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Defining Success: The Politics of Evaluation in Alcohol and Drug Abuse Treatment Programs

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Alcohol and drug abuse treatment programs must respond to several important stakeholders or beneficiaries of services who have an investment in how success is defined. Utilizing data from recent statewide studies of treatment outcomes of alcohol and drug abuse services, this paper concludes that a strict adherence to an abstinence-only model of success, rigidly adopted by many in the treatment industry is counterproductive. Multiple measures of success are essential to fully understand and assess a changing model of intervention in the chemical dependency field.

Cronbach and Associates (1980) eleventh thesis of program evaluation reads, "A theory of evaluation must be as much theory of political interaction as it is a theory of how to determine facts" (p. 3). Their thirteenth thesis states, "The evaluators' professional conclusions cannot substitute for the political process" (p. 3). While these admonitions provide clear guidance regarding the political nature of program evaluations in general, in the volatile world of assessing the value of alcohol and drug treatment, they have been elevated to commandments. This paper will explore the political process that envelops the initiation and use of outcome evaluations in alcohol and drug abuse treatment

programs. Specifically, the competing definitions of treatment success held by key actors and the subsequent ramifications of these differing standards will be discussed.

The total economic costs of drug and alcohol abuse in the United States is staggering. It has been estimated that the total cost of chemical dependence is over \$200 billion a year (Kinney and Leaton, 1990; Hubbard and Associates, 1989). While the majority of these costs are derived from law enforcement expenditures and lost productivity, billions of dollars each year are spent to treat those individuals suffering from alcohol and drug abuse. These expenditures on treatment services suggest two important functions of the evaluation of those efforts. First, there is an increasing call for accountability from the public and private sector. Second, treatment programs theoretically are designed to benefit the consumer of service and the relative effectiveness of treatment should be demonstrated.

Concept of Prime Beneficiary

On close inspection, it appears that alcohol and drug abuse treatment services are asked to satisfy multiple actors, each of whom may support a definition of success. To examine this process, the concept of prime beneficiary as developed by Blau and Scott (1962) will be used as a point of departure. It is argued that the force of competing beneficiary claims shapes the effort to conduct outcome evaluations and to arrive at a consensus on client success in the field of substance abuse treatment. Blau and Scott identified four categories of potential beneficiaries of any organization: 1) public at large; 2) owner, politicians, boards of directors; 3) customers or clients; and 4) organizational members. Though more than one of these groups may benefit from the product of the organization's activities, Blau and Scott contend that there tends to be one **prime** beneficiary identified. Accordingly, an organization is expected to be most accountable for its actions to its prime beneficiary. "Any benefits that accrue to other beneficiaries are usually viewed as cost and tend only to reduce the profit or surplus that the organization experience" (Weinbach, 1990, p. 39). It is in light of these competing agendas

of beneficiary groups, and the inability for a prime beneficiary to be designated in alcohol and drug abuse treatment services, that the politics of evaluation can be understood.

The Public at Large

The American public has become very sensitive to the scope of alcohol and drug abuse problems. Indeed, some polls indicate that the public views this issue as one of the major social problems facing the country today (Washington Post, ABC News Poll, 1990). National campaigns to combat drug use and abuse, drunk driving and fetal alcohol syndrome, and drug production have garnered much attention. The fear and trepidation that the specter of hard drugs such as heroin, cocaine, and crack promote in a community is well documented. Thus, much of the media spotlight focuses on the control of the supply of drugs and attendant crime that surrounds drug trafficking and usage. Treatment successes appear to be of secondary interest to the general public.

Elected Officials

The second constituency, elected officials, may have varying knowledge of the treatment process, but are acutely conscious of the political necessity to address this problem in some form. Realistically, this response is tempered by the diverse claims for attention and dollars. The task for elected officials is to weigh the claims of various interest groups some of whom may appear more deserving, more needy, more responsive, more helpless, or, on the other hand, more powerful, more militant, and more organized than others. For this constituency, definitions of treatment success are filtered through a long standing historical lens of law enforcement and efficiency.

Clients

The third constituency consists of the clients of treatment programs. It is generally agreed that approximately 5% of the population between the ages of 12–18 are having significant life problems with chemicals, primarily alcohol (Kinney and Leaton, 1990). Moreover, the figures for the adult population

experiencing problems with chemical dependence range from 7–10% (Ray and Ksir, 1990). Additionally, it is projected that for every one person diagnosed as chemically dependent, four family members are directly affected (Kinney and Leaton, 1990). Simply stated, there are literally millions of people in the United States who are living with emotional pain, economic hardships, and physical deterioration as the result of chemical dependence. In response, the number of treatment facilities have proliferated in this country commensurate with an increased awareness of the nature of substance abuse. Predictably, the primary client and involved others desire services that are effective and satisfying and assess the worth of programs in that context.

The Treatment Industry

Finally, there is the constituency of professionals, paraprofessionals, service providers, and vendors of various sorts, who profit from the problem of chemical dependence. These actors desire continued sanction for such programs and outcome evaluations can be viewed as supportive or detrimental to survival. Their concerns may result in rejection, resistance, and fear of evaluation. The rejection may stem from a belief that outcomes cannot adequately be measured and that lack of documented success will result in the discontinuance of programs. Evaluation can also be seen as supportive if outcomes indicate that programs are effective. However, as will be discussed, effectiveness can be defined in multiple ways and can be shaped by a host of disclaimers and qualifiers. Additionally, the disease model and a strict adherence to an abstinence standard of success is understandably widespread among many in the treatment industry who have benefitted from twelve step programs.

Competing Beneficiary Claims

The discussion of the claims of various beneficiaries has demonstrated a lack of congruence among groups. The existence of various claims results in differing outcome standards used to determine the relative effectiveness of substance abuse programs. Figure 1 compares the competing interests and the standard of effectiveness likely to be employed by each group.

Figure 1

Competing Interests of the Four Beneficiary Groups

<i>Beneficiary</i>	<i>Interest</i>	<i>Desired Outcome</i>
Public-at-Large	Protection, Punishment	Reduced Crime/ Reduced Supply/ Incarceration of Abusers
Elected Officials	Reflect public will Balance Competing Claims	Reduced "costs"
Clients	Adequate treatment	Improve life satisfaction
Treatment Industry	Increased resources; Acceptance of dominant treatment ideology	Abstinence

The Politics of Evaluation: A Case Example

To ground this discussion, ongoing efforts by the state of Missouri to conduct program evaluations of its alcohol and drug abuse programs will be considered. The state has funded chemical dependency treatment programs for several decades through combinations of federal block grant dollars and state general revenue dollars. As a matter of policy, these detoxification, residential, and outpatient services have been provided by way of purchase of service agreements awarded to vendors through a competitive bid process. Despite the long standing nature of the delivery of chemical dependency services in Missouri, only in the last three years has there been any expectations that the Division of Alcohol and Drug Abuse demonstrate the utility of expending these dollars on alcoholics and drug addicts. In response to numerous inquiries from state legislators, the administrators of the Division of Alcohol and Drug Abuse developed a five year program evaluation plan. To that end,

several outcome evaluation studies have been commissioned to assess the affects of treatment services around the state.

Three evaluation studies provide the primary experience on which this paper is based. The first study was a precipitously commissioned and rapidly designed retrospective study done in 1990 of 242 completed telephone surveys with clients discharged a year earlier from state funded substance abuse treatment programs. While respondents were representative of the total population on a majority of identified variables, the responding sample did under-represent blacks, inner-city residents, unemployed and unmarried individuals (Hartmann et al 1990).

The identified flaws limited the degree to which results were generalizable and gave impetus to the second statewide study. This project is currently in the second year of its three year research design. It involved prospective contact with treatment programs and incoming clients to facilitate later contact and followup. Currently over 500 three month followup interviews (post-discharge) have been completed and there has only been about a 10–15% attrition rate at the twelve month followup date. Both interview points have succesfully achieved representation of state funded clients. Subsequent interviews will be conducted at 18 and 24 months post-discharge.

The third study will be an evaluation of the implementation of case management services into substance abuse treatment programs. This project will allow in-depth contact with participating treatment programs.

Standards of Success

The assessment of treatment services has not produced any consensus regarding the nature of success. On the contrary, the process of performing the evaluations has generated more rather than less confusion about the definition of successful treatment outcomes for alcohol and drug abuse clients. The two primary forces or beneficiaries in this political struggle regarding the definition of success have been the elected officials who fund the various treatment programs around the state and the providers of those services.

As elected officials, they want to be convinced that the allocation of state dollars are having a positive effect on broad social concerns such as crime, unemployment, and the economy. They are less concerned about the change that occurs in any single individual life, unless of course it is one of their constituents.

While there has not been a negotiated concept of success between the Division of Alcohol and Drug Abuse and the state legislature regarding minimal or expected percentages of abstinence, the elected officials continue to fund the programs of the Division. Moreover, the legislature has recently agreed to significantly expand alcohol and drug abuse services under the state medicaid program. In Missouri, this program is referred to as C-STAR (Comprehensive Substance Abuse Treatment and Rehabilitation). Though the state will have to provide 40% of the costs from general revenue, the federal government will be paying 60% for services.

These C-STAR services include the traditional services of detoxification, residential, and outpatient, but include an additional intervention method, namely case management. The case management services, offered in conjunction with the more traditional counseling and therapeutic interventions, concede a very important point. Some clients can be worked with even if abstinence has not yet been achieved. A case management model accepts the notion that stress can be a predeterminate to relapse or a contributor to sustained heavy drinking. Since the goal of case management is to enhance an individual's social functioning through assistance in such areas of daily living as employment, residential stability, family issues, it is inherent in the service that inevitably some clients will not be totally abstinent as they access the resources. As a result, the concept of abstinence in the mind of the legislature has been challenged. The evaluations have provided information about consumption, life style, and perceptions from clients and other family members that offers alternatives to an abstinence only orientation of success. While this concept of success may be subsequently challenged as more sophisticated measures of short and long term behavior are derived, for now, the Division has augmented earlier definitions, and the state legislature has tacitly agreed. The third evaluation will likely refine further these definitions.

The second major beneficiary of the alcohol and drug treatment system in Missouri are the service providers. As mentioned previously, the providers are significantly comprised of people who support conceptually the disease model or who they themselves have achieved an improved quality of life through the use of a twelve step program such as Alcoholics Anonymous which is based on the disease model. This group has traditionally been hostile to any definition of success that was not restricted to total abstinence as the goal. Relapse was expected, but relapse was seen as failure and sobriety, the measure of success was only counted from the last drink or chemical usage. Moreover, any attempt to consider success using any variables other than abstinence if abstinence had not been achieved and sustained was summarily rejected. Therefore, success was conceived of as an all or nothing phenomena. Since a very high percentage of people relapsed post discharge, there was predictable resistance from this group regarding any attempt to evaluate outcomes.

This resistance to evaluation was compounded by the history of Alcoholics Anonymous and Narcotics Anonymous which historically refused to participate in any kind of systematic research efforts. The rationale given is that an evaluation might compromise the anonymity of the members. While this explanation makes good sense, the tentativeness towards evaluation was also a function of the high drop-out rate. And, since there is no consensus about what ought to be the expected success rate, there was legitimate concern about what the appropriate levels of expected abstinence should be.

Lastly, treatment personnel are very aware of the variables that are harbingers of post discharge abstinence; length of drinking history, economic and employment status, residential stability, in place family and social system networks. The Division of Alcohol and Drug Abuse, by definition, is serving a poorer, more transient population. Agencies have purchase of service contracts with the Division to provide no or low cost treatment. It is a given that the clients have no or limited support systems and economic stability, certainly as compared to clients who access chemical dependency programs in the private sector and through third party payments. Thus, there is limited expectation

by treatment personnel that people utilizing purchase of service contract slots will have sufficient life supports that generally denote positive outcomes. On the other hand, treatment personnel, who subscribe to a disease model, are generally militant in their belief that services must be withheld from clients that continue to drink. To do otherwise, is to help the client maintain their dependent life style.

Dealing with Resistance

During the retrospective study, the first of the three outcome evaluations, there was considerable suspicion towards the evaluation effort. The Division of Alcohol and Drug Abuse sent the names of all clients discharged from residential and outpatient programs in a three month period from the previous year, or approximately 1500 people. Each program was asked to fill out locator sheet information on their selected clients and send that information directly to the Center for Social Research. The locator sheet information was to include the client identification numbers, treatment center numbers, and as up-to-date addresses and phone numbers as possible. First, the agencies were very slow in sending the information. Second, some agencies did not send it directly to the Center, but sent it through the Division of Alcohol and Drug Abuse. Third, and most importantly, the necessary information was often missing, inaccurate, or illegible. As a result, for almost one third of the sample, there was absolutely no opportunity to reach the client for evaluative purposes. With another 600 clients, the information provided was so sketchy, that no contact could be made despite numerous efforts. Throughout this data gathering phase of the research, many treatment personnel were less than cooperative.

In order to overcome some of the methodological problems experienced in the retrospective study, the Division contracted with the Center for Social Research to conduct a prospective study of a similar group of clients. Each of the twenty five agencies that had state contracts to serve adult residential and outpatient clients were contacted and a training session was arranged. At these agency based training sessions, the purpose of the study, the intake questionnaires, consent to participate

forms, and the important locator information sheet were fully explained and discussed. Many of the trainings were positive and constructive, but some were very tense. Generally, the clinical director attended the training, but rarely did people who would actually be filling out the forms directly participate. Thus, the substance of the training was translated at least once to other workers. Also, each agency was given more than enough admission packets and self-addressed stamped return envelopes.

The resistance to the prospective evaluation project manifested itself in several ways. While not every agency was hostile or intimidated by the specter of evaluation, and specifically, feedback on the quality of their services, many were clearly concerned. Almost half the agencies participating had to be called to return their admission packets. One third of the packets received did not contain client identifier numbers so there was no way to link the data with the state's existing management information system. Many of the questionnaires were inappropriately completed. Though improved from the retrospective study, much of the locator information was either missing or inaccurate. Perhaps most telling as an act of resistance, approximately 30% of the clients refused to participate in the study. In checking on this high rate, it was determined that many of the workers at intake were negative towards the study and either actively or implicitly encouraged clients to resist.

As mentioned, the third evaluation will be conducted on the newly developed C-STAR program. A primary component of that program is case management services. While case management is an accepted and invaluable part of psychiatric services and services to the developmentally disabled, it is a very recent addition in alcohol and drug abuse services. During the training sessions that have been offered to date on the philosophy and goals of case management, the trainers have met with often undisguised hostility. The basis of the hostility is the ideological rejection of the belief that clients who are continuing to use substances are entitled to receive support services.

Discussion

It is the argument of this paper that outcome evaluation studies of alcohol and drug abuse services are subject to relent-

less political struggles. Much of this struggle is over the thorny issue of what constitutes a successful intervention with a client and by extrapolation, what constitutes a successful program. Incorporating the work of Blau and Scott, it is suggested that the absence of a designated prime beneficiary contributes to competing definitions of successful treatment. Furthermore, strict adherence to various ideological positions precludes a meaningful dialogue about reasonable expectations for treatment.

It appears that two prime beneficiaries have emerged in this political debate, elected officials and treatment personnel. Each stakeholder has an investment in the political decisions that are made in the area of substance abuse prevention, control, and treatment.

It is not uncommon for those in the treatment industry to condemn elected officials for insufficiently supporting alcohol and drug abuse treatment programs with funds to expand services, who rebel at the suggestion by these lawmakers that their services are ineffective, and who regard punitive measures as insensitive. However, if successful treatment is discussed only in terms of abstinence then it certainly is understandable, given existing data, why elected officials would opt to support the more politically popular law enforcement initiatives.

The treatment industry may unknowingly contribute to misconceptions about reasonable outcome expectations. These misconceptions occur as a result of the strict adherence by a powerful group of service providers who fail to consider alternative measures of success other than abstinence. Yet, Goode (1989) is not optimistic, "Abandoning the abstention-only model for treated alcoholics, even if they constitute only a substantial minority, represents something of a revolution in thinking about the subject" (p. 134). It is recognized that many, perhaps most people who seek treatment for alcohol and drug abuse programs, abstinence is the only viable treatment goal. Nevertheless, it is also recognized that levels of success can occur irrespective of chemical usage.

Thus far, the findings from the several outcome evaluations suggest that abstinence has been achieved for many clients who have completed treatment in state funded programs. Significant numbers of additional clients, while not remaining abstinent, have decreased their consumption. Moreover, commensurate

with those findings, is an overall increase in the employment status of clients, more stability in their living situations, and a decline in clients' involvement with the legal system. Other programs, with similar clients, have reached comparable conclusions. Each of these positive outcomes also results in reduced costs to society.

Unfortunately, many service workers in the treatment industry undermine their own success with clients by rejecting or denying the documented improvements. These workers have difficulty accepting anything but abstinence as a demonstration of an enhanced quality of life for the individual and fewer social costs.

This rigid, ideological position is potentially damaging to the abstinence-only group and the clients they serve. As the evaluation research evidence mounts, it is obvious that many clients do not remain totally chemically free, but have periods of sobriety and periods of usage or relapse. Yet, the clients' self reports augmented by substantial collateral data, strongly indicate that treatment made a difference in their lives and that their heavy usage had been altered through intervention. If an abstinence-only criterion is the sole barometer of success, then existing data argues that programs will be seen as not very successful (eg. 50% of the located sample remained abstinent during first year after treatment) and funding from elected officials will be adversely affected.

On the other hand, if success of treatment is viewed through multiple lenses including not only abstinence, but reduced usage, higher employment, better personal relationships, fewer legal entanglements, then programs can report better success rates. When such results are not communicated to elected officials, the treatment industry fails to capitalize on its own success.

Moreover, as the outcome information increases on the range of positive changes that occur with clients, individual treatment programs can offer and elected officials can expect a greater level of sophistication. Programs should begin to set measurable objectives for their clients. Making allowances for the chronicity of the clients, available resources, and relevant environments, programs should then be held accountable for

meeting their objectives. When objectives are not met, programs, especially under governmental auspices have a responsibility to analyze their performance and make appropriate adjustments. Such a process would not eliminate the politics in defining the success of alcohol and drug abuse programs, but it would make them more accountable for their services.

References

- Blau, Peter and Scott, Richard. *Formal organizations*. Scranton, PA: Chandler Publishing Co., 1962.
- Cronbach, Lee J., Ambron, Sueann Robinson, Dornbusch, Sanford, Hess, Robert, Hornik, Robert, Phillips, D. C., Walker, Decker F., and Weiner, Stephen S. *Toward reform of program evaluation*. San Francisco: Jossey-Bass Inc., 1980.
- Goode, Erich. *Drugs in american society*. New York: Alfred Knopf, 1989.
- Hartmann, David, Sullivan, William P., and Wolk, James L. *Final report on a follow-up assessment of Missouri alcohol and drug treatment programs*. Springfield, MO: Center for Social Research.
- Hubbard, Robert, Marsden, Mary Ellen, Rachal, J. Valley, Harwood, Henrick, Cavanaugh, Elizabeth R., and Ginzburg, Harold M. *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, NC: University of North Carolina Press, 1989.
- Kinney, Jean and Leaton, Gwen. *Loosening the grip*. St. Louis: Mosby-Year Book, 1991.
- Ray, Oakley, and Ksir, Charles. *Drugs, Society, and Human Behavior*. St. Louis: Mosby, 1990.
- Weinbach, Robert. *The social worker as manager: Theory and practice*. White Plains, NY: Longman Publishing Co., 1990.

