical program day; if not, arrangements should be made to visit on a typical day.

(3) *Client Records Checklist*

Several randomly selected client records should be reviewed to get a "feel" for the types of data maintained and the overall quality of the client files. If medication or other records were used to verify the number of clients, five or ten names should be selected from those lists. Client files should be requested for those individuals. This will help serve as a check on the validity of the records used for verification purposes. If the program conducts follow-up on clients who have left treatment, a few files on these individuals should also be reviewed.

We selected the verification of client loads and the review of client records to serve as good indicators of the veracity and quality of all program records and data. We have assumed that if the program is reporting its client load accurately, it is probably reporting other information accurately. Moreover, we have assumed that if the program's client records seem well-maintained, then its other records are probably also well kept. Therefore, we have not provided checklists and worksheets for verifying other types of data or for reviewing other types of records. In cases where client data and records are poor, however, the

evaluation team may decide that additional verification and record review needs to be done. In those cases good notes should be kept of the on-site activities, and a narrative discussion of the findings should be included in the final report.

E. *Use of Data Collected*

One principle adhered to in the development of the quick evaluation methodology was that no data element should be collected which was not used. Suggested additions to the data collection forms were carefully scrutinized in terms of both their usefulness for our purposes and the manner in which they would be reported upon.

In most cases, collected data items are included in the final report. In some cases, however, they are included only if they are unusual (e.g., if there is a very high percentage of vacant staff positions). Such data items appear on the subjective assessment checklist. Therefore, all data collected are used to complete either the tables in the final report or the subjective assessment checklist. These tables appear in Appendix C, with the data collection source indicated. Please note that if some element of reported data is not considered useful, then it can be deleted from the relevant data collection form.

F. *Evaluation Team*

The quick evaluation was designed to be implemented by two people in two days, for programs with no more than three facilities. Programs with additional facilities will, in most cases, require more time. However, these time estimates should be viewed as rough ones. The exact time required will depend on the evaluation team's experience and familiarity with the specific program.

The ideal evaluation team probably consists of an experienced clinician, who would be able to assess what is occurring in the program relatively quickly, and a research assistant, who would make sure that all forms are completed fully and correctly. Evaluation teams could have different compositions (for example, two experienced clinicians or two clinicians and a research assistant). Selection of the team will depend on the available staff and the needs that the specific quick evaluation is designed to meet. It is essential that the evaluators be able to retain objectivity about program operations and not be swayed by pressures from the program or other sources. In some cases, training sessions may be needed for the quick evaluation teams, in order to review FDA guidelines and other basic information about treatment programs.

The two-day estimate for a quick evaluation is divided equally between off-site and on-site work. Approximately one-half day would be required off-site for advance preparation (making appointments, reviewing files, etc.) An additional one-half day off-site would be needed after the visit to analyze the data and write the report.

Approximately one day is needed on-site to interview the program director, insure that the necessary data forms are completed, tour the facility, observe clinic operations briefly, verify the number of clients in treatment, and review various records. In most cases, the one-day site visit will be sufficient for the purposes designed to be met by a quick evaluation. In some cases, however, a second evaluation visit may be needed, perhaps by a specialist not included on the initial evaluation team.

G. *Pretest of Methodology*

The quick evaluation methodology was tested, refined and considerably revised during a five-program pretest conducted during late January and early February of 1973. In addition to identifying problems with the wording and ordering of questions and with various on-site procedures, the pretest showed three major problems:

(1) Minimal advance work had been done. Consequently, on-site time was not as well-utilized as it could have been. The current recommended quick evaluation procedures emphasize the value of adequate advance work.

(2) The data forms were in some cases left with the program to be completed and returned within a day or so. Getting these data forms returned took much longer than had been anticipated. Once an evaluation team leaves the premises, other activities seem to take priority with most programs. In addition, some of the returned forms were incomplete or inconsistent. Follow-up telephone calls were needed to clarify the situation. Arranging for the data forms to be completed on the day of the site visit and reviewing them at that time is a much more efficient procedure.
(3) The initial data forms used by the quick evaluation team were too complex. During the course of the pretest, some forms were deleted as not being worth the effort involved to complete them (e.g., a detailed analysis of urinalysis results). Others were considerably simplified.

Since the pretest, the quick evaluation procedures have been used for a variety of purposes, including:

- to assess the Office of Economic Opportunity treatment programs which were candidates for transfer to the National Institute of Mental Health;
- to identify technical assistance needs at selected programs; and
- to provide a quick overview of treatment program operations at selected Department of Defense installations and Veterans Administration hospitals.

In some cases the basic quick evaluation procedures were modified to meet somewhat different needs. In general, however, the quick evaluation format provided a useful approach for assessing treatment programs quickly but systematically.

IV. POSSIBLE ADDITIONS TO QUICK EVALUATION

A. *Background*

Many areas are not addressed at all by the quick evaluation methodology; others are addressed only superficially. A quick evaluation is designed to collect only those data considered absolutely critical to any analysis of a program's operational efficiency. No one yet knows if the data collected are in fact sufficient for making anything except very crude decisions about programs. A quick evaluation seems capable of identifying programs at the extremes (i.e., very bad and very good programs). We do not, however, know much about the adequacy of making distinctions among programs in the middle range of performance (where most programs probably lie). At this time no one really knows how much data is needed to make such distinctions with confidence. Nor does anyone know how much better the decisions become as different types of data are added to the assessment of the program. Some systematic studies in this area would be useful. Until such studies are done, we have decided to keep the quick evaluation format relatively simple, straightforward and easy to implement. However, the quick evaluation approach could be considered as an evaluative "core" to which additional "modules" could be added by people particularly interested in certain items or with more time available for program evaluations. Several possible additions are discussed below.

B. *Staff Questionnaire*

A short questionnaire could be distributed at a staff meeting which would collect information on:

- the staff's characteristics, experience, education and other training;
- the major staff activities, particularly the amount of time spent with clients; and
- comments about the program.

Such a questionnaire was discussed during the development of the quick evaluation methodology, and two possible versions appear in Appendix D. We finally excluded this element from the quick evaluation

approach because the analysis of the responses would significantly increase the amount of time required to prepare the final report. The additional time required on-site would, however, be minimal (probably less than an hour), and the responses, particularly any spontaneous comments, would probably increase the evaluation team's insight into the program substantially. If we were to add one item to the quick evaluation approach, it would probably be some form of staff questionnaire.

C. *Detailed Urinalysis Results*

The percent of positive urine tests is included as an analytical criterion but no detailed assessment of urinalysis results is made. Better understanding of urinalysis data would require distinctions by type of drug, and by the length of time clients had been in treatment. Information on the percent of clients who are consistently positive would also be of interest, as would an assessment of the reliability of the testing lab and the procedures for collecting urine specimens.

Again, these issues were considered during the development of the quick evaluation procedures, and possible data collection forms were designed (see Appendix E). However, the additional usefulness of the detailed data did not seem sufficient to offset the additional time required to collect it.

D. *Detailed Client Retention Analysis*

The quick evaluation approach handles client retention only by asking the director about the rate. However, retention should be considered by the cohort group and should indicate the percent of people remaining in the program who entered 6, 12, 18, etc. months ago. These rates should, of course, be calculated separately for different modalities and residence categories. Once again, we considered including such detailed data, developed possible data collection forms (see Appendix F), and finally rejected them as too time-consuming.

E. *Quality of Care*

If skilled clinicians are included on the evaluation team and if sufficient time is available, observation of clinic operations and of staff-client interactions could yield important information on the quality of care provided. It would also be useful to try to identify the specific ingredients of a "high" quality of care and to develop ways of training non-clinicians to make reasonable judgments about the quality of care. No attempt was made to cover these issues within the quick evaluation format.

F. *Client Outcome*

Quick evaluations focus on assessing a program's efficiency. However, more important indications of program worth would focus on effectiveness in changing client behavior toward more socially desirable activities. A quick evaluation of program efficiency assesses the cost of treating a client for a year. To address program effectiveness would require assessing the cost of achieving a specified level of change in client behavior. Time considerations are important, since "improved" behavior during treatment may not continue after a client leaves the program.

Although quick evaluations do not consider client outcomes, follow-up client interviewing could be added to the core efficiency evaluation. If this is too costly, interviewing a sample of clients in treatment might provide some insight concerning behavioral change.

G. *Non-Treatment Components of Programs*

Quick evaluations are designed to assess treatment programs only. However, some programs include other components, particularly education/prevention activities. An evaluation module to assess these activities could be added to the quick evaluation core.

H. *Community Information*

Quick evaluations rely on information collected at the treatment program. However, information could be collected from other sources which might affect the assessment of the program. Such sources of information might include the police department, probation officials, narcotics bureau, corrections officials, medical examiner, mayor's assistant for drugs, local drug abuse coordinator, other treatment programs, and so on. Interviews, perhaps by telephone, could be added to the quick evaluation core, if they seem useful for certain purposes.

APPENDIX A

EXAMPLE: Quick Evaluation of XYZ

Drug Treatment Program

February 1973

HIGHLIGHTS

Background

The XYZ drug treatment program is currently providing methadone maintenance and detoxification services to 221 clients, which represents operation at 126% capacity. The cost per client-year averaged $1,252 for the first half of FY 1973. The current rate of spending on client treatment is much less: $748 per client-year.

The program had been treating 22 clients in July 1972, after one year of operation. At that time the program was restructured and restaffed. During the last seven months the clientele has grown at a steady and rapid rate, which as yet shows no signs of leveling off. Moreover, the program is planning to move to a different, probably more accessible, facility in the near future. Although the impact of the move is uncertain, it may well increase the number of applicants for treatment.

There are virtually no Federal funds involved in this project at the present time. An ABC agency grant of $145,000 was largely spent in FY 1972, although $35,000 carried over to FY 1973. The program's major funds come from the state budget. In addition, the County Health Department provides in-kind services.

Program Strengths

The program appears to have a very capable and highly motivated staff. Although clearly strained by the current client load, the staff appears to be doing an admirable job of trying to handle it. Procedures seem reasonable, and client records are maintained as well as can be expected with the current counselor-client ratio of 1 to 37.

Program Weaknesses

The staff resources are severely strained. Only minimal counseling and other support services are being provided, and client retention is relatively low. Over the past seven months, there have been more than 500 separate admissions, which is more than double the number of clients currently in treatment. Admission requirements (e.g., intake physicals and interviews) seem to have consumed a large portion of the total staff time, with relatively little time being left to provide a high quality of care to clients already admitted. The high admissions rate placed an especially heavy burden on what was an essentially new program in the process of staffing up.

The director continued to accept clients after the program reached its capacity of 175. That action may have been influenced by the fact that the XYZ drug treatment program is the only methadone program in the county. The program's staff resources are now so strained, however, that the director indicated he would soon have to start reluctantly turning applicants away. The program has been adding about 20 clients per month over the last few months, and there is no reason to assume that the methadone treatment demand in the county has yet been saturated.

The program appears to need a second facility. However, the program had a difficulty time finding a single permanent site and locating a second one may be even more difficult.

In terms of strained program resources, the major problem does not appear to be inadequate funds. Through December, the program had spent approximately $95,000 of the $275,000 available for FY 1973. The remaining $180,000 would provide treatment for 240 clients for six months at a rate of $1,500 per client-year. Currently, the program has 221 clients, but is spending at a rate of $748 per client-year.

The problem may be that the director does not want to turn clients away until he absolutely has to do so. If so, he may be unwilling to allocate $1,500 per client-year to client care until admissions level off and he can better estimate the stable client load. If this explanation is correct, then a mechanism is needed which would assure the director that if he provides adequate client care at a cost of approximately $1,500 per year and if his client load becomes so great that his funds are exhausted before the end of the year, then his budget will be supplemented.

Technical Assistance Needs

Technical assistance might help this program better cope with the problems it faces. Perhaps streamlined management and record-keeping procedures could permit more staff time to be spent with clients. In addition, it appears that a second methadone facility is badly needed in the county and would, if opened, alleviate some of the problems currently being experienced. Finally, the program needs additional counselors, but none are currently authorized in the staffing plan; the two staff vacancies are for a nurse and a medical technician. Thus, the counselor-client ratio of 1 to 37 will not decline unless the client load declines, which seems unlikely, or unless additional counselor slots can be authorized.

Recommendation

The evaluation team believes the XYZ drug treatment program merits further Federal assistance. The program may need technical assistance more than additional funds. It does, however, appear to need some assurance that Federal funds would be provided if state funds were exhausted (assuming that adequate client care was being provided at reasonable cost).

DESCRIPTIVE SUMMARY

I. Background

Program Name: XYZ Drug Treatment Program

Location: _____

Number of Facilities: 1 Capacity: 175

Date First Client was Treated: July 1971

Director: _____ Telephone: _____

II. Funding

Item	Past Fiscal Year	Current Fiscal Year
Federal Funds*	$144,593	$ 35,015
Total Funds	NA	$274,809
Amount Spent	NA	$ 95,156**

*Federal Agency: ABC agency

**As of: December 31, 1972

III. Clients

A. Number of clients being treated as of January 22-27, 1973

Modality	Outpatient	Residential	Inpatient	Total
Maintenance	179			179
Detoxification	40			40
Drug Free	2			2
Other	—			—
TOTAL	221			221

B. Characteristics of clients currently in treatment

Average age	24
Percent male	77%
Percent black	49%
Percent primarily abusing heroin	85%*
Percent referred from criminal justice system	NA
Average length of time in treatment	3 mos.

*15% abuse illegal methadone

C. Client Loads

Item	Outpatient	Residential	Inpatient
Client-years of treatment:			
Past fiscal year	NA		
Current fiscal year through December	76		
Percent change in client load from July of current fiscal year to present	426%		

IV. Staff

Currently authorized positions	15
Currently filled positions	13
Professional and paraprofessional person-years	
Past fiscal year	NA
Current fiscal year through December	4.0

Table 1. ANALYTICAL SUMMARY

A. Cost per client-year:	Outpatient	Residential	Inpatient
(1) Current rate	$ 748		
(2) Current FY through December	$1,252		
(3) Past FY	NA		
B. Other Quantitative Indices:			
1. Ratio of actual to standard budget		0.83	
2. Staff-client ratio		1 to 17	
3. Counselor-client ratio		1 to 37	
4. Staff turnover rate		20%	
5. Percent of positive urinalysis tests		15%	
C. Qualitative Indices:			
1. Level of services provided to clients		low	
2. Scope of record-keeping systems		high	
3. Quality of records		low	
4. Validity of reported data		high	

DEFINITIONS:

A.1: [(Costs for most recent month) X (12)] ÷ (number of clients seen at least twice last week).

A.2: (Costs for current FY to date) ÷ (current FY client-years of treatment to date).

A.3: (Costs for past FY) ÷ (past FY client-years of treatment).

B.1: [Actual budget] ÷ [number of clients seen at least twice last week) X (standard cost per client)]. Standard cost per client is $1,500 for outpatient care, $4,500 for residential care and $30,000 for inpatient care.

B.2: (Number of staff-members) ÷ (number of clients seen at least twice last week).

B.3: (Number of counselors) ÷ (number of clients seen at least twice last week).

B.4: [Number of people employed during past and current FY) – (number of positions filled at least half the time during past and current FY)] ÷ [number of positions filled at least half the time during past and current FY].

B.5: (Number of positive urinalysis tests) ÷ (total number of urinalysis tests).

C.1: "Medium" consists of individual counseling at least once a week; vocational rehabilitation (i.e., job counseling, training or placement); and two of the following: legal, social or health services. "High" consists of more services and "low" of less.

C.2: "Medium" means the program (a) was able to complete the data forms easily; (b) keeps a formal budget, prepares authorizing documents before disbursing funds, records all expenditures and receipts, and makes periodic financial statements; (c) keeps individual client records, including admission forms and counselors' notes. "High" consists of more records and "low" of less.

C.3: "Medium" means that 70-80% of the records are relatively complete, up-to-date, and consistent. Client records include weekly counselors' notes which seem relevant and useful. "High" indicates that more than 80% meet these conditions and "low" less than 70%.

C.4: "Medium" indicates that data verified by the evaluation team and data reported by the program differ by 10-20%. "High" indicates differences of less than 10% and "low" of more than 20%.

SUBJECTIVE ASSESSMENT

Facility: The existing facility is rather inadequate, with small offices and a poor lay-out. However, the program is soon to move to a different facility. The program's client load and the fact that it is the only methadone program in the county would warrant a second facility. However, the program had great difficulty locating one permanent site and would probably have an even harder time locating a second. Its present site (within a County Health Department outpatient clinic) apparently cannot be retained.

Director: Very capable and highly motivated.

Staff: Capable and motivated but unable to contend adequately with the current workload.

Admission and Intake: Program accepts county residents who are at least 18 years old with a two-year history of heroin abuse. Intake procedures consist of a physical examination and interview.

Discharge and Follow-Up: Clients can be dismissed for continuing to abuse drugs or disrupting the program's operations. No follow-up is being done at present.

Client Services: The program provides individual counseling, group therapy and vocational rehabilitation services. Health care is provided on a referral basis. No educational, legal, social or emergency services are provided. In general, the level of services seems inadequate as illustrated by a counselor-client ratio of 1 to 37.

Financial Procedures and Records: Good.

Client Records: As good as can be expected, given the workload. Counselor's notes are sometimes recorded less often than once per week, but entries seem relevant and useful.

Validity of Reported Data: High agreement.

Adequacy of Resources: Staff resources are severely strained. Program needs more counselors and probably a second site. At present, funding seems to be adequate; but if the client load continues to grow, this situation may change.

Utilization of Resources: Non-financial resources seem to be reasonably well utilized, although overall management and record-keeping procedures could be improved. Funds are being spent at a low rate (i.e., $748 per client-year), although money seems to be available to provide higher quality, higher cost client care.

Other Problems or Comments: None.

Technical Assistance Needs: The program could use technical assistance to improve its management and record-keeping procedures; locate a second site; and assess ways to increase the amount of counseling being done.

Recommendations: The evaluation team believes the XYZ Drug Treatment Program merits further Federal assistance. The program may need technical assistance more than additional funds. It does, however, appear to need some assurance that Federal funds would be provided if state funds were exhausted (assuming that adequate client care was being provided at reasonable cost).

APPENDIX B

DATA COLLECTION FORMS

TABLE OF CONTENTS

DIRECTOR'S INTERVIEW

1. What are the specific objectives of your treatment program?

2. (a) How do you assess your progress toward meeting those objectives?

(b) Do you measure client retention (that is, do you keep aggregate records of the length of time clients remain in your program)? _____Yes _____No

(c) What is your client retention rate (by modality)?

Percent			
Time Period			
Modality			

(d) Do you conduct urinalysis tests?_____Yes _____No

(e) How often?_____

(f) What percent of your urinalysis tests are positive?

Percent			
Time Period			
Total Number of Tests			

(g) What lab does your urinalysis tests?_____

(h) What is the cost per test?_____

3. What is your treatment capacity (as indicated in the Federal grant)?

Outpatient	
Residential	
Inpatient	

4. (a) How many clients are now being treated in your program?_____

(b) How do you define a "client"?_____

_____

_____

_____

(c) How do you determine and verify the number of people being treated?_____

_____

_____

_____

(d) How many clients are now being seen at least twice per week?_____

5. What percent of your clients are in the following treatment modalities:

Maintenance	
Detoxification	
Drug Free	
Other:_____	
TOTAL	100%

6. For the clients currently in treatment:

(a) what is their average age?_____ years

(b) the percent male?_____%

(c) the percent black?_____%

(d) the percent primarily abusing heroin?_____%

(e) the percent referred from the criminal justice system?_____%

(f) the average length of time clients have been in treatment?_____Mo.

(g) What is the source of your information (e.g., recent analysis of client characteristics, estimate based on familiarity with clients, etc.)?

_____

_____

_____

_____

_____

SERVICES	7. (a) Do you provide (services), either directly or through referral? (Code D, R or No)	7. (b) Please describe that service.
Individual counseling		
Family counseling		
Group therapy		
Job counseling		
Job training		
Job placement		
Educational services		
General health care		

table continues

SERVICES	7. (a) Do you provide (services), either directly or through referral? (Code D, R or No)	7. (b) Please describe that service.
Legal services		
Social services (welfare, housing assistance, etc.) . . .		
Cultural/recreational programs		
Other:_____		

8. (a) How often does a client receive individual counseling?_____

_____

(b) Family counseling?_____

(c) Participate in group therapy?_____

9. (a) Are there services you would like to provide that you are currently unable to provide?
_____ Yes _____ No

(b) What are these services?_____

_____

_____

(c) Why are you unable to provide these services?_____

_____

_____

_____

_____

_____

_____

10. Do any of the following characteristics affect admission to your program and, if so, in what way?

Characteristic	Check If No Effect	Description of Effect
Age		
Sex		
Residence		
Duration of drug use		
Type of drug used		
History of emotional illness		
History of alcoholism		
Other:_____		

11. (a) What are your specific intake procedures?_____

_____

_____

_____

(b) How much time does the intake process require?_____

_____

12. Under what conditions would a client be dismissed from your treatment program (please include program completions as well as dismissals for cause)?

_____

_____

_____

_____

_____

13. What sort of follow-up activities, if any, do you conduct for clients who have graduated, dropped out or otherwise left treatment?

14. (a) Approximately how many people, if any, are requesting treatment who cannot be admitted to your program?

(b) What is the basis for that estimate (e.g., formal waiting list, guess, etc.)?

(c) What are the reasons you cannot serve them?

(d) How many people did you turn away last week?

(e) What is the basis for this estimate?

15. What do you consider the most serious problems you have to deal with in meeting the objectives of your overall treatment program?

16. What additional resources do you need to deal with these problems? (Money, staff, training, etc.—PROBE for *specific* needs.)

17. What is the structure of your organization (that is, what does your organization chart look like)?

18. (a) What are your days and hours of operations?

(b) What are your days and hours for dispensing medication?

(c) What is the daily schedule of activities?

19. Are there any features of your program which you consider particularly innovative or unusual?

Interviewee

Title

Interviewer Date

INTERVIEWER INSTRUCTIONS AT COMPLETION OF DIRECTOR'S INTERVIEW

1. Ask for copies of the following materials, if available:
   (a) latest organization chart
   (b) any written policy statements or treatment guidelines
   (c) any studies of treatment effectiveness, including analyses of urinalysis results, employment, criminal activity, retention rates, etc.
   (d) financial statement for the latest month available.
2. Explain the data forms which must be completed:
   (a) Funding by Source of Funds
   (b) Allocation of Funds to Facilities and Residence Categories (for programs with more than one facility or residence category)
   (c) Grant Information
   (d) Financial Procedures
   (e) Client Data (one form for each facility)
   (f) Staff Data (one form for each facility)
   (g) Vacant Staff Positions (one form for each facility)
3. Leave a copy of the materials checklist with the director.
4. Determine a way to verify the current number of clients being seen at least twice per week.
5. Make arrangements for reviewing several client files.
6. Tour the facility.

MATERIALS CHECKLIST

Facility Name: _____

Item	Provided Yes	Provided No	Comment
A. *Existing materials:*			
1. Organization chart			
2. Treatment guidelines or policy statements			
3. Studies of treatment effectiveness (e.g., urinalysis results, employment, criminal activity, retention rates, etc.)			
4. Financial statement for latest month available			
B. *Tables to be completed:*			
1. Funding by Source of Funds			
2. Allocation of Funds to Facilities and Residence Categories (for programs with more than one facility or residence category			
3. Grant Information			
4. Financial Procedures			
5. Client Data (one table for each facility			
6. Staff Data (one table for each facility)			
7. Vacant Staff Positions (one table for each facility)			

FUNDING BY SOURCE OF FUNDS

PROGRAM NAME: _____

Note: The fiscal year (FY) is July 1—June 30.

Source	Date of First Funding	Amount Available (Budget)				Amount Expended			
		Past FY		Current FY		Past FY		Current FY*	
		Total	For Staff	Total	For Staff	Total	For Staff	Total	For Staff
Federal Agency:									
NIMH									
OEO									
LEAA									
VA									
HUD									
BOP									
Other: _____									
State									
Local									
Private									
TOTAL		$	$	$	$	$	$	$	$

*Through month of _____.

ALLOCATION OF FUNDS TO FACILITIES AND RESIDENCE CATEGORIES

PROGRAM NAME: _____

Note: The fiscal year (FY) is July 1—June 30.

Facility Name	Residence Category*	Date of First Funding	Amount Available (Budget)				Amount Expended			
			Past FY		Current FY		Past FY		Current FY**	
			Total	For Staff	Total	For Staff	Total	For Staff	Total	For Staff
Total***			$	$	$	$	$	$	$	$

*Inpatient (I), Residential (R) or Outpatient (O). Use separate line for each.

**Through month of _____.

***These totals should be the same as those shown in the table "Funding by Source of Funds."

GRANT INFORMATION

Note: One column should be completed for each grant in effect during the past or current fiscal year.

ITEM	AGENCY				
Grant:					
Amount					
Starting date					
Ending date					
Status:					
Amount spent through _____					
Date funds are expected to be exhausted					

FINANCIAL PROCEDURES

PROGRAM NAME: _____

1. Are budgets prepared on a regular basis showing salaries, rent, phone, supplies, lab services, etc?
   _____Yes, formal budget _____informal budget _____no budget

2. How frequently is a budget prepared? _____

3. Is a sequential record kept of all commitments (i.e., services or items ordered but for which bill has not yet been received)?
   _____Yes, formal records _____informal records _____no records

4. Is an authorizing document (e.g., purchase order) generated before funds can be disbursed?
   _____Yes _____No _____Sometimes

5. (a) Is there any amount above which more than one signature is required on a check? ___Yes ___No
   (b) If so, what is this amount? $_____
   (c) If not, are checks cleared through a higher authority than the treatment program? ___Yes ___No

6. Is a journal (sequential record) kept of all expenditures and receipts? ____Yes ____No

7. Are records kept to account for all petty cash expenditures? ____Yes ____No

8. How frequently are cumulative expenditures to date calculated? _____

9. (a) How often is an accounting statement prepared? _____
   (b) What is the date of the most recent accounting statement? _____
   (c) Who prepared that accounting statement (name and title)? _____

10. (a) How often is an audit performed? _____
    (b) When was the last audit done? _____
    (c) Who did that audit? _____

The above information was provided by:

Signature: _____

Title: _____

Date: _____

Records checked above can be examined at the following location:

_____

_____

_____

CLIENT DATA

Facility Name: _____

Note: The Fiscal Year (FY) is July 1—June 30.

Inpnt., Res. or Outpnt.[1]	Modality[2]	Date First Client Was Treated	Average Client Load, Past FY[3]	Current FY Client Load[3]												Current Clients[4]
				July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	
		TOTAL														

[1]Use separate line for each residence category: Inpatient (I), Residential (R) or Outpatient (O).

[2]Use separate line for each modality: Maintenance (M), Detoxification (D), Drug Free (F), or other (describe)_____

[3]In these totals "client" is defined as _____

[4]"Current clients" are clients now being seen at least twice a week.

Information provided by:

Name: _____

Title: _____

Date: _____

Source records can be examined at the following location:

_____

_____

_____

STAFF DATA

Facility Name: _____

Note: This form should contain information on all persons who have worked at the facility during the past or current fiscal year. Include volunteers as well as paid staff.

Name	Position Title	Date Hired	Date Left (If Applicable)	Annual Salary	Hours Worked Per Week

Information provided by:

Name: _____

Title: _____

Date: _____

Personnel records can be examined at the following location:

_____

_____

_____

VACANT STAFF POSITIONS

Facility Name: _____

Position Title	Length of Time Position has been Vacant	Annual Salary	Hours Per Week

SUBJECTIVE ASSESSMENT—CHECKLIST

Facility Name: _____

ITEM	PROBLEM	NOT A PROBLEM	DON'T KNOW
1. Facility:			
(a) accessible			
(b) clean and orderly			
(c) laid out reasonably			
(d) adequate space			
2. Smooth flow of client traffic (e.g., no long waits for service)			
3. Staff:			
(a) motivated			
(b) helpful			
(c) knowledgeable			
(d) organized			
(e) interested in clients			
(f) busy			
4. Are there any obvious problems in the following areas:			
(a) procedures for controlling and dispensing medication			
(b) urine testing procedures			
(c) nature and tone of relationship between clients and staff			
5. (a) Are the days and hours of operation reasonable?			
(b) Were the official hours kept on the day of the visit?			
(c) Are the days and hours for dispensing medication reasonable?			
(d) Are the daily activities reasonable?			

SUBJECTIVE ASSESSMENT—CHECKLIST—Continued

ITEM	PROBLEM	NOT A PROBLEM	DON'T KNOW
6. Are the program's objectives reasonable?			
7. Is the program trying to assess its progress toward meeting its objectives?			
8. Is the client retention rate reasonable? . .			
9. Are the urine test costs reasonable?			
10. (a) Is a reasonable range of client services provided?			
(b) Do individual clients receive counseling and/or participate in group therapy fairly often? . . .			
11. Does the program have:			
(a) reasonably open admission criteria?			
(b) reasonable intake procedures			
(c) reasonable criteria for dismissal. . .			
(d) reasonable treatment guidelines . .			
12. Does the program conduct follow-up activities on clients who have left treatment?			
13. Is the organizational structure reasonable?			
14. Is the salary structure for the staff reasonable?			
15. Is there a serious problem with current staff vacancies?			
16. Does the program have adequate financial procedures?			
17. Does the program maintain adequate records?			

SUBJECTIVE ASSESSMENT—CHECKLIST—Continued

ITEM	PROBLEM	NOT A PROBLEM	DON'T KNOW
18. Did the director cite any of the following problems:			
(a) clients requesting particular services which cannot be provided?			
(b) people requesting admission to the program who cannot be accepted?			
(c) other problems?			
19. Did the director indicate the program had adequate resources?			
20. In the evaluator's judgment:			
(a) are the program's resources adequate?			
(b) are the program's resources being effectively utilized?			

Subjective assessment done by: _____

SUBJECTIVE ASSESSMENT—DESCRIPTION OF PROBLEM AREAS

Checklist Item Number	Description

INDEPENDENT VERIFICATION OF CLIENT LOAD

Facility Name: ____________________

1. Describe the verification procedure used: ____________________

2. Client load for week of ____________________:

Number of Times Seen	Number of Clients
Seven or more	
Six	
Five	
Four	
Three	
Two	
Subtotal	
One	
Total	

3. Did the independent client verification roughly coincide with the numbers given by the program?

   ________Yes ________No

4. Discuss major discrepancies: ____________________

CLIENT RECORDS CHECKLIST

(To be completed by reviewing several client files)

Facility name: _____

1. At the time a client enters treatment, is any of the following information obtained:

Item	Yes	No
Drug use history		
Previous treatment for addiction		
Criminal history		
Social adjustment history (e.g., employment, homemaking, etc.)		
Educational level		
Occupational level		
Medical history		

2. During the time a client is in treatment, is any of the following information obtained and, if so, is it recorded on a standard reporting form, in counselor's notes, or kept in some other manner?

Item	Recorded			
	Standard Reporting Form	Counselors' Notes	Other	Not Recorded
Drug use				
Criminal activity				
Social adjustment (e.g., employment, home-making, etc.)				
Health				

3. Approximately how often is a progress note recorded? _____

4. Make comments on overall scope and quality of client records on the following page.

COMMENTS ON SCOPE AND QUALITY OF CLIENT RECORDS

OTHER COMMENTS

APPENDIX C

DATA REPORTING FORMS,
ILLUSTRATING USE OF ALL COLLECTED DATA

NOTE

The following abbreviations are used:

D.I. —Director's Interview

Form 1—Funding By Source of Funds

Form 2—Allocation of Funds to Facilities and Residence Categories

Form 3—Grant Information

Form 4—Financial Procedures

Form 5—Client Data

Form 6—Staff Data

Form 7—Vacant Staff Positions

DESCRIPTIVE SUMMARY

I. Background

Program Name: _____

Location: _____

Number of Facilities: _____ Capacity: D.I. 3

Date First Client was Treated: Form 5

Director: _____ Telephone: _____

II. Funding

Item	Past Fiscal Year	Current Fiscal Year
Federal Funds*	all entries	
Total Funds	from	
Amount Spent	Form 1	**

*Federal Agency: _____

**As of: _____

III. Clients

A. Number of Clients being treated as of _____

Modality	Outpatient	Residential	Inpatient	Total
Maintenance				
Detoxification	Completed from D.I. 4 and 5, Form 5 and Independent Verification of Client Load			
Drug Free				
Other				
TOTAL				

B. Characteristics of clients currently in treatment

Average age	D.I. 6 (a)
Percent male	D.I. 6 (b)
Percent black	D.I. 6 (c)
Percent primarily abusing heroin	D.I. 6 (d)
Percent referred from criminal justice system	D.I. 6 (e)
Average length of time in treatment	D.I. 6 (f)

C. Client Loads

Item	Outpatient	Residential	Inpatient
Client—years of treatment:			
Past fiscal year			
Current fiscal year through _____		Completed from Form 5	
Percent change in client load from July of current fiscal year to present			

IV. Staff

Currently authorized positions	Forms 6 & 7 organization chart
Currently filled positions	Form 6
Professional and paraprofessional person—years	
Past fiscal year	Form 6
Current fiscal year through _____	Form 6

Table 1. ANALYTICAL SUMMARY

		Outpatient	Residential	Inpatient
A.	Cost per client-year:			
	(1) Current rate	Financial statement, Form 5 and independent verification of client load		
	(2) Current FY through _____	Forms 1, 2, and 5		
	(3) Past FY	Forms 1,2, and 5		
B.	Other Quantitative Indices:			
	1. Ratio of actual to standard budget	Forms 1 & 5; independent verification		
	2. Staff-client ratio	Forms 5 & 6; independent verification		
	3. Counselor-client ratio	Forms 5 & 6; independent verification		
	4. Staff turnover rate	Forms 6 & 7		
	5. Percent of positive urinalysis tests	D.I. 2 (e)		
C.	Qualitative Indices:			
	1. Level of services provided to clients	D.I. 7 & 8		
	2. Scope of record-keeping systems	Form 4 & Client Records Checklist		
	3. Quality of records	Comments on client records		
	4. Validity of reported data	Form 5; independent verification		

DEFINITIONS

A.1: [(Costs for most recent month) X (12)] ÷ (number of clients seen at least twice last week).

A.2: (Costs for current FY to date) ÷ (current FY client-years of treatment to date).

A.3: (Costs for past FY) ÷ (past FY client-years of treatment).

B.1: [Actual budget] ÷ [number of clients seen at least twice last week) X (standard cost per client)]. Standard cost per client is $1,500 for outpatient care, $4,500 for residential care and $30,000 for inpatient care.

B.2: (Number of staff-members) ÷ (number of clients seen at least twice last week).

B.3: (Number of counselors) ÷ (number of clients seen at least twice last week).

B.4: [Number of people employed during past and current FY) – (number of positions filled at least half the time during past and current FY)] ÷ [number of positions filled at least half the time during past and current FY].

B.5: (Number of positive urinalysis tests) ÷ (total number of urinalysis tests).

C.1: "Medium" consists of individual counseling at least once a week; vocational rehabilitation (i.e., job counseling, training or placement); and two of the following: legal, social or health services. "High" consists of more services and "low" of less.

C.2: "Medium" means the program (a) was able to complete the data forms easily; (b) keeps a formal budget, prepares authorizing documents before disbursing funds, records all expenditures and receipts, and makes periodic financial statements; (c) keeps individual client records, including admission forms and counselors' notes. "High" consists of more records and "low" of less.

C.3: "Medium" means that 70-80% of the records are relatively complete, up-to-date, and consistent. Client records include weekly counselors' notes which seem relevant and useful. "High" indicates that more than 80% meet these conditions and "low," less than 70%.

C.4: "Medium" indicates that data verified by the evaluation team and data reported by the program differ by 10-20%. "High" indicates difference of less than 10% and "low" of more than 20%.

SUBJECTIVE ASSESSMENT—CHECKLIST

Facility Name: _____

ITEM	PROBLEM	NOT A PROBLEM	DON'T KNOW
1. Facility:			
(a) accessible	Facility tour		
(b) clean and orderly	Facility tour		
(c) laid out reasonably	Facility tour		
(d) adequate space	Facility tour		
2. Smooth flow of client traffic (e.g., no long waits for service)	Facility tour		
3. Staff:			
(a) motivated	Facility tour		
(b) helpful	Facility tour		
(c) knowledgeable	Facility tour		
(d) organized	Facility tour		
(e) interested in clients	Facility tour		
(f) busy	Facility tour		
4. Are there any obvious problems in the following areas?			
(a) procedures for controlling and dispensing medication	Facility tour		
(b) urine testing procedures	Facility tour		
(c) nature and tone of relationship between clients and staff	Facility tour		
5. (a) Are the days and hours of operation reasonable?	D.I. 18 (a)		
(b) Were the official hours kept on the day of the visit?	Observation		
(c) Are the days and hours for dispensing medication reasonable?	D.I. 18 (b)		
(d) Are the daily activities reasonable?	D.I. 18 (c)		
6. Are the program's objectives reasonable?	D.I. 1		

ITEM—Continued	PROBLEM	NOT A PROBLEM	DON'T KNOW
7. Is the program trying to assess its progress toward meeting its objectives?	D.I. 2; studies of treatment effectiveness		
8. Is the client retention rate reasonable?	D.I. 2 (c)		
9. Are the urine test costs reasonable?	D.I. 2 (e)		
10. (a) Is a reasonable range of client services provided?	D.I. 7		
(b) Do individual clients receive counseling and/or participate in group therapy fairly often?	D.I. 8		
11. Does the program have:			
(a) reasonably open admission criteria?	D.I. 10		
(b) reasonable intake procedures?	D.I. 11		
(c) reasonable criteria for dismissal?	D.I. 12		
(d) reasonable treatment guidelines?	Treatment guidelines		
12. Does the program conduct follow-up activities on clients who have left treatment?	D.I. 13		
13. Is the organizational structure reasonable?	D.I. 17; organization chart		
14. Is the salary structure for the staff reasonable?	Form 6		
15. Is there a serious problem with current staff vacancies?	Form 7		
16. Does the program have adequate financial procedures?	Form 4		
17. Does the program maintain adequate records?	Form 4; Client Records Checklist; observation		

ITEM—Continued	PROBLEM	NOT A PROBLEM	DON'T KNOW
18. Did the director cite any of the following problems?			
(a) clients requesting particular services which cannot be provided	D.I. 9		
(b) people requesting admission to the program who cannot be accepted	D.I. 14		
(c) other problems	D.I. 15		
19. Did the director indicate the program had adequate resources	D.I. 16		
20. In the evaluator's judgment:			
(a) are the program's resources adequate?	Forms 1, 3, 5; observation		
(b) are the program's resources being effectively utilized?	Overall assessment		

Subjective assessment done by: _____

APPENDIX D

POSSIBLE STAFF QUESTIONNAIRES

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. Related experience: _____ Years _____ Months
   d. Please describe this related experience: _____

2. Education and training:
   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. Are you an ex-addict? _____ Yes _____ No

4. How many hours per week do you work:
   a. At this facility? _____ hours per week
   b. At other treatment facilities? _____ hours per week

5. (a) How many clients do you see on an average day? _____
   (b) How much time do you spend with each client you see on an average day? _____

6. (a) Do you have a regular caseload of clients? _____Yes _____No

(b) If so, how many clients are in your current caseload?_____

(c) How often do you see each client in your current caseload? _____

(d) In your judgment, is your current caseload of clients too many, too few, or about right?

_____ too many _____ too few _____about right

7. What do you do on an average day? Please use the following table and be as specific as possible (e.g., counsel individual clients, run group therapy sessions, dispense medication, etc.)

Time	Activity
7:00 a.m.	
8:00 a.m.	
9:00 a.m.	
10:00 a.m.	
11:00 a.m.	
12:00 noon	
1:00 p.m.	
2:00 p.m.	
3:00 p.m.	
4:00 p.m.	
5:00 p.m.	
6:00 p.m.	
7:00 p.m.	
8:00 p.m.	
9:00 p.m.	
After 9:00 p.m.	

Additional comments on your work, problems, needs and so forth are welcomed.

Thank you very much for your time and help.

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. Related experience:_____Years _____Months
   d. Please describe this related experience: _____

2. Education and training:
   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:
   a. At this facility?_____hours per week
   b. At other treatment facilities?_____hours per week

4. Which of the following activities did you perform during the past week? Please check as many as apply.

☐ Client intake	☐ Locating prospective clients (outreach)
☐ Diagnosis	☐ Supervision of staff
☐ Individual counseling	☐ Management
☐ Family counseling	☐ Clerical, secretarial, bookkeeping, etc.
☐ Group therapy	☐ Housekeeping, maintenance, security, etc.
☐ Job counseling	☐ Maintaining client records
☐ Job training	☐ Research and evaluation
☐ Job development	☐ Staff training
☐ Educational services	☐ Community relations
☐ Medical services	☐ Other (please describe):
☐ Legal services	_____
☐ Emergency services	_____
☐ Social services (housing, welfare, etc.)	_____
☐ Client follow-up or aftercare	

5. For the activities you checked above, which *one* would you say you spent the most time doing?

_____

Additional comments on your work, problems, needs and so forth are welcomed.

Thank you very much for your time and help.

APPENDIX E

POSSIBLE DATA COLLECTION FORMS FOR DETAILED URINALYSIS RESULTS

URINALYSIS RESULTS

Facility name: _____

1. Have you done any analysis of your urinalysis results? _____ Yes _____ No
   If so, please provide copies.

2. Please summarize your analytical approach and your major findings. _____

3. Do your urinalysis records distinguish:

   _____ type of drug

   _____ number of clients with consistently positive results (e.g., positive more than 50% of the time)

   _____ length of time clients have been in treatment

4. Two tables follow: a short version and a detailed version of urinalysis results. Please complete as much of these two tables as possible from your records.

Urinalysis Results—Short Version

Lab name and address: ____________________

Time period covered in data below: ____________________

Tests Results	Current Clients Total	Current Clients Excluding Recent Entrants*
Morphine/quinine:		
Positive results at least half the time		
Some positive results but less than half the time		
No positive results		
TOTAL		
*Other drugs of abuse***:		
Positive results at least half the time		
Some positive results but less than half the time		
No positive results		
TOTAL		

*A recent entrant is defined as ____________________

____

**These drugs are as follows (methadone should be excluded for clients in methadone programs):

____

____

____

____

Urinalysis Results—Detailed Version

Lab name and address: ____________________

Time period covered in data below: ____________________

	Number of Clients in Treatment for:								
	Less Than 8 wks.	9 wks.-4 mo.	5-6 mo.	7-9 mo.	10-12 mo.	13-18 mo.	19-24 mo.	More than 24 months	TOTAL
Drug: ____									
Number of positive results									
Number of negative results									
TOTAL									
Drug: ____									
Number of positive results									
Number of negative results									
TOTAL									
Drug: ____									
Number of positive results									
Number of negative results									
TOTAL									
Drug: ____									
Number of positive results									
Number of negative results									
TOTAL									
Drug: ____									
Number of positive results									
Number of negative results									
TOTAL									

APPENDIX F

POSSIBLE DATA COLLECTION FORMS FOR DETAILED CLIENT RETENTION ANALYSIS

CLIENT RETENTION

Facility Name: _____

1. Have you done any analysis of client retention rates?

   _____Yes _____No

   If so, please provide copies.

2. Please summarize your analytical approach and your major findings:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

3. Two tables follow: "Client Flow By Month for Current Fiscal Year" and "Client Retention By Cohort Group." Please complete as much of these two tables as possible from your records.

CLIENT FLOW BY MONTH FOR CURRENT FISCAL YEAR

Facility Name: ______________________________

Note: Treat each modality/residence combination separately. *Modalities:* Maintenance (M), Detoxification (D), Drug Free (F) or other (describe). *Residence categories:* Inpatient (I), Residential (R), or Outpatient (O).

Item	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
Modality and residence: ____________ Admissions during month												
Successful* completions during month . .												
Others who left treatment during month .												
Clients at end of month												
Modality and residence: ____________ Admissions during month												
Successful* completions during month . .												
Others who left treatment during month .												
Clients at end of month												
Modality and residence: ____________ Admissions during month												
Successful* completions during month . .												
Others who left treatment during month .												
Clients at end of month												

*Defined as ______________________________

CLIENT RETENTION BY COHORT GROUP

Note: Treat each modality/residence combination separately. *Modalities:* Maintenance (M), Detoxification (D), Drug Free (F) or other (describe). *Residence categories:* Inpatient (I), Residential (R), or Outpatient (O).

Modality and Residence: _____

For Clients who entered:	Total Entrants	Still In Program	Successful Completions*	Others Who Left Treatment
Within last 3 months				
4-6 months ago				
7-9 months ago				
10-12 months ago				
13-18 months ago				
19-24 months ago				
25 or more months ago				

*This facility defines "successful completion" as _____

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END