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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Action Needed To Improve Management And Effectiveness Of Drug Abuse Treatment

Cutting across racial, cultural, social, and economic lines, drug abuse is estimated to cost society about $10 billion a year. An essential part of the Federal strategy to prevent and control this abuse is the treatment of abusers. Nationwide, about $518 million is spent annually to treat drug abusers, with over $130 million coming from HEW's National Institute on Drug Abuse.

This report identifies a number of program policies and management problems that operated as disincentives to providing adequate treatment to the greatest number of drug abusers. GAO makes a number of recommendations to HEW to improve program management.

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COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ACTION NEEDED TO IMPROVE MANAGEMENT AND EFFECTIVENESS OF DRUG ABUSE TREATMENT

D I G E S T

In response to the growing drug abuse problem, the Nation's treatment system has grown from a handful of clinics in the early 1970s to a network of over 3,200 treatment units. Nationwide, about $518 million is spent annually on treatment programs. The National Institute on Drug Abuse (NIDA) supports about 1,500 clinics at an annual cost of $130 million.

GAO's review identified a number of program policies and management problems that operated as disincentives to providing adequate treatment to the greatest number of drug abusers. Also, NIDA is spending millions on some treatment methods that GAO believes may not be effective.

MORE DRUG ABUSERS COULD BE SERVED

Not enough slots in NIDA's treatment program are being used by high-priority drug abusers--individuals with chronic and compulsive drug abuse--because ineligible people are being treated and treatment slots go unused. Additionally, providers are not treating as many people as reported. These conditions are largely caused by NIDA's not

--enforcing admission criteria,

--determining reasons for differences in utilization rates and using information gained to increase the use of the treatment capacity, or

--enforcing proper reporting by providers.

(See ch. 2.)

Since there are many more people abusing both legal and illegal drugs than the Nation's treatment system can handle, resolving these problems could result in more drug abusers being treated.

ADEQUATE TREATMENT NOT BEING PROVIDED

Although NIDA funded the States and providers to furnish comprehensive treatment, many abusers were not receiving necessary services. Treatment could be more effective if providers would

--give the necessary services at admission,

--furnish adequate counseling,

--maintain complete information on client's background, and

--develop adequate treatment plans. (See ch. 3.)

NIDA's present funding method does not motivate providers to furnish their clients adequate treatment. Specifically, to receive NIDA funding, providers are required to show only that minimal services are furnished.

Other reasons for inadequate treatment are: (1) NIDA's cost ceilings may not reflect the amounts required to provide necessary treatment, (2) medical histories and treatment plans are incomplete, and (3) providers are not using NIDA's guidelines. (See p. 33.)

NIDA funds some treatment programs that are of questionable effectiveness. NIDA contributes about $3.6 million annually to support a 21-day outpatient methadone detoxification program for some heroin-abusing clients, although studies have found this treatment method to be ineffective. NIDA also supports outpatient drug-free treatment to daily opiate

abusers, although a NIDA-financed study showed that such treatment was relatively ineffective. (See p. 41.)

THE TREATMENT SYSTEM NEEDS TO BE UPGRADED

NIDA should upgrade the quality of the nationwide treatment system. The present method of funding States and treatment providers (as discussed in chs. 2 and 3) does not provide incentives for programs to deliver treatment services to the greatest possible number of high-priority drug abusers or to deliver all the services clients need. Whether the correction of these problems requires a completely new funding method or changes to the existing method is under study by NIDA.

Certain elements of the funding criteria, which must be met by every provider receiving NIDA funds, are so vague they cannot be uniformly interpreted and/or enforced. Important elements, necessary for quality drug abuse treatment programs, are not adequately addressed by the funding criteria. (See p. 55.)

A competent staff is vital to proper treatment. State competency-based credentialing programs could allay public doubts about counselor competency and help

--improve quality of care;

--obtain third-party reimbursement for providers; and

--expand the employment potential, particularly for paraprofessionals.

As of May 1979, only 15 States had credentialing programs in operation. (See p. 61.)

Although NIDA reports that about one in five clients complete treatment, there is no generally accepted standard for defining successful

completion of treatment. Essentially, providers are the judges of "successful completion." Since a uniform definition does not exist, the question of how many individuals completed treatment cannot be adequately answered. (See p. 65.)

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

GAO is making a number of recommendations (see pp. 25, 47, and 75) to the Secretary to improve the efficiency and effectiveness of NIDA's program. Among these are recommendations to:

--Evaluate reasons for the wide variance in slot utilization rates and apply the knowledge gained to increase overall utilization.

--Increase the minimum required number of monthly client contacts and establish criteria defining what should be considered as contacts.

--Increase efforts to convince the States to require providers to keep adequate treatment records.

--Require that providers offering outpatient methadone detoxification incorporate it into a longer term treatment plan.

--Assure that (1) the necessary evaluation procedures for the revised funding method are completed in a timely manner and (2) if proven successful, the revised method is implemented by early 1982.

--Upgrade and clarify the funding criteria.

AGENCY COMMENTS

The Department of Health, Education, and Welfare (HEW) agreed that improvements can be made in NIDA's administration of the drug abuse treatment program. HEW agreed in principle with most of GAO's recommendations, but stated that in several instances alternative actions would achieve the recommendations' intent.

HEW said that continuing efforts to monitor the States' program management activities, the implementation of a new incentive funding mechanism, improvements in management information systems, and a review and clarification of drug abuse treatment standards would address GAO's specific concerns. While these actions may help reduce the problems identified, GAO believes that, for the most part, the specific actions recommended are also necessary.

HEW disagreed with a proposal in a draft of this report regarding the suspension of funding for outpatient methadone detoxification as a separate treatment modality until a decision is made regarding the most appropriate treatment period for this modality. HEW believes that the treatment should continue while the issue of treatment length is being resolved. Based on available evidence, GAO believes that outpatient methadone detoxification needs to be combined with longer term treatment to be effective. GAO has therefore revised its recommendation to require that this be done.

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ABBREVIATIONS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
NIDA	National Institute on Drug Abuse

CHAPTER 1

INTRODUCTION

Drug abuse in the United States has evolved from an acute to a chronic problem crossing racial, cultural, social, and economic lines. Although the heroin epidemic of the late 1960s and the sudden increase in drug use seem to have subsided, the rate of psychoactive drug consumption continues to be high. Currently, there is no general agreement on the causes of, or the cures for, drug abuse.

The President's Domestic Policy Staff periodically issues an updated publication, "Federal Strategy," describing the Federal activities relating to drug abuse prevention and control. The 1979 issue discusses the three major elements to reduce the serious effects of drug abuse:

--Domestic treatment, rehabilitation, and prevention.

--Domestic drug law enforcement.

--International narcotics control.

This report focuses on aspects of domestic treatment and rehabilitation. 1/

In 1972 the Federal Government, responding to a drug abuse problem judged by the President to be of almost crisis proportions, greatly intensified its efforts to treat and prevent drug abuse. On March 21, 1972, the Drug Abuse Office and Treatment Act (Public Law 92-255, 86 Stat. 65) was enacted. To administer this effort, the Congress elevated the drug abuse division of the Department of Health, Education, and Welfare's (HEW's) National Institute of Mental Health to a separate institute. The new institute, the National Institute on Drug Abuse (NIDA), was created in 1973.

The act and subsequent amendments enlarged the national treatment system. As of December 31, 1972, HEW's program was treating about 29,000 people; by 1979, the NIDA-assisted program was treating about 88,000 people.

1/GAO reports issued since 1974 on drug abuse treatment are listed in appendix II.

Treatment is a program of (1) basic health services to allow a person to overcome the physical problems of addiction or serious drug abuse and (2) psychological and social counseling services promoting mental well-being and the ability to cope without drugs. Treatment is also the linking of basic services and other health, social services, rehabilitation, and employment programs. As discussed later in this report, the answer to the question--which treatment method works for which drug abuser and when--is still unknown.

THE NATURE AND EXTENT OF THE DRUG PROBLEM

From the magnitude of annual drug consumption in the United States, it is apparent that the use of drugs has become an integral feature of our society. In 1977, 280 million prescriptions for psychoactive drugs were written.

According to the 1979 "Federal Strategy," the estimated number of people using selected legal and illegal drugs for nonmedical purposes in 1977 was:

Drug	Nonmedical use
Stimulants:	
Amphetamines	1,780,000
Cocaine	1,640,000
Cannabis products:	
Marijuana	a/16,210,000
Depressants-narcotics:	
Heroin	b/550,000
Depressants-sedatives:	
Tranquilizers	1,360,000
Barbiturates	1,060,000
Alcohol	c/92,300,000
Psychedelic/ hallucinogens (including LSD)	1,140,000

a/The number of marijuana users is based on the number estimated to have used it in the month preceding the date the data were obtained.

b/The estimated number of heroin abusers dropped to 450,000 in 1978.

c/The National Institute on Alcohol Abuse and Alcoholism estimates there are 9.3 to 10 million adult problem drinkers in the United States.

Many, but not all, of the individuals who use drugs experience negative health or social consequences.

Drug use is divided into three patterns: rational use, drug misuse, and drug abuse. Rational use is the use of any prescribed or over-the-counter drugs in appropriate amounts for therapeutic purposes for appropriate lengths of time. Drug misuse is the inappropriate use of drugs intended for therapeutic purposes. Drug abuse is the nontherapeutic use of any psychoactive drugs, including alcohol, in a manner that adversely affect some aspect of the user's life.

The "Federal Strategy" states that the drug problem is the sum of the negative medical, social, and economic consequences of drug abuse and misuse as they affect the individual, the individual's family, and the community at large. For any given drug, consequences will vary with the pattern of use. The period between drug use and evidence of damage can vary from minutes to decades. The longer the time period, the more difficult it becomes to establish the link between use and impact.

Another major consequence of the drug problem is the heavy financial burden to society. According to HEW, the annual social cost of drug abuse is $10.3 billion. The cost includes absenteeism, unemployment, and death; law enforcement (including the judicial system); drug traffic control and prevention efforts; medical treatment; and about $518 million for providing drug abuse treatment services. The estimate does not include the range of intangibles that cannot be priced, but represent the pain of mental and physical debilitation, the destruction of families, the disruption of neighborhoods, and other human suffering associated with drug abuse.

CHARACTERISTICS OF PEOPLE IN DRUG ABUSE TREATMENT

During the years 1975-78, over 170,000 people were admitted for treatment each year to clinics receiving some of their funds from NIDA. Although most clients admitted were men, the percentage of women admitted each year increased slightly.

	Year of admission			
	1975	1976	1977	1978
Number of clients	177,866	179,726	173,887	180,016
	(percent)			
Male	71.4	70.9	70.3	69.8
Female	28.6	29.1	29.7	30.2
Total	100.0	100.0	100.0	100.0

Most clients admitted during these years were between the ages of 21 and 30. Clients admitted in 1978 tended to be older than those admitted in 1975.

Age at admission	1975	1976	1977	1978
	(percent)			
Under 18 years	14.0	10.5	11.2	12.4
18-20 years	14.0	12.1	11.9	12.2
21-30 years	53.5	57.1	55.5	52.6
31-44 years	15.0	16.6	17.6	18.8
Over 44 years	3.5	3.7	3.8	4.0
Total	100.0	100.0	100.0	100.0

At admission, most clients cited opiates (principally heroin) as their primary drug problem, although the proportion in this category has dropped from about 66 percent in 1976 to about 53 percent in 1978.

Primary drug problem at admission	Year of admission			
	1975	1976	1977	1978
	(percent)			
All opiates	59.2	65.5	60.0	52.5
Marijuana	15.3	8.8	10.0	13.0
Alcohol (note a)	7.5	6.2	6.3	6.8
Barbiturates	5.2	5.2	5.4	4.9
Other sedatives (note b)	2.4	3.2	4.5	5.2
Amphetamines	4.6	5.1	5.6	6.6
Cocaine	1.0	1.3	1.9	2.8
Hallucinogens	2.9	2.8	4.1	5.6
Other	1.9	1.9	2.2	2.6
Total	100.0	100.0	100.0	100.0

a/Our views on alcohol abusers being in NIDA-assisted treatment begin on page 13.

b/Includes hypnotics and tranquilizers.

Most treatment programs do not focus on a specific drug problem, but instead look at the whole person to help understand the complex social and emotional factors that may have led to the drug-abusing behavior. Drug treatment is generally offered in one of four environments: outpatient, residential, day care, or inpatient. A client may be treated in one of three modalities, or types, of treatment: detoxification, drug free, or methadone maintenance.

In detoxification treatment, there is a planned period of withdrawal from drug dependency supported by the use of prescribed medication--often methadone. In the drug-free method, counseling, rather than chemotherapy, is the primary therapy; medication is not a part of the prescribed treatment. In methadone maintenance, the abuser is administered methadone for a period in excess of 21 consecutive days, as a substitute for heroin or other morphine-like drugs. Methadone relieves the craving for, and blocks the euphoric effects of, heroin. Also, the abuser is provided counseling and other appropriate social and medical services.

In 1978 over 90 percent of clients were being treated in one of three treatment combinations:

Type of treatment	Percent
Outpatient drug free	48
Outpatient methadone maintenance	35
Residential drug free	8
Total	91

Although the average treatment time for all clients has remained constant over the years (about 22 weeks), the treatment period for those in outpatient methadone maintenance has increased from 44 weeks in 1975 to 53 weeks in 1978.

EXECUTIVE BRANCH ORGANIZATION FOR TREATING DRUG ABUSE

The President established the Special Action Office for Drug Abuse Prevention in 1971. In 1972 Public Law 92-255 made that office responsible for leadership of the Federal Government's effort to provide treatment and rehabilitation for drug abusers. Public Law 92-255 also authorized drug abuse prevention and treatment programs and required the President to establish a Strategy Council to prepare a comprehensive drug abuse strategy.

Amendments in 1976 (Public Law 94-237, 90 Stat. 241) to Public Law 92-255 established the Office of Drug Abuse Policy, within the Executive Office, as a successor coordinative agency to the Special Action Office. The Director of the Office of Drug Abuse Policy was also a Special Assistant to the President for Health Issues. In March 1978 the office was terminated, and a core staff was transferred to the President's Domestic Policy Staff. Executive Order 12133, dated May 9, 1979, designated the Associate Director for Drug Policy of the Domestic Policy Staff to carry out the responsibilities of the Office of Drug Abuse Policy.

In 1974 Public Law 93-282 (88 Stat. 125) placed NIDA in HEW's newly established Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). NIDA's policy is guided by a 15-member advisory council composed of Government and non-Government experts in various drug-related fields. NIDA handles its drug abuse prevention and treatment responsibilities with a staff of about 400, most of whom are located at Rockville, Maryland. Although NIDA has the major Federal involvement in treating drug abuse, other Government agencies

also treat drug abusers in special populations, such as veterans, military personnel, and prison inmates.

THE TREATMENT PROGRAM

The national treatment system has grown from two inpatient prison hospitals and a handful of clinics in the early 1970s to a total national network of over 3,200 treatment units, employing over 35,600 paid staff workers, as of April 1978. The National Drug Abuse Treatment Utilization Survey reported estimated annual expenditures of $518 million from Federal, State, local, third-party, and other sources as of April 30, 1978.

Source	Estimated expenditures	Percent
	(millions)	
State agencies	$164	32
NIDA	132	26
Third-party reimbursements	74	14
Local governments	58	11
Federal agencies other than NIDA (note a)	47	9
Private contributions	25	5
Client fees	18	3
Total	$518	100

a/The Veterans Administration, the Department of Justice, and the Department of Housing and Urban Development.

Under the authority of section 410 of Public Law 92-255, NIDA supports a nationwide network of treatment clinics providing a variety of treatment methods. In 1978 NIDA supported over 1,500 units across the country.

Section 409 of Public Law 92-255 authorizes a formula grant program to assist States in combating the drug abuse problem. Under this program, Federal funds are distributed on the basis of a State's relative population, financial need, and need for more effective conduct of drug abuse prevention. The States have considerable freedom in determining how these funds are used.

The Statewide Services Contract 1/ is the primary means through which treatment services have been funded by NIDA. The contract is a cost-reimbursement/cost-sharing agreement with State government agencies, often referred to as Single State Agencies. The States then subcontract for treatment services.

The State agency has the responsibility for administering and coordinating treatment programs. NIDA allocated $3.8 million in fiscal year 1978, which when matched with State money, provided about $6.1 million for the States' administration and management of the treatment system.

In fiscal year 1978, NIDA distributed over $130 million for drug abuse treatment services--$95 million through statewide service contracts and the remainder by direct grant or contract. 2/ NIDA estimates that about $20 million, or 50 percent of the fiscal year 1978 formula grants awarded to the States, were also used for treatment.

NIDA requires that providers of treatment comply with specific requirements that include its Federal funding criteria. Funding criteria are minimal standards of acceptable treatment that must be met in order to receive NIDA funds.

NIDA's funding method

NIDA uses a treatment slot method to fund its services. Under this method, unique in HEW's Public Health Service, NIDA contracts or awards grants for a given number of slots in the various treatment combinations. A slot is defined as the capability to treat one abuser for a 12-month period.

A treatment provider, after considering the drug abuse characteristics of the expected clients, the type of treatment program it will provide, and similar factors, determines how many slots it is capable of filling at any given time during the funded period. Then the provider prepares a

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1/Beginning in fiscal year 1979, NIDA is converting all contracts to grants.

2/NIDA was directly funding 87 programs as of June 1979, but soon expects to fund virtually all of its treatment assistance through the statewide program.

1-year budget, including estimated costs for salaries, rent, utilities, supplies, equipment, and other items and services needed to treat the expected number of clients. The annual budget is then divided by the number of treatment slots to arrive at the estimated annual cost for treating one client.

NIDA has set predetermined slot cost ceilings for its participation; NIDA will not participate in any costs that exceed the provider's estimated annual slot cost or the slot cost ceiling. The 1979 slot cost ceilings are:

Environment	Cost ceiling per slot
Outpatient	$ 1,940
Day care	2,620
Residential	5,670
Residential detoxification	15,000

For example, a State or provider with a contract for 100 outpatient slots will have a ceiling of $194,000 for a year. The State or provider prepares a budget showing the estimated costs for personnel, facilities, utilities, and other items. If the budget does not exceed $194,000, NIDA will fund at least 60 percent of the budget. NIDA will not participate in any of the costs exceeding $194,000.

After the contract period begins, a key feature in NIDA's control is the provider's slot utilization rate. This rate is computed by dividing the actual number of clients in treatment by the contracted number of slots.

However, States and providers can have utilization rates of more than 100 percent. For example, NIDA participates in the funding of 178 slots in Maine. In January 1979, providers in Maine reported that 233 clients were being treated. Therefore, the utilization rate for Maine was 131 percent.

There are at least two reasons why the rate can be over 100 percent:

1. NIDA's reporting system counts a client as anyone having a face-to-face treatment contact with a counselor at least once in a 30-day period. One client could be treated at the beginning of the period, then discharged, and a new client treated within that period, thus reporting two clients in one slot.

2. Unlike an inpatient slot where the capacity is generally static because of available beds, a provider may be able to treat more outpatient clients at any one time than originally agreed. Conditions, such as available staff, adequate space, and type of treatment required, may permit the provider to treat the additional clients. Over 80 percent of NIDA's slots are in the outpatient environment.

NIDA officials require that a provider's utilization rate be at least 85 percent. If at least an 85-percent rate is not maintained within a specified time period, a provider may have its slots (and the accompanying funds) reduced within the contract period or at the time of renewal.

SCOPE OF REVIEW

We reviewed literature on drug abuse and its treatment, including publications on the causes of drug abuse and the methods, types, and effects of treatment. We reviewed publications on (1) research and demonstration projects to aid in upgrading treatment efforts, (2) the quality of treatment, and (3) the needs of staff to provide quality treatment and reports on treatment results.

We reviewed applicable Federal statutes; congressional testimony and reports; 1/ and pertinent NIDA policies, procedures, guidelines, and records. We interviewed NIDA officials, members of its National Advisory Council, and a member of the President's Domestic Policy Staff. We considered the results of work performed by Touche Ross and Company, 2/ a firm providing management consulting services to NIDA, and by the HEW Inspector General. 3/

1/Any reference to Senate and House subcommittees in the body of this report, unless otherwise noted, refers to the Senate Subcommittee on Alcoholism and Drug Abuse and the House Subcommittee on Health and the Environment.

2/The firm monitors the efficiency of the management, fiscal, and programmatic activities of NIDA-assisted treatment providers and makes recommendations to NIDA.

3/At NIDA's request, the HEW Inspector General's audit staff reviewed six programs in six States.

In three States (New York, California, and Illinois) accounting for 33 percent of the NIDA-assisted treatment slots, we interviewed officials, reviewed pertinent State records, and tested policies and procedures of selected providers. Our aim was to explore the extent of implementation of selected NIDA objectives and procedures, not to select a statistical sample of providers or to perform either a fiscal audit or an extensive management review.

We complemented our work by obtaining points of view, copies of studies related to our work, and other pertinent information from such organizations as the Liaison Task Panel on Psychoactive Drug Use/Misuse, President's Commission on Mental Health; National Association of State Alcohol and Drug Abuse Directors; Joint Commission on Accreditation of Hospitals; Alcohol and Drug Problems Association of North America; Drug Abuse Council; and Alcohol and Drug Dependence Division, Mental Health and Behavioral Sciences Service, Veterans Administration.

We started this review as a follow-on to earlier work in 1977 in which we had identified several weaknesses in the operations of NIDA and its grantees and contractors. NIDA was aware of many of these problems and had initiated corrective actions. Our current review, directed in part at assessing NIDA's progress in solving these problems, was begun about 1 year after NIDA started its corrective actions. We did not make a comprehensive review of the nationwide treatment system.

On June 20, 1978, the Chairman of the Subcommittee on Alcoholism and Drug Abuse, Senate Committee on Labor and Human Resources, requested that we provide input to the Subcommittee by March 1979 for its use in considering drug abuse legislation. We testified before the Subcommittee on March 2, 1979, on some of the issues discussed in this report.

CHAPTER 2

NIDA COULD SERVE MORE DRUG ABUSERS WITH ITS RESOURCES

Not enough of the NIDA-funded treatment slots are being used by high-priority drug abusers--individuals with chronic and compulsive drug abuse--because ineligible people, or people who do not have documented acute drug problems, are being treated and treatment slots go unused. In addition, providers are not treating as many people as reported. These problems are largely caused by NIDA's not (1) enforcing admission criteria, (2) determining the reasons for variations in utilization rates and applying the knowledge gained to assist in increasing the overall rates, and (3) enforcing proper reporting by providers. Also, there are no incentives under the present funding system for providers to treat more clients than the minimum required by NIDA. (See section beginning on p. 52.)

Resolving these problems could result in additional high-priority drug abusers being treated. The number of additional abusers would depend on a number of factors, including how long each client stays and whether providers actually have the capacity to treat the number of abusers they have contracted to treat. Low utilization rates might indicate that providers are giving a higher level of treatment to the clients they are serving. Our analysis of available counselor/client contact data shows, however, that these providers are not necessarily giving more treatment.

As shown in chapter 1, more people are abusing both legal and illegal drugs than the Nation's treatment system can handle. The New York State Office of Alcoholism and Substance Abuse estimated in July 1978 that, in addition to about 52,000 drug abusers in treatment in the State, over 500,000 abusers were in need of treatment. NIDA and State officials advised us that there are abusers who meet the admission criteria but are not in treatment for various reasons.

Although NIDA does not require States and providers to maintain waiting lists, information provided by some States shows that abusers are waiting for treatment. For example, one State with about 2,700 NIDA treatment slots reported a waiting list of 476 people as of April 1978.

INELIGIBLE PERSONS ARE TREATED

Treatment providers were admitting clients who were not eligible for treatment in NIDA-assisted programs because they were not drug abusers as defined in NIDA's admission policy. Since NIDA was not adequately enforcing its admission criteria, its treatment slots were not being used as effectively as possible.

NIDA's admission policy directing NIDA-assisted providers to accept only people with a primary drug of abuse other than alcohol is contained in its Federal funding criteria. 1/ NIDA, consistent with Federal policy requiring those with the greatest clinical need be treated first, has directed providers to give priority to chronic and compulsive drug abusers. The funding criteria require that each provider develop admission criteria. Clarifying guidance has been issued, on several occasions, partly because NIDA's monitors were identifying programs that admitted individuals who did not meet the admission criteria.

Date of clarification	Selected comments
July 25, 1975	"* * * NIDA treatment and rehabilitation funds must be targeted exclusively on those seriously drug-dependent individuals * * *. Individuals who use any drug, including marijuana, should be occupying a treatment slot only if their compulsive use of the drug(s) has resulted in their physio-biological dependence on the drug(s) and/or has assumed a central and negative role in their life style and coping mechanisms."

1/HEW has a program specifically to fund treatment of alcohol abusers.

Date of clarification	Selected comments
June 1, 1977	"Those individuals whose primary drug of abuse is alcohol, or who indicate no drug usage but who state a need for treatment services, should be referred to other, more appropriate service providers within the community."
November 25, 1977	NIDA, answering questions about using its funds to treat casual or recreational drug abusers and non-opiate abusers, stated that "its July 1975 definition of drug addiction stood, and * * * the Institute supports treatment of non-opiate abusers * * *."
February 17, 1978	"It has been, and it continues to be, NIDA policy that Institute-funded drug treatment programs admit drug abusers with the greatest clinical need first, on a priority basis. The programs may then focus on those with the next highest level of clinical need, and so forth. However, casual recreational drug users should not * * * [be] in a drug treatment slot."

Despite these clarifications, various material which we researched showed that individuals are treated who do not meet NIDA's criteria.

NIDA reported to a House subcommittee in April 1979 on the number of clients in its treatment slots with either alcohol or marijuana as their primary drug of abuse and showed the comparable number in 1975.

Primary drug	October 31, 1975	January 31, 1979
Alcohol	1,439	46
Marijuana	5,971	641

The numbers of clients shown above were compiled from an unofficial data collection system used by a division in NIDA. According to a division representative, NIDA's official data collection system was not giving the kind of information needed to manage the utilization of the treatment slots, including the number of persons in NIDA-funded treatment slots with either alcohol or marijuana as the primary problem. The representative acknowledged that the data could not be verified, and the division plans to discontinue the informal system soon and rely on an upgraded official reporting system.

Although NIDA's official data collection system could not show how many clients were admitted to NIDA-funded slots by their type of drug problem, the system reports such data for the approximately 1,500 providers who receive NIDA funds. Despite the restriction that treatment providers may not serve alcohol-abusing individuals in any of their slots (not just NIDA-funded slots), NIDA's reporting system shows that in 1978 about 11,800 people suffering primarily from alcohol abuse were admitted to NIDA-assisted providers.

The Director of the NIDA division operating the official system explained that NIDA assumes there are valid reasons for these clients being reported in the data system, but he said that NIDA does not have specifics. He advised us that a first step in getting answers began in September 1979, when NIDA started studying data from treatment providers that have just NIDA-funded slots.

NIDA's management consulting firm routinely reviews NIDA-assisted programs, and their results show that alcohol is the primary drug of abuse for a few clients. We were informed by a member of the firm that generally they have not questioned the eligibility of such clients. However, we noted that, in a June 2, 1978, report, the firm recommended that alcohol-abusing clients be immediately removed from the NIDA slots in the New Mexico programs.

While only 641 marijuana clients were reported in NIDA slots during January 1979, many more were treated in NIDA-assisted providers. For example, NIDA's reporting system showed that about 23,000 people--or 13 percent of all persons entering treatment in 1978--were admitted by these providers with marijuana reported as their primary drug of abuse.

Whether funded by NIDA or others, people admitted to a slot must meet NIDA's criteria of dysfunction from drug misuse. According to the Task Panel on Drugs of the President's Commission on Mental Health, the treatment for marijuana users is often crisis oriented, short term, and inappropriate. While noting that State laws often require or encourage treatment as a preference to imprisonment, the panel believed that placing marijuana users in drug treatment programs makes little sense for either the individual or society. The panel also explained that experiments in diverting people from the criminal justice system into the treatment system have funded some treatment for the wrong people.

The reported marijuana use of these 23,000 people shows that about 9 percent had not used marijuana in the month before admission. Another 5 percent were using it only once a month. The frequency of marijuana use and number of clients treated in NIDA-assisted programs for 1978 were:

Frequency of use	Number treated (note a)	Percent
No use during month before admission	2,073	9
Once a month	1,152	5
At least once a week but not daily	10,366	45
At least once a day	9,444	41
	23,035	100

a/NIDA's data show frequency of use by percent only. The number treated was calculated using these percentages rounded to the nearest whole percent.

ADAMHA advised a House subcommittee in May 1979 that the exact nature of the users' problem was unclear.

NIDA's reporting system shows that 30 to 35 percent of the clients admitted with marijuana as their primary drug of abuse were referred by the courts, police, or correctional officials. These referrals could place providers in the difficult position of admitting persons for treatment to avoid incarceration.

In response to a question from a Senate subcommittee, ADAMHA's Administrator stated that quarterly reports are received from providers to identify the number of marijuana users being treated in NIDA-funded slots and to verify that those individuals are dysfunctional because of marijuana use. He told the subcommittee that the approximately 1,000 marijuana users in NIDA slots as of October 31, 1978, were verified by the programs as dysfunctional.

The management consulting firm's reports routinely list the clients' primary drug of abuse in its sample. Data from some of the reports are presented below.

Period of sample	Contractor or grantee	Number of files sampled	Clients with marijuana as primary drug of abuse	
			Number	Percent
September 1978	The Bridge Therapeutic Center at Fox Chase, Philadelphia, Pennsylvania	57	7	12
October 1978	Orange County Drug Abuse Services, California	347	52	15
November 1978	Meharry Alcohol and Drug Abuse Program, Nashville, Tennessee	123	7	6
December 1978	Kansas	124	12	10

These reports were selected because the sample periods were near the date (Oct. 31, 1978) when NIDA reported that all marijuana users in treatment had been verified as dysfunctional. Although the firm does not routinely test for marijuana dysfunction, the firm concluded in some reports that the providers' records did not contain evidence of that fact.

In the Orange County and Meharry programs, the firm could not find sufficient evidence to conclude that most of the marijuana-using clients were dysfunctional. 1/ In addition, some of the clinics did not have formal procedures established for determining marijuana dysfunction.

The June 1979 HEW Inspector General's report 2/ included a discussion of client eligibility at 18 clinics. As explained on pages 13 and 14 of this report, NIDA requires providers to give priority to chronic and compulsive drug abusers and to abstain from admitting casual and recreational users. Because NIDA does not have a quantifiable definition of "casual users," the Inspector General's staff defined casual users as individuals who used drugs once a week or less often and were not users of high-risk drugs--heroin, amphetamines, and barbiturates.

Using this definition, the staff reported that 203 (7 percent) of the 2,800 clients admitted at nine clinics for a 14-month period may not have been compulsive drug abusers; that is, the clients did not meet NIDA's criteria reserving treatment for compulsive abusers. For example, their test of the records for 77 clients at six clinics showed that 16 clients were only casual users of marijuana.

The Inspector General recommended that a national admission criterion, relating to drugs of abuse and frequency of use, be issued. NIDA rejected the recommendation because, in its opinion, the changing drug treatment needs and the variations in characteristics of individuals and geographic areas work against a specific national policy. NIDA further explained that it would be inappropriate to define a casual user because such judgment is the clinician's responsibility.

In the spring of 1979, a Senate subcommittee asked how NIDA keeps casual, recreational, and experimenting users out

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1/NIDA's policy requires that providers put a statement in the client's file certifying that there is a dysfunction caused by use of drugs.

2/It should be noted, as pointed out by NIDA, that the Inspector General's review was made at the request of NIDA and the programs visited were considered by NIDA to be "atypical."

of NIDA-assisted treatment programs. The ADAMHA Administrator furnished copies of admission policy statements 1/ and stated that monitors routinely review client records to ensure that programs adhere to NIDA's admission policy.

In an appearance before the House Select Committee on Narcotics Abuse and Control, the NIDA Director explained that part of NIDA's monitoring system was an intensive program management review of providers. These reviews are conducted by a management consulting firm in each State every 3 years. However, based on discussions with a representative of the firm and our review of its reports, we concluded that the firm does not routinely test the recorded drug-abusing characteristics of clients.

During its review of a draft of this report, NIDA advised us informally that, while there may be ineligible clients in NIDA-funded treatment slots, the extent and degree of this problem is much less than indicated in this report. Because client records are frequently not well documented and reporting errors are made by providers, it is difficult to accurately determine the number of ineligible clients being treated by NIDA-assisted providers. We believe that our recommendations for improved monitoring of recordkeeping and reporting by providers, as well as our recommendations to clarify and enforce the admission criteria, will help eliminate these uncertainties.

SLOT UTILIZATION RATES VARY WIDELY-- NIDA HAS NOT DETERMINED REASONS

The slot utilization rates reported by providers vary widely from rates below NIDA's minimally acceptable rate of 85 percent to rates considerably over 100 percent. However, NIDA has not determined the reasons for these variances. Such information could be used to improve the quantity and quality of drug abuse treatment.

A slot, as discussed in chapter 1, is the capacity to provide treatment to one active client for 1 year. As of October 1978, NIDA had 98,500 treatment slots in its nationwide system and reported an average utilization rate of 89

1/The statements dated July 25, 1975, November 25, 1977, and February 17, 1978, are briefly outlined on pp. 13 and 14.

percent. The rate had declined from 95 percent in October 1975, to 91 percent in October 1976, and to 88 percent in October 1977.

NIDA has established a minimum level of performance for the States and the providers. The objective for fiscal years 1978 and 1979 was a utilization rate of at least 85 percent. Some States set 90 percent as the minimum level of performance, and our review showed this to be the case in California.

In April 1979, the ADAMHA Administrator explained to a Senate subcommittee that NIDA is perhaps unique in requiring that programs meet an 85-percent standard and that slot funding allowed NIDA to increase and maintain a higher utilization rate than ever existed before NIDA was established. In his opinion, most health care systems consider an 85-percent standard acceptable and desirable. He explained that NIDA reduces the number of treatment slots when providers are unable to maintain the 85-percent level.

Most States reported a utilization rate higher than the 85-percent minimum level set by NIDA. However, the following three States, with about 7 percent of NIDA's nationwide treatment slots, reported a rate averaging about 80 percent for the year ended January 1979.

State	April 1978	July 1978	October 1978	January 1979	Average
	(percent)				
Michigan	80	78	76	79	78
Nevada	80	79	77	80	79
Tennessee	79	82	80	79	80

As described on page 9, a utilization rate of 100 percent is not the maximum achievable because more clients can be treated than the number of slots. Nine States reported utilization rates over 100 percent in January 1979. While these States had 6,654 slots, or about 7 percent of the nationwide total, they had over 7,100 abusers in treatment. The utilization rates for these States were:

State	Utilization rate
	(percent)
North Dakota (note a)	160
West Virginia	140
Maine (note a)	131
Georgia	112
Delaware	106
Idaho	105
Hawaii	104
North Carolina	104
Massachusetts	103

a/A management consulting firm periodically reviews and reports utilization rates to NIDA. The firm's reports for Maine and North Dakota covering utilization tests for November 1978 and January 1979, respectively, show that the reported utilization rates were generally correct. The other States were not reviewed during this period.

Thus, some providers and States may have implemented techniques that permit them to serve more drug abusers than their assigned slots.

Evidence available to us does not conclusively demonstrate that the quantity or quality of treatment given by States and providers with low utilization rates were necessarily any better than that given by States and providers with high utilization rates. For example, NIDA obtained data for a 3-month period ended March 31, 1977, from five States on the average number of formal counselor contacts with clients per month. We compared utilization rates in four of those States (the fifth State was excluded because data were incomplete) during that period and found that States with higher utilization rates also had a greater average number of formal counselor contacts with clients. However, we also reviewed NIDA's management consultant firm's reports on several States and providers, some with high and some with low rates. We noted that the percentage of clients (primarily outpatient) with three or more counselor contacts during the sample month did not appear to be directly related to the level of utilization as shown in the following schedule.

State or program	Documented utilization rate (note a)	Percent of clients with 3 or more counselor contacts during month sampled
Maine	128	51
PROJECT CURE, Dayton, Ohio	107	30
Tampa-Hillsborough County Drug Abuse Comprehensive Coordinating Office, Florida	97	60
Community Organization for Drug Abuse, Mental Health and Alcoholism, Phoenix, Arizona	95	67
Orange County Drug Abuse Services, California	92	49
Kansas	79	25
Central Community Health Board of Hamilton County, Ohio	77	15
Ohio	77	21
New Mexico	75	28
Michigan	66	52

a/These rates are those computed by NIDA's management consulting firm and are not necessarily the same as the rates reported by the providers.

SLOT UTILIZATION RATES ARE INFLATED

Although several States have reported high utilization rates and for some the rates have been shown to be accurate, other States and providers have overstated their utilization rates. Overstated rates mean that several thousand abusers are erroneously reported as being under treatment. To the extent that an unused slot actually equates with unused capacity, these providers may be able to treat additional drug abusers.

There could be several reasons why providers' rates are overstated, such as (1) failure to review all case files and terminate inactive clients and (2) intentionally keeping clients on the rolls to make the program appear in the best possible light or to avoid having their slot utilization questioned by NIDA.

NIDA requires that a provider's staff have face-to-face contact with each client at least once a month. If this contact is not made, the provider may not count the abuser as an "active client." Using this criterion, NIDA's consulting firm often reports that providers overstate the number of clients being treated. While the firm does not go to every provider in a State, it does verify the reported utilization rate for a selected provider using a scientific sample.

As shown below, in a summary of its findings for the 13 months ended July 31, 1977, the firm reported that it could document only about 22,400 active clients, or 89 percent of the 25,200 reported clients in its sample. Although the sample was drawn at various times during the 13-month period, the 25,200 reported would represent almost one-third of all those in treatment on July 31, 1977.

Type of program	Sample size	Number documented	Percent documented
Outpatient drug free	12,002	9,722	81
Outpatient methadone maintenance	10,097	9,794	97
Residential drug free	2,047	2,047	100
Day care drug free	1,134	885	78
Total	25,280	22,448	89

Although the results of later tests were not summarized, the following schedule illustrates that providers continued to report inflated utilization rates.

Composite Utilization Rates for Sampled Providers in Selected States

Date of report	State	Reported	Documented	Difference
		(percent)		
3/08/78	New York	88	74	14
5/16/78	Michigan	77	66	11
6/02/78	New Mexico	81	75	6
2/09/79	Kansas	96	79	17

NIDA had about 10,000 slots under contract in New York during the firm's testing period. In January 1978, the firm visited 14 outpatient and day care clinics having 1,103 slots and a reported 976 active clients--a utilization rate of 88 percent. However, the firm could document only 821 active clients, or a utilization rate of 74 percent.

A June 1979 HEW Inspector General's report commented on HEW's efforts to validate utilization rates. In two clinics with reported utilization rates of 109 percent and 87 percent, the HEW tests showed that the actual rates were 76 and

56 percent, respectively. NIDA monitors have also found problems with the reported utilization rates.

Because of the extensive work done by others, we did only limited testing in our review. We also found reporting of inflated rates; for example, of the 65 active client files sampled at one California provider, 14 clients did not have documented face-to-face contact in the previous 30 days, including 8 who had no contact in the 30 days before the last reporting date and therefore should not have been reported as active clients.

In testifying before a Senate subcommittee on March 2, 1979, we reported on the inflated slot utilization rates. In response to the testimony, the ADAMHA Administrator advised the subcommittee that NIDA's method of funding does not contribute to the inflation of reported treatment utilization rates any more than any other method of funding contributes to a program's attempt to put itself in the most favorable light.

CONCLUSIONS

Notwithstanding NIDA's numerous statements defining qualified drug abusers as those who are chronic and compulsive and do not have alcohol as the primary drug of abuse, people were admitted to NIDA-assisted facilities who

--had alcohol as their primary drug of abuse and

--were not documented as chronic and compulsive drug abusers.

One possible cause for treating ineligible people, explained the Task Panel on Drugs of the President's Commission on Mental Health, is that empty slots encourage the acceptance of inappropriate clients. Another cause could be the confusion of providers in interpreting the admission policy because it is stated, explained, reiterated, and revised in numerous documents rather than in one complete policy statement. Further, NIDA does not adequately enforce its admission policy; for example, NIDA's management consulting firm does not routinely test the eligibility of clients in treatment.

Also, marijuana users who may not be dysfunctional are referred by the criminal justice system. Although this problem is primarily that system's responsibility, we believe that NIDA should increase its efforts to discourage the use of traditional drug abuse treatment for casual drug users. NIDA should also encourage the criminal justice system to develop and use other alternatives to incarceration for casual drug users.

NIDA needs to clarify and update its admission policy in the Federal funding criteria. Also, NIDA should increase its enforcement of the policy. NIDA will then have greater assurance that only eligible clients are being treated by NIDA-assisted providers.

Some States and providers report high levels of slot utilization, including several with utilization rates exceeding 100 percent, while other States and providers report rates below NIDA's acceptable minimum. We believe NIDA should determine what techniques or other factors influence the wide variance in slot utilization. After this analysis, NIDA should disseminate and apply any appropriate knowledge gained to increase the number of abusers served.

Many States and providers have been found to overstate their utilization rates. While, as ADAMHA explained, providers may want to show themselves in the most favorable light, we believe it is NIDA's responsibility to assure that utilization rates, a key element of the slot funding concept, are accurately reported.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary require the Director of NIDA to:

- --Clarify and update the admission policy in the Federal funding criteria.
- --Enforce the admission policy through procedures, such as (1) requiring its management consultant to test client eligibility and (2) increasing its and the States' monitoring of the admission data reported by providers.

--Increase efforts to discourage the use of traditional drug abuse treatment for casual drug users and encourage the development and use of other alternatives to incarceration of casual drug users.

--Evaluate reasons for the wide variance in slot utilization rates and apply the knowledge gained to increase overall utilization.

--Improve monitoring to assure that providers report accurate slot utilization data.

AGENCY COMMENTS AND OUR EVALUATION

HEW agreed in principle with our recommendations and pointed out a number of actions being taken in response to them. (See app. I.)

With respect to our recommendation that the admission policy in the Federal funding criteria be clarified and updated, HEW advised us that the policy will be clarified and that the policy statements will be codified by early 1981. We were told that the codification will consist of consolidating the various policy statements into the funding criteria. We believe these actions are responsive to our recommendation.

In a draft of this report, we proposed that NIDA enforce the admission policy through such procedures as requiring its management consultant to test client eligibility and increasing its monitoring of the admission data reported by providers. In its comments HEW pointed out that the States have primary responsibility for enforcing admission policy; and that NIDA's role is to monitor the States' performance. HEW stated that, as part of that role, NIDA will continue to provide technical assistance and guidance to the States.

HEW further stated that, because of priority commitments, NIDA's management consultant cannot in this fiscal year test client eligibility. However, to better carry out its monitoring responsibilities at the State level, guidance is also being developed for use by NIDA's project officers to more effectively identify instances where admission policies are not adequately enforced. This guidance is to be published by the second quarter of fiscal year 1981.

We recognize the States' responsibilities and had intended by our proposal that NIDA's actions would include assuring that the States carry out their responsibilities. We have not analyzed the priorities that preclude NIDA's management consultant from including testing of client eligibility in these reviews; however, we believe that the consultant could perform some testing without appreciably affecting its other responsibilities since the client files are already being examined for other purposes.

We also proposed in the draft report that NIDA increase efforts to discourage the use of traditional drug abuse treatment for casual drug abusers and encourage the development of other alternatives to incarceration of casual drug users. NIDA officials advised us that there are alternatives but that educational efforts are needed to encourage their use. We have revised our recommendation to clarify our intent that alternatives should not only be developed but also be used. HEW officials agreed with our revised recommendation and outlined efforts initiated by NIDA, including pilot efforts to establish State criminal justice coordinators.

HEW agreed with our recommendation that NIDA evaluate the reasons for the wide variance in slot utilization rates. Pointing out that NIDA already evaluates programs with low utilization rates, HEW stated that NIDA would examine, on a sample basis, programs with high utilization rates to determine if characteristics exist that can be applied to increase utilization in other programs. HEW expects NIDA to complete its work by early 1981.

HEW agreed with our recommendation to improve monitoring to assure that providers report accurate slot utilization data and outlined actions to be implemented by the summer of 1980. NIDA is implementing a computer-generated report on utilization that will be reconciled with information reported by the providers. NIDA is also developing a manual for its project officers to use in monitoring statewide services' grantees and will delineate procedures to be used in validating utilization data.

CHAPTER 3

CHANGES NEEDED TO ASSURE THAT ADEQUATE TREATMENT IS GIVEN

Providers are not furnishing enough treatment to their clients, in part because the slot funding method does not motivate providers to furnish adequate treatment. To receive reimbursement for allowable costs, providers are required to demonstrate only that they furnish minimal services to the abuser. In addition, NIDA's slot cost ceilings need adjustments; in some cases, inadequate funding may handicap providers in furnishing appropriate treatment. Providers claim that limited funding also hurts their effort to evaluate program effectiveness, including followups with discharged clients.

Another cause of the problem is the failure of providers to document key elements of client treatment, which handicaps an assessment of whether proper treatment was given. With a system that reports admitting more than 180,000 persons in 1978 at over 1,500 clinics, NIDA needs meaningful records of counseling sessions to help provide accountability for the use of Federal funds. The provider needs these records to help management assess the accomplishments of its counseling staff and the results of the treatment provided to abusers.

For some heroin-abusing clients, NIDA assists in providing a relatively ineffective form of treatment. NIDA contributes about $3.6 million annually to treat persons in a 21-day outpatient methadone detoxification method, although studies conclude this treatment method is ineffective. One study has also shown that outpatient drug-free treatment may be an ineffective form of treatment for daily opiate abusers.

MAJOR AREAS WHERE TREATMENT COULD BE IMPROVED

Although NIDA funded the States and providers so that comprehensive treatment is provided, many abusers were not receiving the necessary services. The major areas where providers could improve treatment are to (1) give the necessary services at admission, (2) furnish adequate counseling, (3) maintain ample client background information, and (4) develop adequate treatment plans.

Services necessary at admission are not provided

Although our work was limited, we found that some services were not provided to clients. For example, laboratory tests, such as blood tests and urinalyses, were not given to clients during initial physical examinations at an outpatient drug-free provider in California, and physical examinations and laboratory tests were not always given to clients at selected providers in Illinois.

NIDA's funding criteria require that physicals and laboratory examinations be given to clients because they are important in determining the treatment plan for a client.

Reviews by others show that providers do not give the required services. NIDA's management consultant firm sampled 7,127 records of outpatient clients and found no evidence of required blood tests being given to about 2,200 clients. From the same sample, they found that required physical examinations were not given to about 1,700 clients. The analysis covered the 11 months ended May 1977. The firm's reports issued since that time have similar findings.

Period of sample	Contractor or grantee	Number of client files sampled	Type of treatment not given			
			Physical exam		Blood test	
			Number	Percent	Number	Percent
November 1978	Meharry Alcohol and Drug Abuse Program, Nashville, Tennessee	123	34	28	39	32
December 1978	Kansas	124	24	20	23	19

The HEW Inspector General's staff also found in their tests of selected providers that there was often no evidence that physical examinations and laboratory tests were given.

Counseling sessions are infrequent

Counseling, considered to be the backbone of drug treatment, is inadequate. Despite the importance of counseling,

NIDA requires only one client/counseling session per month. It does not specify the length of the session or what constitutes a session for treatment and reimbursement purposes. As shown by NIDA and other studies, clients receive few counseling sessions.

In December 1977, NIDA informed program directors that agency studies showed the number of monthly contacts to be low. This finding is corroborated in reviews by NIDA's management consultant. The firm continually reported minimal counseling. For example:

Period of sample	Contractor or grantee program	Percent of clients with two or fewer contacts per month
October 1978	Orange County Drug Abuse Services, California	51
November 1978	Meharry Program, Nashville, Tennessee	57
December 1978	Kansas	75

In its June 1979 report, the HEW Inspector General concluded that clients in five sampled outpatient programs received an overall average of about 30 minutes of counseling per week. The average weekly counseling session ranged from 10 to 45 minutes.

On March 2, 1979, we testified before a Senate subcommittee on the low levels of treatment given to drug abusers in NIDA-assisted facilities. In responding to the testimony, ADAMHA's Administrator stated that the apparent low levels of treatment are a reflection of inadequate recordkeeping. He claimed that interviews with treatment staff and clients had convinced NIDA that adequate services are actually provided. Since NIDA requires providers to document client care in treatment records, 1/ evaluators, such as the management consulting firm, HEW, and us, cannot practicably verify that an abuser was treated unless there is documentary evidence (a record) of that treatment.

1/The Federal funding criteria require that a client record system be established which documents client care.

While counseling frequency and duration vary, authorities generally recognize that only drug abusers needing extensive rehabilitation should be in NIDA-assisted treatment. For example, in its March 1978 report, the President's Office of Drug Abuse Policy stated that, regardless of the drug abused, clients in federally assisted slots require intensive treatment and counseling because of many complex needs. Likewise, a member of HEW's National Advisory Council on Drug Abuse, also a treatment provider, said that heroin abusers in an outpatient drug-free program could require counseling sessions as often as three to five times a week.

Although we did not find any studies establishing a cause-and-effect relationship, the low level of counseling may be contributing to the large number of clients leaving the program and to the high rate of recidivism. As shown on page 66, over 48 percent (99,000 abusers) of those discharged in 1978 quit before treatment was completed. Also, in 1978 about 52 percent of those admitted to treatment were being treated for at least the second time.

Background information on clients not maintained

Basic to adequate treatment is the continual collection and assessment of client information. Such information includes drug, medical, and social histories and results of health examinations. NIDA's funding criteria require that such information be contained in a client's record.

Yet, the management consulting firm, the HEW Inspector General, and others have found that client histories are often missing or incomplete. For example, according to a 1977 California study, 46 of 112 providers (41 percent) had inadequate client record systems. Obviously, inadequate client histories work against the planning for treatment.

Adequate treatment plans are not developed

Treatment plans, an integral part of the treatment process, are often incomplete, vague, or missing. A treatment plan is based on background information (discussed in the previous section) and preliminary counseling sessions. NIDA's funding criteria require the plan to include a statement of long- and short-term treatment goals and a description of the type of supportive services needed by the client. These plans are developed with the individual's concurrence.

NIDA's management consulting firm often reports that treatment plans are incomplete or missing and that, even when present, they are not periodically assessed. In its summary report covering July 1976 through May 1977, the firm reported that 2,893 (12 percent) of the 24,053 client files reviewed did not contain treatment plans. As shown below, the problem continues.

Period of sample	Contactor or grantee	Number of client files		
		Sampled	With incomplete or without treatment plans	
			Number	Percent
February 1978	Michigan	150	15	10
March 1978	Tampa-Hillsborough County Drug Abuse Comprehensive Coordinating Office, Florida	201	24	12
March/April 1978	New Mexico	435	54	12
November 1978	Community Organization for Drug Abuse, Mental Health and Alcoholism, Phoenix, Arizona	518	119	23

Although the firm normally did not comment on the individual elements of incomplete treatment plans, we noted that in one report the firm found many of the plans did not have the required long- and short-term goals or the type and frequency of services to be provided. Furthermore, in this and other reports, the firm stated that providers were not periodically updating treatment plans, as required by NIDA's funding criteria.

Our testing of treatment plans also indicated incompleteness and vague terminology. For example, treatment goals stated in active client files were written in such general terms as:

--To be honest.

--To calm down.

--To become a drug-free, independent, healthy, and happy individual.

--To have goals for life.

--Detoxification.

These goals could have been written without determining the client's individual needs.

REASONS FOR INADEQUATE TREATMENT

The principal reasons for inadequate treatment are: (1) NIDA's funding method does not motivate a provider to give extended (indepth) treatment, (2) NIDA's cost ceilings may not reflect the amount required to provide necessary treatment, (3) medical histories and treatment plans are so incomplete that giving appropriate treatment is difficult, and (4) providers are not using the guidelines NIDA issues.

Funding method does not motivate providers

Providers do not have an incentive to give adequate treatment. Although blood tests and medical examinations are required, providers are reimbursed for their operating costs regardless of whether this treatment is provided. Further, providers' counselors are required by NIDA to see the abuser only once a month; the providers could receive the same funds whether the client is seen once or 15 times a month. In short, NIDA's method of funding is based not on the providers' quantity or quality of service, but on the utilization rate of the contracted number of slots. 1/

1/The slot funding method is described on p. 8.

Cost ceilings need to be adjusted

NIDA's cost ceilings--the maximum amounts in which NIDA will share in the cost of drug abuse treatment--do not consider

--differences in the cost of providing the various modalities of treatment,

--differences in the cost of personnel and other elements of treatment in different geographic areas, and

--the extent of inflation in the cost of treatment.

In some cases the ceilings may be lower, and in other cases higher than necessary for providers to give the required treatment. We believe NIDA, to be more equitable, should develop ceilings that recognize these variances. To the extent that the ceilings are too low, clients may be prevented from receiving adequate treatment.

The ceilings for 1975-79 were:

	Ceilings per slot			
Environment	1975-76	1977	1978	1979
Outpatient	$ 1,700	$ 1,750	$ 1,850	$ 1,940
Day care	2,300	2,370	2,500	2,620
Residential	5,000	5,150	5,400	5,670
Inpatient	40,000	40,000	40,000	(a)

a/Beginning in 1979, NIDA is phasing out its funding of inpatient slots. The Institute has set a cost ceiling of $15,000 for residential detoxification slots.

NIDA's management consulting firm reported in January 1978 that the average cost for treating a drug abuser in an outpatient drug-free program was close to the NIDA ceiling, while the average cost in day care and residential programs far exceeded the ceiling. A technical assistance contractor to NIDA reported in May 1978 that the actual treatment cost may have little relationship to the budgeted slot cost.

Officials in the States we visited--California, New York, and Illinois--believe that treatment costs are higher than ceilings. A March 1978 study by the California Division of

Drug Abuse showed that the estimated annual cost to treat a client in a California residential program would be $12,000, whereas NIDA's ceiling was $5,400.

According to NIDA officials, the cost ceilings were established in 1973 based on the opinions of several experts rather than on historical cost data. The ADAMHA Administrator told a Senate subcommittee in April 1979 that the ceilings are lower than the actual costs. We were advised that, as long as NIDA must operate the drug abuse treatment program with a static budget and a static treatment capacity, it does not plan to significantly raise the ceilings.

Compounding the problem is the fact that the ceilings do not recognize variances in salaries of clinical personnel in different parts of the country and differences in the cost of drug-free treatment versus methadone treatment. For example, Federal regulations require that providers dispensing methadone have at least one physician and two nurses. According to the chief of planning for the Los Angeles County Drug Abuse Office, this requirement leads to higher personnel costs in outpatient methadone maintenance programs than in outpatient drug-free programs even though the NIDA ceilings are the same.

A 1975 study done for NIDA indicated that methadone treatment cost as much as $1,000 a year more than drug-free treatment. Information obtained in a NIDA survey, as of April 1978, further illustrated the differences. 1/ The survey showed that the average cost for outpatient methadone maintenance for each client was $1,568, while the average for outpatient drug free was $1,409--a difference of $159 (about 11 percent). In addition, the survey showed that providers with large numbers of slots had lower average costs per slot, as shown by the following examples.

Outpatient Treatment

Budgeted number of slots	Average cost for 1 year	
	Methadone maintenance	Drug free
51-100	$2,201	$1,439
151-200	1,624	1,054

1/Cost data from 1,555 treatment providers were used in this portion of the survey.

Yet, the same cost ceiling applies to both types of treatment and to all providers, regardless of the number of slots.

A member of HEW's National Advisory Council on Drug Abuse advised us that the inequity in slot ceilings between treatment modalities could be resolved by reimbursing units of service rather than client slots. However, he cautioned that a reimbursement method using units of service would increase paperwork and cause problems in verifying documentation.

Not all provider agreements were negotiated at the NIDA ceilings. A NIDA official stated that some slot cost agreements are lower because the providers cannot raise the necessary matching funds, while others had lower slot costs set before the NIDA ceilings were imposed. Illinois and California officials explained that some providers are below the ceilings because:

--Some are able to have necessary services, such as education and vocational training, provided through the community.

--Those with a large number of slots may have lower unit costs than those with a small number of slots.

The Senate Committee on Labor and Human Resources reported its concerns about the NIDA slot cost ceilings in April 1979. The Committee advised NIDA that variations in treatment costs by geographic areas should be taken into account in funding providers. 1/

Recordkeeping and self-evaluation manuals not used

To help providers improve treatment and related recordkeeping, NIDA has issued various publications. Three manuals NIDA issued for such purposes were generally not being used by the providers. Unless necessary records are prepared, an assessment of the appropriateness of the treatment given is difficult, and perhaps impossible. Also, without appropriate self-evaluation and followup, providers are not obtaining information critical in upgrading their programs. Since providers have recordkeeping problems and need to upgrade the

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1/Senate Report 96-104, April 30, 1979, reporting on S. 525.

quality of their treatment, we believe NIDA needs to increase its efforts to persuade, and may have to require, providers to use the key elements of these manuals.

Recordkeeping manual

As part of NIDA's efforts to improve the quality of care, a client recordkeeping manual was issued in May 1978. NIDA summarized the problems of existing recordkeeping systems as follows:

--Information about the client is collected haphazardly by the counselor or intake (admissions) worker and may be sketchy or irrelevant.

--Important facts about the client--for example, his/her medical history and health status assessment--may not be present in the client record.

--Forms used to collect data and document treatment may be poorly designed or overly complicated.

--Treatment plans are inadequate and not directly related to the client's identified problems.

--Goals set for the client may not be measurable, objective, or realistic.

--The client's responses to treatment and program activities are not properly documented. Existing progress notes may be vague and fail to address specific problems.

--Case conferences and peer review of client progress are severely impeded by the lack of a concise but complete client record.

NIDA emphasized these problems and proposed solutions in its recordkeeping manual. The manual describes how providers' recordkeeping could be tailored to indicate program weaknesses and identify staff members who do not follow established procedures. The manual stresses the critical nature of treatment plans, stating that they are needed for identifying client's problems; establishing client goals; and determining the type, intensity, and duration of necessary treatment. It states that:

"* * * excessive paperwork is not defensible, but documentation of the therapeutic process, the treatment plan, counselor activity, and client progress is a critical necessity."

The client recordkeeping manual could help greatly in identifying treatment needs and monitoring client progress. Training in using the manual did not begin until the summer of 1979.

Comparatively few providers are using it. More specifically:

--Some providers had received but did not use the manual, some used only parts, and some had not received the manual.

--Some State agency officials used parts of the manual; others stated they had not determined if the manual would be used by drug treatment providers in their State.

--Some NIDA officials, responsible for monitoring drug abuse treatment providers, knew the manual existed but were unfamiliar with its contents.

Self-evaluation manuals

NIDA's guides on self-evaluation and followup were generally going unused because providers considered other demands and priorities more important. Because self-evaluation is essential in upgrading the quality of treatment, providers need to give greater emphasis to this function.

An essential element to self-evaluation is followup to determine if treatment works. If treatment does work, NIDA can publicize its effectiveness to other providers.

Public Law 94-237, approved March 19, 1976, requires that providers propose performance standards for self-evaluation. NIDA's original proposal for the Federal funding criteria included a requirement for a client followup system (21 C.F.R. 1402 Dec. 23, 1974). However, the final regulations (21 C.F.R. 1402,

May 27, 1975) deleted this proposal because of too many problems. The "Federal Register" did not identify these problems, and officials said they could not recall the specific reasons but thought it may have been that costs were prohibitive.

Providers have cited difficulties in effectively evaluating their treatment. According to a June 1976 report by NIDA's management consulting firm, provider followup is hampered because former clients may be in jail or may have moved without leaving a forwarding address. This difficulty has impeded evaluation efforts by outside organizations.

Our 1977 survey disclosed that some providers had followup procedures while others did not. Also, some providers with followup procedures were not always following them. In addition, the HEW Inspector General's study noted that providers were not following up on separated clients.

In response to the concerns of others and its desire to assist providers, NIDA issued in April 1977 the "Manual for Drug Abuse Treatment Program Self-Evaluation." In the guidance given to the States and providers, NIDA explained that using the manual's process would be relatively inexpensive.

In its Policy and Practice Manual, NIDA encourages the use of the self-evaluation manual as follows:

> "For detailed guidance on what treatment goals might be established and on how service providers might assess their progress in reaching these goals, NIDA encourages the contractor to review the Manual for Drug Abuse Treatment Program Self-Evaluation published by the Institute. Copies of this manual have been distributed to all Statewide Services Contractors and service providers."

NIDA also published in 1977 "Conducting Followup Research on Drug Treatment Programs" stressing the importance of followup:

> "No issues are as important to local program staff as the questions of what happens to clients in treatment and what happens to them when they leave treatment programs."

Both manuals were issued to over 1,400 providers and to State drug abuse agencies. 1/

To determine how providers are using the self-evaluation manual, we made selective reviews in California, Illinois, and New York. We also reviewed various NIDA actions to improve or monitor provider self-evaluation. We found neither the selected States nor providers made satisfactory use of the manual.

Some providers interviewed in the summer and fall of 1978 had not received the manual, while others received the manual but were not using it. The common reason given for not doing self-evaluations or using the manual was the lack of funds.

Generally, the NIDA staff responsible for monitoring providers and State agencies had at least heard of the manual but were unfamiliar with its contents and had not received any training in its use. A NIDA official stated in October 1978 that the manual was being used infrequently.

A NIDA official responsible for developing the manual explained that a cost-benefit study was not made because it was assumed the costs would be minimal (i.e., use of the manual was a simple process).

Because so little was known about providers' actual practices, NIDA contracted in September 1978 for a study to assess providers' evaluation procedures, including the use of these manuals. The contractor's report, costing $70,000, was originally expected to be received in September 1979, but NIDA now estimates a receipt date in February 1980.

NIDA encourages the manual's use. A clause in each NIDA grant in 1979 requires that the grantee have specific evaluation plans and cites the evaluation manual's procedures as acceptable. Also, beginning in January 1979, NIDA implemented a system to track the progress being made by the States and providers in self-evaluation.

1/Selected extracts from these two manuals, highlighting the importance of self-evaluation and followup, can be found in appendix III.

In responding to questions by a Senate subcommittee in April 1979, ADAMHA's Administrator explained that NIDA places great emphasis on the importance of self-evaluation in planning for improved client treatment. He also stressed that providers have enough money under the slot cost ceilings to implement the provisions in these two manuals. In his opinion, less than 8 hours per month of secretarial time per 100 clients would be needed, assuming adequate records are kept.

NIDA FUNDING INEFFECTIVE TREATMENT

NIDA helps fund the 21-day methadone detoxification for about 31,000 heroin abusers annually, but many consider this short-term treatment to be inadequate. NIDA estimates that the cost of this treatment was about $5.8 million for fiscal year 1978--of which NIDA's share was about $3.6 million. Also, about 8,200 daily opiate abusers were admitted to outpatient drug-free treatment in 1978, although a NIDA-funded research study shows that it may be an ineffective form of treatment for such abusers.

Outpatient detoxification

The period of detoxification is limited by law and regulation. 1/ The treatment process consists of giving an individual decreasing doses of methadone for up to 21 days. The following table shows the number of residential and outpatient detoxification slots funded by NIDA for 1976-79.

	Slots		
	Residential	Outpatient	Total
April 1976	151	1,861	2,012
April 1977	129	1,878	2,007
April 1978	156	a/2,572	2,738
April 1979	151	2,385	2,536

a/New Jersey, New York, and Pennsylvania had large increases.

1/In 1972, HEW's Food and Drug Administration published regulations which specified the conditions for using methadone in detoxification treatment. Public Law 93-281 (88 Stat. 124), passed in May 1974, gave the 21-day limit the force of law.

Because this form of treatment is very short, one slot could be filled by about 17 clients in a year. NIDA reported that 31,000 heroin-abusing clients were admitted in fiscal year 1978 to detoxification, or 35 percent of all (88,300) heroin abusers entering treatment in NIDA-assisted clinics.

According to providers, only about 19 percent of the clients complete the detoxification treatment process. The high dropout rate is consistent with the views of many people in the drug treatment field who have reported that 21-day methadone detoxification is ineffective. For example:

--In a 1971 study, published in the International Journal of the Addictions in 1974, the authors concluded that short-term outpatient detoxification is not usually associated with long-term abstinence.

--A study published in 1975 in the Journal of the American Medical Association concluded that 21-day outpatient detoxification yielded a low rate of heroin abstinence.

--A paper presented at the 6th World Congress of Psychiatry in August 1977 stated that methadone detoxification had never resulted in significant social rehabilitation or long-term abstinence.

--A 1975 study, published in the Journal of Psychedelic Drugs in December 1977, pointed to earlier studies (1971, 1973, and 1974) which showed that most addicts resume heroin use. The study concluded, however, that detoxification is effective when complemented with other long-term rehabilitation-oriented programs.

--A 1977 paper, done in part by the Chief of the Clinical Behavioral Branch of NIDA's Division of Research, summarized many studies on the 21-day detoxification method which stated that most patients are unable to complete such treatment.

--In a report sent to the States and to providers, NIDA summarized selected findings from a longitudinal study. 1/ NIDA stated that detoxification clients

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1/See p. 69 for more details on this nationwide longitudinal outcome study.

showed generally smaller and nonsignificant improvement or no change at all, compared to other modalities of treatment. A report issued in June 1978 on this study states that outpatient detoxification cannot be considered an effective treatment in the sample group or, as stated in the Handbook on Drug Abuse, "the evidence reviewed does not justify consideration of detoxification as an effective independent treatment."

--In February 1978, the chief of the drug abuse program for Washington State wrote NIDA that he was puzzled by the continuation of a 21-day restriction when information provided by NIDA indicated much better success when clients were detoxified over a more extended period of time.

--In October 1978, the Chief of NIDA's Services Research Branch stated that detoxification had a horrendous track record and that the consensus among knowledgeable people is that it is useless.

A number of reasons have been given for the failure of clients to complete 21-day detoxification. Among these are that clients enter treatment (1) when their heroin habit becomes too expensive or debilitating, (2) when heroin supplies are scarce, or (3) to become eligible for methadone maintenance treatment. Methadone maintenance regulations require that there be a documented 2-year history of heroin abuse and, for those between 16 and 18 years of age, two failures in a 21-day detoxification program to be eligible for admission.

In November 1978, the Director of the Food and Drug Administration's division that monitors methadone regulations acknowledged that for a number of years the effectiveness of the 21-day detoxification has been challenged. However, he explained that considerable evidence is necessary to change the law and rather than try to get the law changed, his agency and NIDA might begin in 1979 to change the regulations to include a new category of treatment, which is not limited to 21 days.

When questioned by the Senate and House subcommittees in the spring of 1979 about the ineffectiveness of detoxification, ADAMHA's Administrator stated that it would be foolhardy to surmise that a 21-day detoxification could alter a person's entire lifestyle. He explained that detoxification is a

public health service and should be offered to individuals who volunteer for it--that it should remain a treatment of choice. It would appear, however, that the potential client really does not have such a wide choice. We doubt that NIDA's 2,500 outpatient detoxification slots are available on a nationwide basis for all opiate abusers desiring treatment; for example, as of July 1979, NIDA did not fund such slots in Chicago.

Studies in progress to help determine appropriate length of detoxification period

NIDA is funding two studies to compare 21-day detoxification with longer treatment periods. One is a University of Chicago study started in January 1977, costing about $156,000. It is comparing 21- and 90-day detoxification, to address frequency and severity of withdrawal symptoms, abstinence progress, retention rates, and use of illicit drugs and alcohol. A draft report was completed in October 1979. In December 1979 NIDA provided the contractor with several suggested revisions and technical comments.

The other, a University of California at San Francisco study started in January 1979, is estimated to cost about $41,000. It is comparing 21- and 42-day detoxification. The results are expected by April 1980. In both studies the elements of detoxification, such as heroin use during treatment, retention in treatment, and patient comfort, are compared over the two periods of time.

According to the ADAMHA Administrator's statement to a House subcommittee in April 1979, any proposal to change the period of detoxification will depend on the studies' results.

Outpatient drug-free treatment for daily opiate abusers

The Drug Abuse Reporting Program study (discussed on pp. 69 to 73) concluded that outpatient drug-free treatment for daily opiate abusers was relatively ineffective. However, NIDA has continued to fund such treatment. Of about 25,400 clients admitted to NIDA-assisted outpatient drug-free treatment in 1978 with opiates as their primary drug problem, about 8,200 (over 30 percent) were daily abusers.

In defending NIDA's policy of funding such treatment, the ADAMHA Administrator explained to the Senate subcommittee in April 1979 that providers cannot refuse to serve the daily opiate abuser if that person wants drug-free treatment, but providers suggest that regular abusers enter another treatment type.

CONCLUSIONS

Under the slot funding method, a provider is reimbursed for costs without regard to the quantity of treatment provided. NIDA requires only that the client be seen once a month and is silent on the required duration and content of the contact. Thus, a provider is not motivated to respond to the total needs of the client since funding is received regardless of the frequency or length of client contacts. While NIDA also requires that health examinations be given to a client, the reimbursement for costs to a provider does not depend on proof that such a service was furnished.

The use of inadequate slot cost ceilings may also lead to providers not giving enough treatment. Further, NIDA's ceilings do not recognize cost variances in different geographic areas or in different modalities of treatment.

As discussed in chapter 4, NIDA is studying alternative funding methods. Until a decision is made on the funding method, we believe that NIDA should increase its minimum requirement for the frequency of counseling, establish criteria for what should be considered as a contact, and compute more equitable slot cost ceilings. Since counseling is very important to the success of treatment, greater emphasis on counseling could decrease unfavorable separations and recidivism and, thus, increase the success of treatment.

NIDA-assisted providers continue to have client recordkeeping problems. Their failure to obtain adequate background information about the client and the incompleteness of treatment plans seriously handicap an assessment as to whether the right kind or the appropriate amount of treatment was given. To the extent that treatment is provided but not documented in client records, as ADAMHA said sometimes occurs, it becomes impossible to determine whether appropriate treatment is provided.

NIDA's distribution of a recordkeeping manual is a forward step. However, we believe that NIDA needs to increase

its efforts to persuade State authorities, whom NIDA relies on to monitor the adequacy of providers' records, to require that providers use this manual or its key elements.

It was apparent that providers and States gave other demands and activities higher priority than self-evaluation. Providers were not implementing the provisions of the self-evaluation manual, and NIDA representatives and State officials were minimally familiar with it. NIDA expected that the self-evaluation process would be simple and inexpensive, and would not require any training or other assistance.

However, we believe that personnel at many providers, as well as NIDA and State staffs, will require training and technical assistance in self-evaluation. Further, although NIDA has expanded the provisions of its grants to require the States to have specific evaluation plans, based on our discussions with various providers, we believe that providers may not perform followup and self-evaluation because of the perceived or actual lack of funds. An adjustment of the slot cost ceilings, discussed previously, might provide the needed funds.

Many studies conclude that 21-day outpatient methadone detoxification is relatively ineffective. Several of these studies have concluded that this treatment is more effective when combined with a longer term treatment process. These and other studies also conclude that a longer term detoxification period would be more effective.

We believe that NIDA should require that providers offering outpatient methadone detoxification integrate that treatment into a longer term treatment process. Also, if ongoing studies demonstrate that detoxification would be more effective if a longer treatment period were permitted, a request for legislative authority to increase the amount of time available for treatment should be made.

We disagree with NIDA's position that it needs to make outpatient drug-free treatment available to those who request it. While a provider's counseling staff needs to consider the desires of a client in selecting appropriate treatment, there is no requirement that such desires be met. More importantly, NIDA needs to assure that its funds are used for the most effective treatment method.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary require the Director of NIDA to:

--Increase the minimum required number of monthly client contacts and establish criteria defining what should be considered as contacts.

--Establish slot cost ceilings that more equitably consider differences in treatment methods, geographic area, and other relevant factors that affect the cost of providing treatment services.

--Increase efforts to convince the States to require providers to keep adequate treatment records by (1) developing minimum requirements for the content of client treatment files based on the key elements contained in the client recordkeeping manual and (2) increasing efforts to train State and provider personnel in establishing and maintaining adequate client files.

--Enforce the requirement that providers perform self-evaluation and followup.

--Require that providers offering outpatient methadone detoxification incorporate it into a longer term treatment plan.

--Assess the validity of the Drug Abuse Reporting Program study's conclusion that placing daily opiate abusers in outpatient drug-free programs is ineffective, to determine whether NIDA should discontinue its support for this form of treatment.

AGENCY COMMENTS AND OUR EVALUATION

In a draft of this report we made a number of proposals to HEW. HEW generally agreed with the intent of several of our proposals and advised us of various techniques it plans to use to upgrade the treatment program for drug abusers. HEW disagreed with our two proposals dealing with the funding of 21-day detoxification and outpatient drug-free treatment for daily opiate abusers. (See app. I.)

We proposed that NIDA increase the minimum required number of monthly client contacts and require a minimum amount of time for each contact. HEW stated that the issues of quantity and quality of client contacts are complex, and it does not believe that requiring an increase in the minimum amount of time for each contact would result in decreasing unfavorable separations and recidivism. HEW added that the requirements for minimums do not take into account the differences in personnel or treatment approaches; it believes that better results can be achieved by using incentives to encourage an increase in the effectiveness of client-counselor contacts. HEW expects to have a system of incentives tested and implemented by early 1982.

We have reconsidered our proposal that a minimum amount of time be required for each contact. We recognize that the quality of the sessions is more important than the length. However, because of our concern that NIDA does not specify what constitutes a contact for treatment purposes, we are recommending that NIDA establish criteria defining what should be considered as contacts.

While we recognize that an incentive system will help increase client contacts, we understand that the system will not replace the present once-a-month minimum contact requirement. We continue to believe that an increase in the required minimum number of contacts with a client is needed.

HEW concurred in principle that attention should be given to the slot cost ceilings and stated that its plans to implement incentives in early 1982 may lead to meeting the intent of our recommendation. In its reply, HEW emphasized that (1) ceilings are a means of estimating the Federal investment in treatment services and of containing escalating treatment costs to the Federal Government, (2) NIDA never intended to fund the total cost of drug treatment services, and (3) ceilings are not intended to relate to actual treatment cost.

We did not mean to imply that NIDA should pay the full cost of treatment or that ceilings were not a means of containing escalating treatment costs. We recognize that NIDA must operate within an established annual budget, and we thus addressed our recommendation to geographic and other inequities in the ceilings. These inequities will not be corrected by the proposed incentive system since the incentives would merely add reimbursements for services provided in addition to the

minimum requirements. We continue to believe that HEW needs to establish more appropriate slot cost ceilings and have revised the wording of our recommendation to clarify our intent.

HEW concurred with the part of our recommendation addressing the need for better client records, but advised us that, while NIDA cannot increase its training efforts, it will continue to provide resources to the States to train treatment program personnel in establishing and maintaining adequate client files. The client record requirements of NIDA's funding criteria will be strengthened in fiscal year 1980, but HEW expressed concern that our proposal for overall required content and format would duplicate other funding sources and create additional burdens on the treatment providers.

As shown by our review, providers' recordkeeping (which aids the counselor and the clinical supervisor and provides accountability for services rendered) needs to be improved. We believe that HEW's proposed action to strengthen the requirements for client records would, if properly implemented, carry out the intent of our recommendation, and we have deleted that part of our proposal suggesting a required format.

Although HEW did not explain why NIDA cannot increase its training efforts, we believe that the new client record requirements, incorporated into NIDA's program for training State and provider personnel, will help NIDA reach the objective of better records. We also believe that NIDA's grant project officers, who are expected to make at least three visits to the grantee (the State agency) each year, by providing technical assistance, will play an important part in helping to train State and provider personnel.

In a draft of this report, we proposed that providers be required to use a percentage of their budget for self-evaluation and followup. However, HEW advised us that NIDA requires such evaluation but believes that providers should have flexibility as to the amount to be spent. Other information contained in the HEW response had been considered in preparing the draft report. We had expected NIDA's formal study, originally scheduled for completion in September 1979, to provide a basis for improving providers' procedures for self-evaluation and to show, as did our review, that some providers believe the funding for self-evaluation is inadequate. NIDA estimates that this study will be completed in the summer of 1980.

Based on HEW's response, we have revised our proposal and are recommending that NIDA enforce its requirement that self-evaluation be performed by providers. In implementing this recommendation, NIDA might (1) consider requiring that proposals from providers include a budget for self-evaluation and (2) assure that the State agencies (the grantees) appropriately monitor the use of the self-evaluation budget.

In our draft, we proposed that the Federal funding of outpatient methadone detoxification be suspended pending a determination of how much longer than the current 21-day period is appropriate for this type of treatment. HEW disagreed with that proposal and stated that it believes that detoxification is a necessary initial step in the treatment process, that it should not be equated with more extensive psychosocial treatment programs, and that its objective is to stabilize the individual who has been dependent upon drugs, thereby facilitating further treatment for the person's chronic condition.

In view of the various studies showing the ineffectiveness of outpatient detoxification as presently administered and the opinions expressed by various program administrators and treatment providers, we continue to believe that NIDA is not making the best use of its treatment resources by funding 21-day outpatient detoxification as a separate form of treatment. We believe that, until the period is lengthened or until detoxification is made part of a more comprehensive type of treatment, the evidence (such as cited on pp. 41 to 44) supports the view that NIDA should use its limited resources for more effective types of treatment. We agree with HEW that outpatient detoxification can be the first step in the treatment process, but we believe that it should be integrated into a longer term treatment process. We have revised our recommendation accordingly.

Although HEW said it does not concur in our recommendation to assess the Drug Abuse Reporting Program conclusion about certain daily opiate abusers, it said that NIDA made an assessment, which showed that NIDA's policy of funding outpatient drug-free treatment for daily opiate abusers should be continued.

We discussed the HEW response with (1) one of the NIDA representatives who made the assessment, (2) the NIDA Director, and (3) the director of the Institute conducting the

long-term study. In our followup, we were advised of data being analyzed from a 1977 data base and from the long-term Treatment Outcome Prospective Study which started in 1979. 1/ These officials advised us that the length of time in treatment, as well as more current data on daily opiate abusers, is being analyzed and the results of the analysis should be used in any decision concerning NIDA's support for outpatient drug-free treatment of daily opiate abusers.

Although HEW said it disagreed with our recommendation, we believe that the actions it is taking are responsive to, and in accordance with, the intent of our recommendation and will assure that attention will continue to be directed to this matter.

1/See p. 72 for background data on this study.

CHAPTER 4

NIDA SHOULD UPGRADE THE TREATMENT SYSTEM

NIDA should upgrade the quality of the nationwide treatment system because various segments of the system have weaknesses that hamper NIDA's efforts to (1) provide quality treatment to drug abusers and (2) effectively use Federal funds. Specifically:

--The funding method does not contain adequate incentives to ensure that funds are used as intended.

--The funding criteria are incomplete, and segments are vague and/or unenforceable.

--Implementation of credentialing programs for counselors has been slow.

--The term "successful completion" of treatment is inadequately defined.

--The dissemination of the results of evaluation research has been slow.

CHANGES NEEDED IN FUNDING METHOD

NIDA needs to change its method of funding treatment services to assure that Federal funds are spent more efficiently and effectively. The funding method, as presently administered, does not provide incentives for programs to deliver treatment services to the greatest possible number of high-priority drug abusers or to deliver all the services these clients may need. Whether these problems require a new funding method or changes to the existing method would depend on whether the slot funding method could be changed sufficiently to assure that maximum quality and quantity of care are given to the highest number of priority drug abusers. Chapters 2 and 3 discuss several problems that we believe are related to the slot funding method. These include:

--Many treatment slots go unused. (See p. 19.)

--Many abusers are reported as served who are not being served. (See p. 22.)

--Empty slots encourage providers to accept inappropriate clients. (See p. 13.)

--Counseling sessions are infrequent. (See p. 29.)

--Slot cost ceilings are inconsistent with actual costs. (See p. 34.)

In a September 1978 publication, the National Association of State Alcohol and Drug Abuse Directors summarized their views on the problems of slot funding by stating that it (1) gives only very imprecise cost information on which to base financial management decisions, (2) fails to clearly state what treatment services are being provided to whom at any specific time, or over a period of time, (3) lacks a precise mechanism to ensure service delivery accountability, and (4) permits or encourages minimum contacts with a client and/or loose standards for client care.

Whether to continue using slot funding has been a question before NIDA for some time. For example:

--In the summer of 1977, we discussed the issue with NIDA officials because of our concern that the funding method may not be effective in assuring that funds are expended in the most efficient and effective manner.

--In a 1977 article in the American Journal of Drug and Alcohol Abuse, a member of HEW's National Advisory Council on Drug Abuse explained that slot funding tended to penalize programs that want to do a quality job and reward programs that play the numbers game (i.e., keep slots filled to maintain funding).

--In its January 1978 report, NIDA's management consulting firm addressed concerns about slot funding.

--In February 1978, the Panel on Psychoactive Drug Use/Misuse, President's Commission on Mental Health, concluded that a fundamental reappraisal of the quality of drug treatment services was necessary, in part because of its concern that slot funding neglects the quality of treatment.

--In March 1978, the President's Office of Drug Abuse Policy recommended evaluation and, if feasible, adoption of a new funding mechanism.

In responding to concerns for greater accountability, NIDA has funded a number of efforts to develop procedures for reimbursement closely related to the quality and quantity of care actually given to the drug abusers.

In fiscal year 1978, NIDA paid about $140,000 for a feasibility study of unit and episodic costs of treatment. The contractor concluded that, generally, the study demonstrated the feasibility and mechanics of compiling unit costs to fund drug abuse treatment services. The report stated that:

--A standardized list of services can be generated that applies to different programs and modalities, but the definition of service varies greatly.

--Direct labor costs can be reasonably allocated to service units by using a discrete time study.

--Donated services can be reasonably valued.

However, the contractor's report explained that (1) although accounting systems usually allow accurate distribution of indirect costs, certain types of program organizations may create accounting problems and (2) even within a single treatment modality, service unit costs varied greatly with the programs studied.

During fiscal year 1979, NIDA's management consultant firm began a multiphased study to compare the advantages and disadvantages of the existing treatment slot system and possible alternatives, including the unit of service system. Based on data developed during the early phases of the study and on the firm's recommendations, NIDA plans to begin field testing an alternative funding concept during fiscal year 1980. This concept is a hybrid of the treatment slot system and the unit of service system.

Under the new concept, NIDA would still fund a set number of treatment slots at a given provider. However, the funded amount would be composed of two segments. The base amount would cover certain services required of all providers, such as screening, intake, and admission services and one face-to-face contact per month. Additional funds would be provided based on the increased services the provider delivers to or on behalf of the client. The total amount of Federal funds provided would be subject to the same slot ceilings and participation ratios currently used by NIDA.

NIDA also awarded a 3-year grant in September 1978, at an estimated cost of $290,000, to the National Association of State Alcohol and Drug Abuse Directors demonstrating, from a State management perspective, whether the unit of service method will result in better drug treatment. This study defines better treatment as providing a greater quantity and more effective delivery of services.

Several States use the unit of service method to fund their programs. Under this method, programs are reimbursed for the cost of service provided to the drug abuser. The advantages claimed are (1) overcoming clinical and financial management accountability problems and (2) meeting third-party reimbursement requirements and thus helping the provider obtain reimbursements. However, some identified disadvantages are more paperwork, higher cost of monitoring, and possible funding instability for some programs.

In May 1979, Illinois officials advised us that the unit of service method would require an undue administrative burden. However, they agreed that the present funding method does not give providers sufficient incentives to treat the greatest number of drug abusers or to provide the services clients need. The State agreed with NIDA's plan to test additional funding methods before a decision is made to change the method.

In September 1978, responding to the President's Office of Drug Abuse recommendation for a new funding method, HEW stated that any new or revised method would probably not be implemented before fiscal year 1980. ADAMHA advised a Senate subcommittee in April 1979 that NIDA hopes to complete its assessment and implement any changes or establish a new funding method in September 1981.

FUNDING CRITERIA FOR CONTROLLING THE OPERATION OF PROGRAMS SHOULD BE CLARIFIED AND UPGRADED

Portions of NIDA's funding criteria are so vague they cannot be uniformly interpreted and/or enforced. Also, important issues which we believe are necessary for quality drug abuse treatment programs are not adequately addressed in the funding criteria. Chapters 2 and 3 discuss other problems we noted in the criteria regarding admission, minimum level of counseling, and client recordkeeping.

Upgrading the criteria will better assure the operation of quality programs and should improve the quality of treatment. As a basis for upgrading, NIDA can use (1) the results of program operation under the criteria, (2) studies related to the criteria, and (3) criteria developed by individual States.

The funding criteria are part of NIDA's policy to assure that drug abusers receive quality treatment. The criteria establish minimum requirements for operating federally supported drug abuse treatment programs. The main elements of a treatment provider's operation covered by the criteria are:

--Admission and discharge policies.

--Acquisition and use of client data, including the development of treatment plans and maintenance of client records.

--Provision of medical services, including physical and laboratory examinations.

--Provision of client counseling and supportive services, such as education, legal assistance, vocational rehabilitation, and job placement.

--Procedures for urine monitoring.

--Hours of program operation.

NIDA requires that providers meet these minimum operating criteria to receive funds because, in their view, they represent established levels of program performance achievable by all drug treatment programs. At the time they were published, NIDA indicated these criteria would provide needed controls on how Federal funds were spent and provide guidance to the nonprofessionals who staff many of the federally funded treatment providers.

However, portions of the criteria are vague. For example, NIDA-funded outpatient treatment programs must "make available" a minimum of 3 hours of formalized counseling per week for each client. Similarly, residential and day care programs must "make available" 10 hours of formalized counseling per week for each client. NIDA personnel responsible for monitoring this requirement could not define "make available" and agreed that the requirement is unenforceable.

Comparison of selected criteria

To assess how well NIDA's criteria deal with treatment quality, we compared them to standards developed by an independent organization and several States.

In 1975 the Joint Commission on Accreditation of Hospitals issued a set of standards for drug abuse treatment programs. NIDA participated in the development of these standards 1/ and informed the States and providers that the Commission's standards might become the new Federal funding criteria. NIDA officials explained to us that such a plan was dropped because the Commission's standards, especially those relating to physical facilities, were not totally achievable at that time for many providers.

We made a comparative analysis of selected elements in NIDA's criteria and the Joint Commission's standards. Our objective was to determine the extent to which the Commission's elements were addressed by NIDA's funding criteria. We selected Commission elements from four main topics that seem to relate to the quality of care: program administration, personnel, intake and assessment procedures, and community linkages. In making these selections, we spoke with NIDA personnel and other drug abuse treatment specialists.

Our analysis showed that several Commission standards exceeded the requirements of NIDA's funding criteria, while others dealt with program elements not found in the criteria.

Program administration

NIDA officials told us that good program administration contributes to a stable and well-run program, which would be more likely to provide quality care. While NIDA's criteria do not address program administration elements, the Joint Commission standards require programs to (1) be controlled by a governing body with ultimate authority for the program, (2) be operated by an executive director appointed by the governing body and having overall management responsibility for the program, (3) have written policies and procedures for fiscal management, personnel (including staff development), and maintenance of client records, and (4) continuously evaluate the quality of services, using explicit and measurable criteria.

1/The President's Special Action Office for Drug Abuse Prevention and NIDA paid about $650,000 for these standards.

Personnel

NIDA's criteria require that each program provide the necessary personnel for operating a drug abuse program. However, they do not specify the type of necessary personnel. The only requirements are that a licensed physician serve as medical director, that client counseling be conducted under the supervision of a "qualified professional," and that mental health consultation to a program be provided by a "qualified mental health professional."

The Joint Commission's standards list 11 distinct client service components and, except for the crisis intervention component, require that each be headed by a qualified coordinator. The standards specify which of these components are required for the different types of treatment programs. For example, a comprehensive residential rehabilitation program would be required to have nine client service components and the appropriate qualified personnel.

Further, the Commission requires that a staff development program be established and include on-the-job training, in-service education, and opportunities for continuous job-related education.

Intake and assessment

NIDA's criteria and the Joint Commission's standards are more closely aligned in their requirements for client intake and assessment procedures than any of the other major topics we included in our comparison. For example, they have similar requirements for administering physical examination and laboratory tests and obtaining medical and drug use histories on each client. Similarly, assessments of each client's social and family background and educational, vocational, and criminal histories are required by both sets of standards. This information is necessary to assess the client's status and treatment needs.

Our comparison showed, however, that, while NIDA's funding criteria state that a personal history, including all of the above categories, must be obtained and kept up to date, it does not specify the types of information to be gathered. The Commission's standards are much more explicit in detailing the information needed for these data categories. For example, the requirements for a client's social assessment include information relating to home environment, religion, childhood history, financial status, drug and alcohol use among family members, and reasons for seeking treatment.

Community linkages

Our comparison of community linkage requirements show that, like the intake and assessment requirements, the Joint Commission's standards are more explicit than NIDA's criteria. NIDA requires that programs use community resources, to the extent possible, in providing educational, vocational, and job development services. In contrast, the Commission lists specific types of facilities, community groups, and individuals that programs should contact to establish at least informal working relationships in providing mental health, legal, social and vocational services. For example, the Commission standards list community resources that can be used to expand mental health services to clients, including

--community mental health centers and

--psychiatrists, neurologists, clinical psychologists, and other mental health specialists as necessary.

Other aspects of our assessment

NIDA was asked to assess certain elements we selected from the viewpoint of (1) whether the selected Joint Commission standards contributed to quality care and (2) what it would cost the providers to implement the standards. In a November 27, 1978, letter, the NIDA Associate Director for Program Operations agreed that the Commission's standards are likely to be related to the delivery of quality care. He explained that some standards could be expensive to implement but that others would not.

During our fieldwork, we asked California, Illinois, and New York officials 1/ whether the selected standards were important, and to what extent providers in their States were meeting them. These officials said that most of the selected standards were important to quality care in program operations. We were advised that providers in these States are required to meet some of the selected standards under State licensing regulations. Of 49 selected standards we presented to Illinois, its providers were required to meet 29.

The Deputy Director of the Joint Commission's Accreditation Council for Psychiatric Facilities advised us that more

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1/As noted on p. 11, about 33 percent of the total NIDA-assisted slots are in these three States.

than one-fourth of the drug abuse treatment providers could meet the Commission's standards. He cited the documentation of counselors' services to clients and the need for counselor in-service training as major concerns needing correction by other providers. The Commission's accreditation specialist told us that many Commission standards could be incorporated into NIDA's criteria without costing the provider even the price of one outpatient treatment slot.

NIDA's policy for several years has been to accept State standards that are at least equivalent to the Federal criteria. Through July 1979, NIDA has approved, in lieu of the Federal criteria, the standards of only six States. According to NIDA officials, these States' standards go beyond the requirements of the Federal criteria. For example, the NIDA-approved Illinois State standards exceed the Federal criteria in several areas, including the scope of counseling activities, program evaluation, client followup procedures, and client referral systems.

At our request, a NIDA official analyzed 17 States' standards that NIDA had received but not yet approved. As shown below, some of the Joint Commission's standards were met by a number of the States.

Type of standard	Number of States meeting the standard
Governing body	12
Executive director	10
Staff development	13
An annual financial audit	9
Program evaluation	8
Policy and procedures manual	10

The States monitor their treatment providers against the funding criteria, and NIDA monitors providers directly funded by NIDA. NIDA's management consulting firm routinely reviews the providers' compliance with the criteria during its program management reviews. Periodic feedback from these sources could be used to evaluate, clarify, and upgrade the funding criteria.

Action by NIDA

In April 1979, ADAMHA reported to a Senate subcommittee that NIDA had taken several actions to upgrade the quality of treatment. The first action was revising requirements for grants to the States in 1979. 1/ The revision included more stringent and/or explicit requirements for client records, program staff training, program evaluation, and community linkages.

In a February 19, 1979, letter to program directors, NIDA strongly encouraged providers to seek accreditation from the Joint Commission. NIDA advised the directors that Commission accreditation of their program would be accepted in lieu of NIDA's criteria. 2/ This letter reiterated NIDA's earlier endorsement of the Commission's standards.

However, ADAMHA's Administrator advised a Senate subcommittee that NIDA did not believe it was appropriate to reconstruct its funding criteria and thereby superimpose another set of standards on treatment personnel. They hoped to exert the necessary level of control through measures associated with its funding method. We disagree. Upgrading the criteria and putting all the minimal funding criteria in one document should help the providers and the monitors assure that all requirements are being met.

SLOW PROGRESS BEING MADE IN CREDENTIALING COUNSELORS

Drug counselor competency is vital to proper treatment. However, mandatory licensure, certification, registration, or other forms of credentialing have not developed in the drug abuse treatment field nationwide. A national credentialing system does not exist, and as of May 1979, only 15 States had credentialing programs in operation. NIDA needs to increase its efforts to help States develop competency-based credentialing programs. Such programs could not only allay public doubts about counselors competency but also help

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1/In fiscal year 1979, NIDA began using the grant process (see p. 8, note 1).

2/As of February 1979, 23 clinics in 17 NIDA-funded treatment programs have been accredited by the Commission. Over 1,500 programs are supported by NIDA funding.

--improve quality of care,

--obtain third-party reimbursements for providers, and

--expand employment potential, particularly for paraprofessionals.

Generally, a breadth of skills is desirable when rehabilitating drug abusers. While some of these skills require education and training, others may best be developed from an individual's experience and background. Section 501 of Public Law 92-255 states that NIDA's program should be administered to encourage the broadest possible participation of professionals and paraprofessionals. The following table shows the number of professional and paraprofessional counselors in the three States we visited and nationwide.

State	Professional counselors (note a)	Paraprofessional counselors (note a)	Total counselors	Total paid staff
New York	855	915	1,770	4,320
California	620	800	1,420	2,970
Illinois	155	260	415	785
Total	1,630	1,975	3,605	8,075
Nationwide total	7,010	6,265	13,275	b/35,640

a/As used in this report, professional counselors are those with degrees in drug abuse treatment related fields and paraprofessional counselors are those without such degrees.

b/In addition to the paid staff, NIDA reports that there were 7,260 volunteer employees, including 960 professional and 3,075 paraprofessional counselors.

Credentialing identifies and grants recognition to workers in a given field who meet certain predetermined qualifications and standards. It helps to ensure that workers have at least the minimum levels of skill necessary for competent performance. Most officials with whom we spoke felt that credentialing the counseling staff would improve quality of treatment and expand career employment potential, especially with reciprocity between States.

Our review did not include an extensive examinati the current status of credentialing. However, we did i a number of key issues needing resolution before a nati credentialing system can be developed.

--Although there is apparently some agreement about types of basic skills and knowledge that a counsel must possess, there are still no generally accepted methods to measure whether an individual possesses these skills and is capable of using them competently.

--Studies have shown that the basic skills and knowledge possessed by different types of counselors generally overlap. A major unanswered question is whether a separate credentialing system is needed for each specialty area or whether a basic system should be developed to evaluate common knowledge and skills needed by all types of counselors, with specialized requirements testing the competency of individuals to function in specific areas.

--A third issue involves the placement of credentialing authority. Traditionally, the States have assumed credentialing responsibility with the national role limited to developing credentialing models, providing technical assistance, and conducting research. This system has resulted in a wide range of credentialing methods and criteria, problems in reciprocity among the States, and in a few States, the lack of any involvement with credentialing. Although a national credentialing program could resolve the issues, it would probably be viewed as an infringement on States' rights.

NIDA's approach to the credentialing issue has followed the traditional model. Emphasis has been placed on the States' responsibility to develop their own credentialing mechanisms. NIDA's primary role has been to provide States with technical assistance and to encourage State cooperation in the development of training programs, credentialing models, and reciprocity agreements. Emphasis has been placed on collaborative efforts among the States and between the States and NIDA.

NIDA's activities are conducted by its Manpower and Training Branch, which administers the State Training Support Program. Through this program NIDA helps the States identify manpower training needs and resources, establish

.ds, and evaluate training programs. An important ement has been the development and accumulation of ıental training modules. These modules focus on spe- skills needed by drug abuse workers. A State or an /idual can choose which modules meet current training s and develop certification systems for specific sets ıodules addressing a specific type or level of worker competence. Vertical and lateral career mobility (that is, promotion potential and geographic mobility) can be enhanced by successfully completing additional sets of modular training courses.

Another achievement of NIDA's efforts has been the development of a data exchange network among the States. Through a microfiche system, the States are able to identify and share training and credentialing resources. We believe this system also facilitates the development of reciprocity agreements among the States.

Although NIDA has been concerned with drug abuse worker training programs since about 1973 and the credentialing process since about 1975, implementation of State credentialing programs has been slow. According to NIDA, as of May 1979, credentialing systems were operating in 15 States and had been developed in 4 others. Five of these systems were mandatory--all drug abuse counselors working in the State must meet the State standards. The two States with the largest number of counselors (California and New York) do not have--or know when they will have--credentialing programs.

Although California does not have a credentialing program, the following exerpt from its 1978 drug abuse prevention plan is pertinent to the credentialing issue:

"There is mounting evidence that a credentialing system for drug abuse workers is essential. Some factors pointing to this conclusion are:

--Increased pressure for programs to develop third party payments for drug related health care;

--Anticipation that with the development of National Health Insurance will come the requirement that workers prove they can perform their jobs effectively;

--A need for increased quality of care and staff excellence;

--For ethical considerations; minimal standards are needed to insure a quality control mechanism in the field; and

--Astronomical rate increases in Workmen's Compensation Insurance are driving programs out of business, and endangering all small programs."

In a March 1978 report, the President's Office of Drug Abuse Policy recommended that NIDA help the States upgrade paraprofessional skills permitting them to obtain appropriate credentials. A May 1978 report by ADAMHA recommended national standards to not impede geographic mobility. The President's 1979 Federal Strategy for Drug Abuse Prevention called for paraprofessionals to be developed and fully used.

NEED FOR STANDARD FOR DEFINING SUCCESSFUL COMPLETION OF TREATMENT

Although NIDA reports that about one in five clients complete treatment, there is no generally accepted standard for defining successful completion of treatment. Essentially, providers are the judges of "successful completion." Since no uniform definition exists, there is no adequate answer to the question of how many complete the treatment given by providers. The number of people completing treatment may be more, or less, than the number reported by NIDA.

Section 406 of Public Law 92-255 requires HEW to gather and publish statistics pertaining to drug abuse and issue regulations specifying the uniform statistics to be furnished. Information on clients in treatment is collected through NIDA's Client Oriented Data Acquisition Process--a mandatory reporting requirement. A clinic must complete a discharge report for each client, listing one of nine stated reasons. The nationwide discharge data for calendar year 1978 follow:

Reason	Clients discharged	
	Number	Percent
Quit	98,978	48.6
Completed treatment:		
No drug use	29,216	14.3
Some drug use	14,197	7.0
Noncompliance with rules	18,199	8.9
Transferred to another clinic within the program:		
In NIDA's reporting system	14,761	7.2
Not a part of the reporting system	1,001	.5
Referred outside the program for continued treatment	18,686	9.2
Incarcerated	8,080	4.0
Died	696	.3
Total	203,814	100.0

The percentage of those reported as completing treatment each year has changed very little from 1975 to 1978, as shown by the graph on the following page.

NIDA and the providers generally had adequate criteria for all but the completed treatment type of discharge. NIDA directed the clinics to record a completion when the client had successfully completed the prescribed regimen in the program and further treatment was not prescribed. The client could be using drugs before or at the time of discharge, but the drug use had to be judged as not constituting a problem.

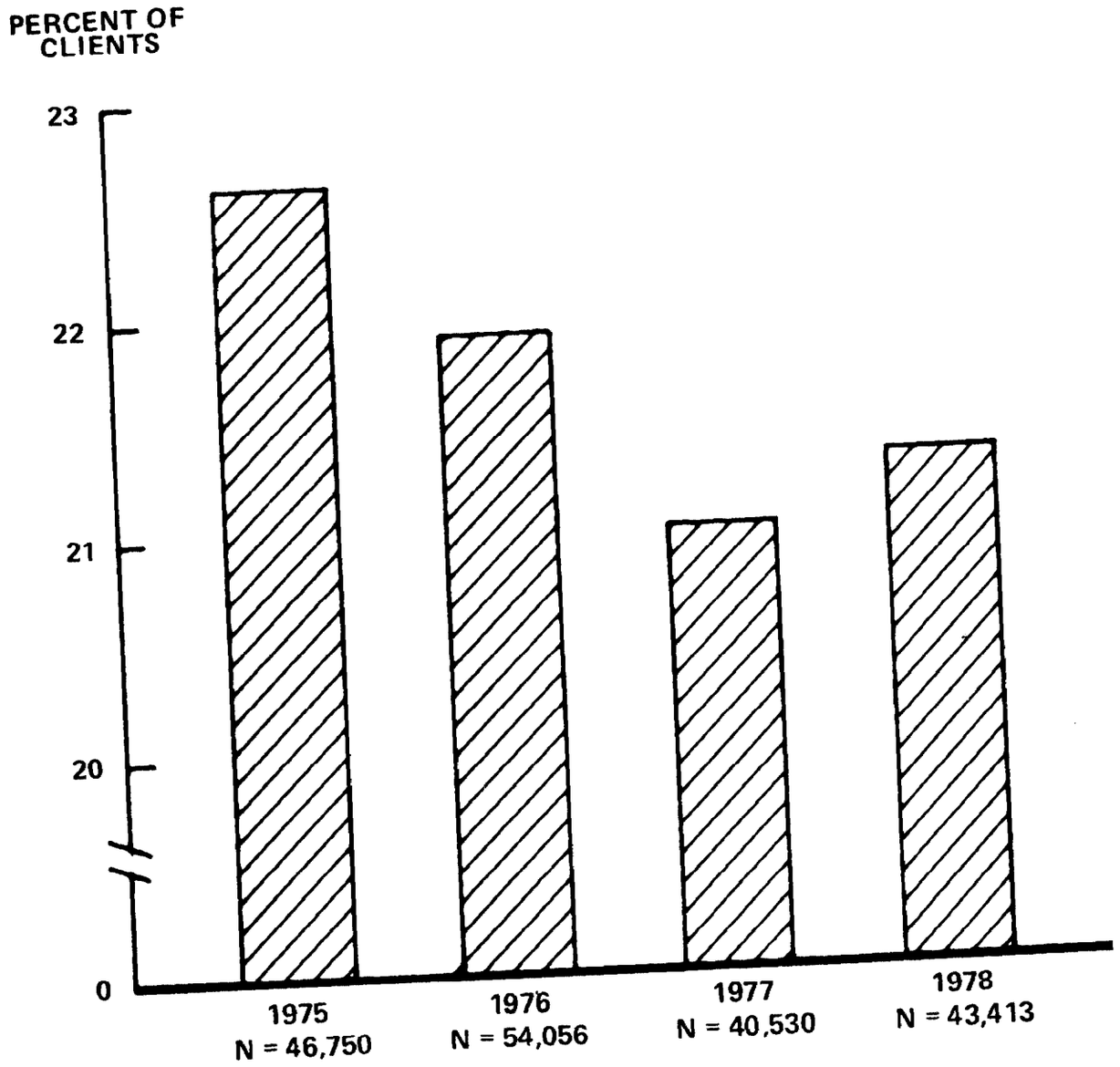
Part of NIDA's policy is that each clinic prepare a treatment plan for each client. NIDA requires that these plans include short- and long-range goals and ways of reaching them. The plans are developed with the individual's agreement.

In programs we visited, the definition of completed treatment varied widely. Some of the providers reported completions:

--When the client and staff "felt" the client had reached his treatment goals.

--On the basis of urinalysis.

CLIENTS COMPLETING TREATMENT
1975 – 1978



--When the client had made any progress toward the treatment goals, even if the client quit the program. 1/

--When the staff concluded the clients were ready.

--When the client scored a certain number of points in a system that considers various outcome measures, such as being free of drugs, having adequate interpersonal relations, and acquiring work-related skills.

We noted that Nebraska's guidance to its providers states:

"Criteria for successful completion of the program must include:

(a) the client must no longer be dependent for social activity upon those who use drugs. A vocational interest, recreation, social pursuits, and other behavior must become established in a socially acceptable fashion.

(b) The client must have assumed responsibility for himself and must have completed his treatment goals.

The degree to which a client meets the criteria for discharge must be documented in the final case review."

The June 1979 HEW Inspector General's report included a sample of the records for clients reported as completing treatment. The staff found that over 14 percent of the "completions" were for clients who (1) did not have a drug problem treated, (2) quit, (3) were discharged for noncompliance with program rules, or (4) transferred to other programs.

Since the subject of discharge reporting is not covered in the reports on reviews done by NIDA's management consulting firm, we asked an official if the subject was examined. He stated that the firm did not test the reporting of discharges by the providers.

1/Using this definition, the provider reported a completion rate of 42 percent for the 18 months ended June 30, 1978--the national average for 1978 was 21 percent.

RESEARCH SHOWS TREATMENT WORKS FOR SOME ABUSERS BUT DISSEMINATION OF THESE RESULTS IS SLOW

Longitudinal evaluation research 1/ shows that outpatient methadone maintenance and residential drug-free programs (therapeutic communities) are successful methods for treating opiate-addicted males. This research, as well as a longitudinal study just begun, should help NIDA eventually determine which treatment methods work for which clients. Disseminating research results to clinicians and others has been slow, and the material has been difficult for non-researchers to understand.

NIDA funds long-term treatment evaluation research to help provide accountability for Federal funds and to help answer questions on which treatment method works for which clients and when. Two major studies are the Drug Abuse Reporting Program and the Treatment Outcome Prospective Study.

The Drug Abuse Reporting Program

The Drug Abuse Reporting Program, a large-scale study, focuses on the effectiveness of four types of treatment. 2/ The evaluation is conducted by the Institute of Behavioral Research at Texas Christian University, Fort Worth, Texas. Through fiscal year 1978, NIDA allocated about $3.5 million for the study. NIDA estimated that about $224,000 would be allocated in fiscal year 1979 to complete the project.

Information was obtained from 52 treatment centers for about 44,000 clients admitted between June 1969 and March 1973. Some of the results from the study of in-treatment performance for 44,000 clients and a subsample of 3,100 clients have been published. Followup data were obtained mainly by interviewing a sample of clients. The most significant findings published, as of March 1979, have centered on a stratified random sample of 2,178 black males and white males admitted to treatment between 1969 and 1972.

1/Longitudinal research collects information on the same subjects at different points in time. Such a study allows a measurement of change in the subjects over a period of time.

2/Residential drug free and outpatient methadone maintenance, drug free, and detoxification. These types of treatment include over 90 percent of the slots supported by NIDA funds.

The treatment population from these 3 years did not include enough men from other ethnic groups, or enough youths and women, for a scientific sample. Data covering a statistical sample of clients admitted in 1972 and 1973 should be available in late 1979 and will be more inclusive.

The number of men in the random sample in each type of treatment was:

Type of treatment	Number in sample
Methadone maintenance	821
Therapeutic community	735
Drug free	289
Detoxification	174
Intake only (note a)	159
Total	2,178

a/The Institute included, for comparison purposes, a group of men who were admitted but quit before receiving any treatment.

In general, the studies reported highly favorable results for clients who had received treatment in methadone maintenance, therapeutic community, and outpatient drug-free programs, while the results for outpatient detoxification programs and the comparison group (intake only) were significantly less favorable. As discussed in chapter 3, the study concluded that outpatient drug-free treatment for daily opiate abusers was ineffective. Further, the favorable results for methadone maintenance and therapeutic community were limited to the group of clients who were daily opiate abusers, 1/ while those in drug-free programs were limited to the nonaddicts group (users of nonopiates only or users of opiates on a less-than-daily basis, usually in conjunction with other drugs). However, because only a small sample of nonopiate users was available, the authors concluded that the 1972-73 data are needed to confirm the results of the study.

Basically, conclusions were drawn by comparing client profiles at admission and those developed 3 years after

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1/Heroin is the primary drug of abuse in the opiate classification.

discharge. Six performance criteria were used: opiate use, nonopiate drug use, alcohol use, criminality, employment, and return to treatment. Measuring the changes statistically, the study concluded that treatment works because there were significant, consistent, and specifiable changes in certain treatment situations that did not occur in other treatment or in nontreatment situations.

NIDA officials provided data from their reporting system which show that the characteristics of the opiate abusers admitted in 1977 were comparable to those admitted in the 1969-73 period.

The need for disseminating research results

Some answers to the questions of which treatment works, as well as other significant findings, have been published. NIDA officials believe that results of the drug abuse reporting program are significant and have many policy implications. However, NIDA has not fully used the results, and dissemination to others has not been timely or in a format to promote maximum use. For instance, one of the reasons providers are admitting so many daily opiate abusers to outpatient drug-free treatment may be that providers are not aware of or do not understand the results of the evaluation research. NIDA is trying many approaches to solve the dissemination problem, but progress is slow. According to a NIDA official, the dissemination of research results is slow because of the time required to analyze the results, rewrite it into laymen's language, and get it printed and distributed. This official pointed out that these problems are not unique to NIDA.

A principal method of disseminating research results is publication in scientific journals. However, appearing before a House committee in June 1978, NIDA's Deputy Director explained that between 18 and 24 months elapsed between the submission of material to a scientific journal and its publication. He added that conferences and other mechanisms were also used to communicate results.

In a speech before psychologists in September 1978, the Chief of NIDA's Services Research Branch discussed the difficulty in making findings available in a form useful to providers. He acknowledged that NIDA is responsible for developing mechanisms for sharing the knowledge gained through Government-funded studies, but noted that journals and conferences have not proven too useful for the clinician.

Our conversations with State and provider officials indicated that they too were concerned about prompt dissemination of research findings. They also requested, in the case of the Drug Abuse Reporting Program studies, that the material be written more clearly.

Concern for reaching people in the treatment field was shared by officials of NIDA and the Institute at Texas Christian University. The implications of the findings and the need for dissemination were discussed in a February 1979 conference, in which NIDA officials and other drug abuse specialists participated. As a result of the conference, NIDA is considering the use of the National Association of State Alcohol and Drug Abuse Directors' newsletter. They also plan to present the overall rates of treatment success in a general descriptive manner. Ongoing techniques, such as technical reports and scientific and professional journals, were endorsed by the participants.

One of the specialists explained that the biggest gap exists between what this information means to the experts at the meeting and what it means to people who need to know that treatment works. He also said the biggest single communication need is to distribute research results.

The Deputy Director of NIDA advised us in March 1979 that getting information to providers and to the public was still a problem. He explained that conferences, journals, periodic notices issued by NIDA's Services Research Branch, and a recently issued Handbook on Drug Abuse helped, but did not completely solve the problem.

In addition to better communicating the results of evaluation research to treatment providers and others, NIDA could use this information better to assure that it is funding the most effective forms of treatment. As discussed on pages 41 to 45, some forms of treatment were found to be relatively ineffective.

Treatment Outcome Prospective Study

The Treatment Outcome Prospective Study, the second longitudinal evaluation research effort, appears to be well designed and useful. While the study will provide some limited information about the actual process or quality of treatment, complete understanding of the effect of treatment is beyond the study's intended scope.

The study was initially planned in 1975 as a prospective study. 1/ It will collect data while clients are receiving treatment and at specific times after they leave treatment. Through fiscal year 1980, about $4.5 million will have been allocated for the study.

Data collection began in January 1979 and is expected to continue for at least 3 years. Twenty programs in six cities 2/ are participating in the study. The programs were selected to provide a geographic distribution of sites that have relatively stable, well-functioning treatment systems. NIDA hoped to begin collecting after-treatment data in January 1980.

According to NIDA, the Treatment Outcome Prospective Study has both policy and research objectives. Its policy objective is to provide valid, current information to help direct and refine NIDA's treatment efforts. The research objectives are to test treatment methods and to identify factors that may help determine why and for whom treatment does or does not work. The study will be used to generate new, more direct research and substantiate, on a broader scale, previous research results. Appendix IV is a list of some questions that NIDA expects to answer.

Our review of the study design and our discussion with NIDA officials lead us to conclude that the study will only indirectly deal with the treatment process. It will collect information from clients and client records regarding what types of services were received and will obtain the opinions of clients on their satisfaction with the services. It will also compile some general information about each treatment program. However, it will not detail the process of treatment for each client or directly assess the quality of treatment. NIDA's Acting Director explained that the study is a statistical model, which may not be applicable for a given individual.

1/A prospective study is one designed to collect data at specified times in the future. Such a study allows the data to be collected when events are occurring in the lives of the subjects.

2/Chicago, Des Moines, New Orleans, New York, Phoenix, and Portland (Oregon).

In the February 1979 conference at Texas Christian University (see p. 72), participants agreed that intensified study of the treatment process should be emphasized. The chairman of the conference told us in March 1979 that answering the question of why the treatment process works is still beyond the state of the art.

CONCLUSIONS

NIDA's present funding method does not provide incentives for providers to increase either slot use or the amount of services provided to abusers. NIDA customarily pays its share of the slot costs regardless of slot utilization rates or the frequency or length of counseling services provided to clients. Resolving these problems will require either substantially revising the present funding method or adopting a new method to assure that Federal funds are spent more efficiently and effectively.

Problems with the funding method were identified as early as 1977, but slippages in NIDA's planned study and implementation of a revised funding method have occurred. NIDA is planning to implement a revised method by 1982.

The Joint Commission standards we reviewed are much more specific than NIDA's funding criteria and, in many cases, address issues not in the criteria. In addition, individual States have adopted or proposed standards that go beyond NIDA's funding criteria.

We believe that NIDA should clarify and upgrade its funding criteria. Selected standards of States and of the Commission can serve as a basis for the revision. In our opinion, such an upgrading is consistent with NIDA's goal of ensuring a framework for quality treatment.

The significance of the counselor's role in drug abuse treatment and the size of the counselor work force (about 13,000 people in 1978) underscore the importance of competent staff. Credentialing programs could, in our opinion, improve quality of care, assist providers in obtaining third-party reimbursements, and strengthen career advancement opportunities for counselors, especially paraprofessionals. With reciprocity of credentials among States, the potential for employment in other geographic areas would be enhanced. A number of key problems need resolution before an acceptable credentialing system can be developed nationally. Although NIDA and the States have successfully collaborated in

developing drug abuse worker training programs, more could be done to address these issues and develop additional State credentialing programs.

In our opinion, NIDA should develop a body of knowledge regarding the effects of differing definitions of the term "successful completion" of treatment. Data obtained could be used as an aid in establishing a single standard to be applied by all providers in reporting successful completions in NIDA's nationwide reporting system. The various definitions currently used by providers not only result in questionable statistics, but also impede progress in determining which providers are models of successful treatment.

We believe that a single standard is necessary not only for good management but also to help meet the legislative mandate requiring HEW to issue regulations specifying uniform statistics. We believe NIDA should also expand the scope of its management consultant contract to include tests of the validity of reported discharge data.

Large scale, long-term evaluation research has shown that treatment works for some drug abusers. Such research is expensive; NIDA has allocated almost $8 million through fiscal year 1980 for two major longitudinal studies. Although the results of the evaluation research have been significant and have policy implications, NIDA needs to overcome dissemination problems so that the results can be more extensively used. One step that could be taken would be to require researchers to submit their research results in more easily understood language.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary require the Director of NIDA to:

--Assure that (1) the necessary evaluation procedures for the revised funding method are completed in a timely manner and (2) if proven successful, the revised method is implemented by early 1982.

--Upgrade and clarify the funding criteria.

--Increase NIDA efforts to (1) resolve problems impeding the development of drug abuse counselor credentialing programs and (2) encourage more States to implement credentialing programs and reciprocity agreements.

--Develop and issue a single standard to define a client's successful completion of treatment for reporting purposes.

--Require NIDA's management consultant to test client discharge information.

--Accelerate the efforts to disseminate and use the results of the longitudinal evaluation research.

AGENCY COMMENTS AND OUR EVALUATION

In a draft of this report, we made a number of proposals addressing the issues discussed in this chapter. HEW concurred in principle with four of our proposals, partially concurred with one proposal, and disagreed with one proposal. (See app. I.) In our draft report, we proposed that NIDA accelerate the funding method studies so that it can expedite the adoption of a revised method. HEW disagreed with our proposal, stating that NIDA has developed a potentially viable alternative funding method (see p. 54) but needs time for field testing to validate the study. This process should be completed by early 1981 and a revised funding method implemented by early 1982.

Our proposal was not intended to imply that field testing or any other necessary evaluation procedure should not be undertaken, but we are concerned about the length of time needed to adopt an alternative funding method. As discussed in this report, problems with the current funding method were raised in 1977, and HEW's first estimate for implementing a new method was fiscal year 1980 at the earliest. This estimate was later revised to September 1981 and now to early 1982.

Our recommendation emphasizes our concern regarding the timely implementation of a revised funding method. If the results of the field tests prove successful, we believe that a concerted effort by HEW and NIDA should achieve the target date.

HEW partially agreed with our recommendation to upgrade and clarify the funding criteria. HEW stated that NIDA is reviewing the funding criteria relative to the changing needs of the drug abuse treatment field as well as other management mechanisms, such as a revised funding method, that may be used to ensure that adequate levels of service are provided.

HEW believes, however, that upgrading the funding criteria will not necessarily enhance service delivery.

We agree that funding criteria clarification could result from an objective assessment of current and future trends in the drug abuse treatment field. NIDA initiated such a study in August 1979 when it asked the State drug abuse directors to provide suggestions for a revision of the criteria. HEW advised us that this study will be completed by early 1981. We also agree that a revised funding method based on incentives could act to increase the amount of services provided. However, we continue to believe that upgraded funding criteria could enhance service delivery, if new minimum levels of performance are properly established and enforced. As pointed out on page 56, the funding criteria are minimum requirements that must be met to receive NIDA funding. Upgrading these minimum requirements to a level consistent with the knowledge, growth, and sophistication achieved in the drug abuse treatment field could yield positive results. NIDA should use its reviews of the funding criteria and other management mechanisms to help identify elements of the funding criteria that could and should be upgraded.

HEW agreed in principle with our proposal regarding drug abuse counselor credentialing programs. HEW stated that NIDA does encourage States to develop credentialing systems and is developing national models that recognize worker competencies and career development possibilities. NIDA is also developing procedures to assure compatibility of State credentialing systems.

We have recognized in this report several achievements from NIDA's involvement with the credentialing process, including the development of worker competency evaluation programs. We believe such efforts should be continued and strengthened, especially in States, such as California and New York, having large numbers of drug abuse counselors but no credentialing programs.

HEW disagreed with our proposal to implement mandatory credentialing programs, stating that mandatory credentialing would probably be interpreted as licensing, which has not been the traditional role of the Federal Government with respect to health care providers. Based on discussions with NIDA officials and further analysis, we have concluded that emphasis by NIDA on mandatory credentialing may not be appropriate at this time. We believe, however, that NIDA should encourage the States to implement credentialing programs.

HEW concurred in principle with our proposals regarding the definition of successful treatment completion and the testing of client discharge information. HEW stated that defining successful treatment is a complex problem. It pointed out that a successful discharge from treatment reported through NIDA's management information system could include such characteristics of treatment as (1) meeting the client's and clinic's goals detailed at admission, (2) completing a prescribed treatment plan, (3) reducing drug usage, and (4) correcting a dysfunctional problem. HEW stated that all of these examples are used by clinicians in assessing when a discharge may be categorized as successful. HEW further stated that the primary responsibility for reviewing discharge data rests with the States and that NIDA will explore ways it can examine the States' performance and better focus the States' monitoring activities on this issue by early 1981.

As discussed on page 65, we recognize that defining successful treatment completion is a complex issue and we thus concluded that NIDA needs to establish a single standard. Also, as noted above, HEW's comments list several examples of how successful treatment completion may be determined. In view of the use of client discharge data reported by clinics to compile treatment completion statistics, particularly successful treatment completion rates, we believe this data should be reported using common criteria. We have revised the language of our recommendation to clarify our position.

We recognize the States' monitoring responsibilities for reviewing client discharge data and believe increased State efforts should enhance the quality of the data. We also believe, however, that NIDA's responsibilities require that specific attention be given to this issue by its own monitors and consultants charged with evaluating State program administration activities.

HEW agreed in principle with our recommendation regarding the acceleration of NIDA's efforts to disseminate and use the results of longitudinal evaluation research, but stated that NIDA will not reallocate resources for this purpose. HEW pointed out that NIDA is concerned with research utilization and has made this a priority area in which it encourages demonstration projects. HEW further stated that a publication strategy to assist utilization and dissemination of research findings has been developed.

In discussions regarding our draft report, NIDA commented that our report was lacking in detail regarding the information dissemination activities carried out by the Services Research Branch of its Division of Resource Development. NIDA stated that these activities include (1) capsule accounts of treatment models found to have efficacy, (2) a reports/monograph series that reports on treatment models found to have efficacy, as well as research findings with treatment implications, and (3) instructional manuals that describe ways in which innovative treatment programs can be implemented. NIDA further stated that it agrees with our conclusion that increased efforts are needed to use the results of all research that has treatment implications. It also pointed out that efforts have been made to highlight this as a problem for the drug abuse field and to stimulate resolution of the problem.

We believe that these efforts are responsive to the intent of our recommendation.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

REFER TO:

OFFICE OF THE INSPECTOR GENERAL

18 DEC 1979

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Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "More Drug Abusers Could Be Treated and Better Treatment Given If the National Institute on Drug Abuse Makes Funding and Program Changes." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Acting Inspector General

Enclosure

APPENDIX I

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "MORE DRUG ABUSERS COULD BE TREATED AND BETTER TREATMENT GIVEN IF THE NATIONAL INSTITUTE ON DRUG ABUSE MAKES FUNDING AND PROGRAM CHANGES"

General Comments

Implicit in the General Accounting Office (GAO) draft report is a description of the National Institute on Drug Abuse (NIDA) treatment program. The following information will assist the reader in understanding the uniqueness of the NIDA operation. In 1972 a nationwide community based treatment system for drug abuse did not exist. Seven years later there are approximately 400 programs encompassing approximately 1600 clinics supported in part by NIDA funds. In the course of structuring the national treatment system, NIDA:

- o introduced a slot concept which controls the amount it will pay for the various modalities;
- o introduced the concept of accountability for the utilization of these slots;
- o mandated a data system which would permit it to assess utilization of these slots;
- o strengthened the Single State Agencies (SSAs) to carry out their Congressional mandate to plan and coordinate drug abuse treatment within their States;
- o introduced a national treatment standard where none existed before;
- o developed a training system responsive to the needs of the treatment system rather than to the support of academic institutions and individual professions;
- o established minimum requirements and developed guidelines for recordkeeping and the content of client records;
- o worked diligently to get States to adopt their own treatment standards, brought into being Joint Commission on Accreditation of Hospitals (JCAH) standards in the field of drug abuse (where none existed), and urged treatment programs to become certified;
- o developed evaluation manuals that are amenable for use by a treatment program;
- o provided management analysis and technical assistance to treatment programs and to SSAs to assist them in upgrading their management capabilities;

- o provided technical assistance to all components of the NIDA treatment system to assist them in upgrading their administrative and treatment capability;

- o developed credentialing models for States to use in credentialing their workers and urged States to adopt credentialing programs.

Many of the GAO recommendations involve instructing, encouraging, pressuring, and requiring grantees to conform to the performance standards and criteria which we hold as necessary to the system's success. NIDA has been instructing, encouraging, pressuring, and requiring. Some of the results of these efforts to date, are criticized by GAO.

We agree that there is room for improvement. One of the reasons we are aware of areas that need improvement is that NIDA has developed data systems, management reviews, standards, technical assistance programs--all of which present information that enables GAO and ourselves to have some sense of what use is being made of the Federal drug abuse treatment funds. Based on these data, and the comments and recommendations provided by GAO, we are reconsidering a number of program areas.

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GAO Recommendation

We recommend that the Secretary of HEW require the Director of NIDA to:

"--Clarify and update the admission policy in the Federal Funding Criteria."

Department Comment

We concur in principle. As a part of NIDA's review of the Federal Funding Criteria (FFC) the admission policy will be clarified to indicate that individuals admitted to NIDA supported drug program treatment slots must have a primary drug abuse problem other than alcohol. NIDA will codify its policy statements on admission. However, NIDA believes that the concepts contained in the FFC admission policy and in its most recent policy statement relative to admission continue to be relevant and are not in need of updating. The review and codification will be completed by the second quarter of FY 1981.

"--Enforce the admission policy through such procedures as

(a) requiring its management consultant to test client eligibility, and

(b) increasing its monitoring of the admission data reported by providers."

Department Comment

We concur in principle. The SSAs have the primary responsibility for managing and monitoring treatment programs which NIDA partially funds. In this role, the SSAs enforce admission policy. NIDA, being accountable for the overall operation of the treatment programs, monitors the performance of the SSAs. NIDA will continue to provide technical assistance and guidance to the SSAs in fulfilling their responsibility.

Due to priority commitments, NIDA's management consultant cannot in this fiscal year, further test client eligibility. In NIDA's role of monitoring the performance of the SSA's, guidance is being developed for use by our Project Officers in more effectively identifying instances where admission policies are not adequately enforced. This guidance will be published by the second quarter of FY 1981.

"--Increase efforts to discourage the use of traditional drug abuse treatment for casual drug users and encourage the development of other alternatives to incarceration of casual drug users."

Department Comment

We concur. NIDA discourages the use of its funds for the treatment of casual drug users. NIDA has initiated efforts which include continuing technical assistance through project "Connection", five State pilot efforts to establish State Criminal Justice Coordinators, and the development of manuals which include initiatives for developing alternatives to incarceration. The last of these manuals will be completed by the fourth quarter of FY 1982.

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"--Evaluate reasons for the wide variance in slot utilization rates and apply the knowledge gained to increase overall utilization."

Department Response:

We concur. NIDA systematically evaluates reasons for variance in utilization rates. Quarterly reviews are conducted by NIDA which examine and evaluate the reasons for program variance in slot utilization. While the majority of reasons are idiosyncratic, NIDA provides guidance on common problems on an ongoing basis.

NIDA recognizes that additional emphasis should be placed on examining programs with high utilization rates. Toward that end NIDA will examine, on a sample basis, these programs to determine if characteristics exist which can be applied to increase utilization in other programs. This will be accomplished by the second quarter of FY 1981.

"--Increase monitoring to assure that providers report accurate slot utilization data."

Department Comment

We concur. NIDA is implementing a computer generated report on utilization which will be compared with utilization reported by programs. This information will be reconciled with the information reported by the programs. NIDA also is developing a manual for its Project Officers to use in monitoring statewide services grantees. This manual will delineate procedures to be used in validating utilization data. Through these means NIDA expects an improvement in the reporting accuracy of slot usage. These activities will be implemented by the third quarter of 1980.

GAO Recommendation

The Secretary of HEW should require the Director of NIDA to:

"--Increase the minimum required number of monthly client contacts, and require a minimum amount of time for each contact."

Department Comment

We partially concur. The issues of quantity and quality of client contacts are ones which NIDA is examining. These are complex issues, and we do not believe that requiring an increase in the minimum amount of time for each contact would result in decreasing unfavorable separations and recidivism as indicated by GAO. Requirements for minimums do not take into account the differences in personnel or the approaches involved in various forms of therapy. We believe that this result can be better achieved through the use of incentives to encourage an increase in the effectiveness of client-counselor contacts. We expect to have tested and fully implemented a system of incentives by the second quarter of FY 1982.

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"--Establish slot cost ceilings that better represent the actual cost of drug abuse treatment."

Department Comment

We concur in principle. Actions, when implemented, based on the previous recommendation, may lead to the accomplishment of this objective. However, treatment slot ceilings are both a means of estimating the Federal investment in treatment services, and a means of containing escalating treatment costs to the Federal Government. They are not intended to relate to actual treatment costs.

NIDA never intended to fund the total cost of drug treatment services. Any presupposition that higher ceilings would result in an improvement in the quality of treatment services we believe to be unfounded. The difference between total costs and Federal share is currently supplied by State and other monies. Increasing the ceiling could encourage supplanting State and other shares with Federal monies. It should be reiterated that slot funding is a means of estimating Federal grant amounts; it does not address actual costs.

"--Increase the efforts to convince the States to require providers to keep adequate records by

(a) developing minimum requirements for the content and format of drug abuse treatment client files based on the key elements contained in the client recordkeeping manual.

(b) increasing efforts to train State and provider personnel in establishing and maintaining adequate client files."

Department Comment

We partially concur. The FFC presently contain minimum requirements for content of client records. The FFC will be revised during FY 1980. During this revision, the requirements regarding client records will be strengthened. In addition, grantees are subject to record keeping requirements from a number of sources other than NIDA. We believe that the institution of an overall required format and content would be duplicative and would create additional burdens upon treatment programs. We have, however, increased efforts to examine and review various training materials on establishing adequate client files.

While NIDA is not able to increase its training efforts, it will continue to provide resources to States to train treatment program personnel in establishing and maintaining adequate client files. It will also continue to provide technical assistance to the States and programs in this area as resources permit.

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"--Require providers to use a percentage of their budget for self-evaluation and followup."

Department Comment

We concur in principle. NIDA is currently assessing--through formal study--the extent to which treatment programs are using evaluation materials, either developed by NIDA or other evaluation efforts, as part of their program. This study will be completed by the fourth quarter of FY 1980. Based on the outcome of this assessment, NIDA will make the appropriate program changes. NIDA currently requires that programs perform self-evaluation although a specific percentage is not made a requirement. Experience with self-evaluation indicates that flexibility as to the amount spent is desirable. In support of this self-evaluation effort, NIDA has developed materials for use during program evaluation and for follow-up evaluation in addition to historical information regarding treatment program efforts.

"--Suspend the funding of outpatient methadone detoxification as a separate modality until the results of ongoing studies are received, analyzed, and a decision is made on changing the treatment period for this modality."

Department Comment

We do not concur. The issue is not whether there should be outpatient detoxification itself, but rather its duration. Further, the basic question derived from the research data is whether detoxification will be more effective if the treatment regimen lasts 30 or 40 days rather than 7, 10, or 14 days, or the maximum 21 days permitted under current FDA regulations. This necessary service should not be suspended while this technical issue is being determined.

The purpose of outpatient detoxification is to provide the individual with a medically safe, humane method of withdrawing physiological dependence from drugs. While outpatient detoxification is, for reporting purposes, recorded as a treatment regimen, it should not be equated with more extensive psychosocial treatment regimens. An individual cannot be effectively rehabilitated while he/she is "high" on a drug. Detoxification is a necessary initial step in the treatment process. It is also frequently the initial contact which an individual has with the treatment system. This also provides the program with an opportunity to initiate a therapeutic relationship with the individual which can lead to referral to further treatment. It may take a number of such contacts before this can be accomplished. Outpatient detoxification is an acute medical treatment similar to the treatment necessitated when an individual is in a diabetic coma. The intent of the detoxification is to physiologically stabilize the individual who has been dependent upon a drug so that further "treatment" can be facilitated for this chronic condition.

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"--Assess the validity of the Drug Abuse Reporting Program study's conclusion that placing daily opiate abusers in outpatient drug free programs is ineffective to determine whether NIDA should discontinue its support for this form of treatment."

Department Comment

We do not concur. NIDA has assessed the results of the Drug Abuse Reporting Program's (DARP) conclusions. An analysis of this material shows the drug treatment program should not be compared across modalities, only within them, unless certain variables are controlled for in the analysis. For example, when the controlling variable is short-term treatment, there are no statistical differences in treatment outcome among short-term clients in methadone maintenance, therapeutic communities, and outpatient drug free or detoxification and intake only. Treatment outcome is related to the length of time in treatment. Drug abusers seek and receive treatment a number of times during their illness; this is an evolving process in which outpatient treatment may serve to establish vital linkages. Our assessment has led us to the conclusion that outpatient drug free programs should be continued for daily opiate abusers.

GAO Recommendation

We recommend that the Secretary require the Director of NIDA to:

"--Accelerate the studies of funding methods so that NIDA can expedite the adoption of a revised method."

Department Comment

We do not concur. To accelerate the funding study being conducted would damage the effort. NIDA has developed what it believes to be a viable alternative to its current funding mechanism. This alternative, however, needs to be field tested. To accelerate the study would mean that this test would not take place. This would invalidate the study. Field testing is scheduled to be completed by the second quarter of FY 1981.

"--Upgrade and clarify the funding criteria."

Department Comment

We partially concur. NIDA is reviewing the FFC relative to the changing needs of the drug abuse treatment field and other management mechanisms (e.g., funding incentives) which may be used to ensure the provision of adequate levels of service. NIDA does not, though, concur with the view that upgrading (i.e., raising the standards levels) the FFC will correspondingly ensure that programs can or will enhance service delivery. NIDA's review of the FFC will be completed by the second quarter of FY 1981.

"--Increase its efforts to (1) resolve problems impeding the development of drug abuse counselor credentialing programs, and (2) encourage States to implement mandatory credentialing programs and reciprocity agreements."

Department Comment

We concur in principle. NIDA is developing national models which assure recognition of competencies, career development possibilities for all direct service providers; and procedures to assure compatibility of State developed credentialing systems. We encourage States to implement credentialing programs. However, we do not concur with the notion of developing mandatory credential programs since this will probably be interpreted by many as licensing. This has not been the traditional role of the Federal Government in respect to health care providers.

"--Develop and issue a nationwide uniform standard which will define a client's successful completion of treatment."

Department Comment

We concur in principle. There is a complex definitional problem in determining "successful treatment." Through the Client Oriented Data Acquisition Process (CODAP), a successful discharge from treatment includes such characteristics of treatment as meeting the client's and clinic's goals detailed at admission; completing a prescribed treatment plan; reducing drug usage; and correcting a dysfunctional problem. All of these examples are employed by clinicians in assessing when a discharge from treatment may be determined as "successful." To address the issue of the impact of treatment, NIDA will be using an alternative approach to this issue. This alternative is the Clinic Management by Exception Report (CMER). CMER will identify clinics with low percentile scores on client's status at discharge with respect to treatment completion rates, time in treatment, drug use at discharge, arrests during treatment, and employment.

"--Require its management consultant to test client discharge information."

Department Comment

We concur in principle. However, the primary responsibility for testing or reviewing discharge data rests with the SSA. We will explore ways of examining the SSA's performance in this area. Based upon this exploration, we shall attempt to better focus the SSA's monitoring activities on this issue. This work will be completed within the second quarter of FY 1981.

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"--Accelerate the efforts to disseminate and use the results of the longitudinal evaluation research."

Department Comment

We concur in principle. While NIDA can and will continue its efforts in this area, it does not plan to reallocate resources to further accelerate the effort. NIDA has long been concerned with the issue of research utilization and it has made this a priority area in which it is encouraging demonstration projects. It also has developed a publication strategy to assist in the utilization and dissemination of research findings.

APPENDIX II

GAO REPORTS ISSUED SINCE 1974

DEALING WITH DRUG ABUSE TREATMENT

"Federal Drug Abuse Efforts in the Hartford, Connecticut Area and the Effectiveness of Federal Drug Task Forces in Other Cities" (B-163123, Oct. 15, 1974)

"The Veterans Administration's Programs to Treat Drug Abuse Among Veterans" (B-114859, Oct. 16, 1974)

"Security Controls for Methadone Distribution Need Improving" (GGD-75-50, Jan. 30, 1975)

"Management of the Community Action Against Addiction Program in Cleveland, Ohio" (MWD-75-92, June 13, 1975)

"More Effective Action Needed to Control Abuse and Diversion in Methadone Treatment Programs" (GGD-76-51, Mar. 9, 1976)

"Alcohol Abuse Is More Prevalent in the Military Than Drug Abuse" (MWD-76-99, Apr. 8, 1976)

"Methadone Deaths in New York City" (GGD-77-25, Mar. 14, 1977)

"Retail Diversion of Legal Drugs--A Major Problem With No Easy Solution" (GGD-78-22, Mar. 12, 1978)

APPENDIX III

SELECTED EXTRACTS FROM NIDA'S

MANUAL FOR SELF-EVALUATION

1. Drug treatment programs must comply with reporting requirements of Federal, State, and sometimes, local funding agencies. A program must divert some of its resources from the direct delivery of services to the provision of formal and objective justification of why the treatment program should continue to receive support.

2. The general purpose of evaluation is to compare the effects of a treatment program with the goals it has set for itself and to use the results of evaluation in making decisions that will help a program better reach those goals.

3. The results of evaluation efforts can be used internally to further your general goal of effective patient care. From this perspective, results of evaluation should be used to confirm (or reject) your opinions about program aspects or practices that need improvement. It would not be prudent, however, to use your findings as the sole justification for a decision.

SELECTED EXTRACTS FROM NIDA'S

MANUAL FOR CONDUCTING FOLLOWUP RESEARCH

1. Perhaps the most attainable objective is to develop some systematic information on the fate of your clients after they leave your program.

2. Another way in which such information may prove helpful is in providing some basis for forewarning your current and future clients of the problems they can expect to encounter after leaving the program.

3. Followup studies include any research in which a sample is identified at one point in time, and then later located personally or in records to learn what has happened in the interval.

APPENDIX IV

SOME OF THE QUESTIONS EXPECTED TO BE ANSWERED BY THE TREATMENT OUTCOME PROSPECTIVE STUDY

1. What types of drug abusers contact and choose to enter the various types of programs?

2. What happens to clients coming to treatment and staying various lengths of time?

3. What is the nature and quality of the services provided?

4. What types of behavior occur and what behavior can be expected both during and after treatment?

5. What changes and rates of behavioral change occur for individuals during and after treatment?

6. How do behaviors and rates of behavioral change vary with different types of clients and different types of treatment?

7. What behaviors and changes, or rates of behavioral change occur for different types of clients within specific types of treatment?

8. What are reasonable expectations of levels and rates of behavioral change, such as drug use, criminality, or employment for clients during and after treatment?

9. What factors are associated with variations in levels and rates of behavioral change?

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