CONTEXTUAL CONSIDERATIONS IN EVALUATING NARCOTIC ADDICTION CONTROL PROGRAMS

Alan S. Meyer, The Burke Rehabilitation Center
and
Stanley K. Bigman, The Washington Center for Metropolitan Studies

The Changing Context for Addiction Evaluation

Implicit in the task of evaluating any program directed at changing human behavior is the need to describe and understand the social and cultural context in which the program is being carried out. This involves understanding the society's attitudes and policies towards the kind of behavior which the program is trying to change. It also involves understanding the influence of this context -- whether constraining or liberating -- on the problem, on the program, and on its evaluation. It is the purpose of this paper to make explicit some ways in which this context might usefully be considered and to define the kind of evaluator role required for this task.

The problem of narcotic addiction provides a strategic example of the necessity of explicitly considering the cultural context of a problem if efforts at evaluating programs to control the problem are to be meaningful. Addiction is a strategic case study in evaluation for two reasons. First, it is a socio-medical problem which is still viewed and handled in some countries -- and our own has been a prime example -- as basically a criminal problem.

Briefly, the history of opiate addiction in this country has been marked by a dramatic change in the characteristics and behavior of addicts following federal action aimed at transferring treatment of addicts from physicians to police. Major results included the growth of a black market, the development of a criminal subculture among addicts, and the recruitment of new addicts increasingly from minority group youth in urban slums.

In recent years, this predominantly punitive approach to addiction, which is relatively rare in the health field, has been moderated by a growing emphasis on mental health aspects of both etiology and treatment. This has resulted in a highly ambivalent cultural context in this country in which addicts are viewed and treated as if they were both criminal and sick.

The second reason that addiction provides a strategic view of contextual problems in evaluation is that significant changes are taking place in the social and cultural context in which treatment of addiction is being carried out. Public policies, if not popular views, have in the last four years begun to undergo major changes with regard to experimentation in the treatment of addiction. For the first time since the 1920's, when narcotic clinics dispensed drugs in a number of major cities in this country with varying degrees of reported success or failure, physicians have obtained the permission of policing agencies to use maintenance dosages of narcotics in the treatment of addiction.

This clearly represents a major change in public policy. A number of physicians in different parts of the United States have successfully reasserted their right to establish treatment goals and methods in this field. When professionals legitimately engaged in treatment are subject to governmental or other constraints which severely limit their freedom to establish the goals and methods of treatment which they may consider professionally appropriate, then questions can be raised not only with respect to the proper professional posture of treatment staff but also with respect to an appropriate approach to evaluation of such programs.

The Role of Evaluator: Data Analyst or Behavioral Scientist

One view of evaluation holds that the evaluator is a technician responsible only for accepting the program's stated goals and preferred success criteria as givens. His job is to implement the basic evaluative design mandated by the program staff. Such a role has been referred to in the addiction field as a "data analyst."

This role might permit the evaluator to make minor modifications in design through his technical suggestions and skills. However, basic questions regarding the "appropriateness" of the program goals and to some extent even of its methods would generally be considered outside the responsibility of the "data analyst."

We would like to consider an alternative approach which views the evaluator as a behavioral scientist rather than as a data technician. A major part of the behavioral scientist evaluator's responsibility would be to raise basic questions about every aspect of the program, including the social and cultural context in which it is carried out, and about the evaluation design before, during, and after the evaluation study.

The key questions to be raised by the evaluator, as we see them, and which we shall discuss here, are: (1) what is the sponsor's purpose in having an evaluation; (2) what are the implicit as well as the explicit goals of the program; (3) what aspects of the program should be included in the evaluation and what aspects, if any, can be excluded; (4) what should be the criteria of success; (5) what methods of measuring success criteria are scientifically and ethically appropriate; (6) how should the recipients of the program be classified; (7) who should do the evaluating; and finally, (8) what are the constraints on public and private dissemination of findings.

On the basis of the answers to these

questions, it seems to us, behavioral scientists can make a professional judgement as to the nature and extent of their role in the proposed evaluation. A more detailed look at these questions as each applies to evaluation in the addiction field highlights a number of contextual problems which evaluators in other fields might usefully take into account.

What is the Sponsor's Purpose in Having an Evaluation

The purpose that people have in mind for doing an evaluation in the addiction field as in other fields is typically complex. Purposes may include a combination of any of the following: to see how well a program is doing, to document the need to maintain or extend the program, to find out how to improve the program within traditional limits, to learn whether to drop the program, to stimulate fundamental innovative changes, to give an aura of scientific respectability to the program, to delay action in a controversial area, to increase our understanding of the nature of the problem which the program is aimed at solving, to meet an administrative requirement, or to achieve some other purpose.

The original purpose or purposes are not so important as the ones ultimately stated after discussion between the program staff and the behavioral scientist evaluator. The latter may decide on the basis of the answer to this question alone that a meaningful evaluation is not relevant or possible. He may, on the other hand, achieve a modification of purpose which at least allows for the possibility of an evaluation which meets professional standards.

The problem pointed up by much of what has been called evaluation in the addiction field is that the purposes have generally been too narrow to allow either for an increase in theoretical understanding or for a realistic consideration of alternative programs. Thus, the implicit purpose of much addiction program evaluation has been to maintain the status quo in public policy as well as in theoretical understanding. It is of course true that demographic data on addicts and relationships of these data to abstinence rates and other post-discharge behavior of addicts provide increments of data which increase somewhat our general fund of knowledge. The question, however, is whether such increments obtained by studies conducted primarily for fund raising, administrative bookkeeping, or public relations can justify the term scientific evaluation.

What Are the Goals of the Program

To evaluate the effectiveness of a program, it is necessary to know the goals of the program. Evaluators are familiar with the difficulties in accomplishing this seemingly simple task. Goals may contain internal contradictions, cliches, ambiguities, pre-conditions, etc.[1]

In narcotic addiction, program goals have tended to be unclear, implicit, contradictory and shifting for several special reasons. In part, because of our ambivalent view of addicts, and in part, because of the extremely high rate of failure in most programs and the subsequent likelihood of staff frustration, explicit goals tend either to be very broad -- i.e., help control addiction, help addicts, etc. -- or to shift to research or training goals.

Perhaps the major reason for lack of clarity in the goals of these programs, however, is the severe governmental constraint which all such programs have until recently labored under. From the mid-twenties to the mid-sixties, law enforcement agencies directly prescribed the methods, and indirectly the goals, of programs to treat addiction. By preventing any use of narcotics in treating addicts, except as a detoxifying drug, federal policy mandated abstinence from drug use as the universal ingredient in all treatment programs of this chronic condition.

Frequently, programs for treating addicts -- whether in hospital or jail -- have been implicitly aimed at achieving the goal of abstinence through the method of detoxification. In recent years, explicit goals have often included such objectives as rehabilitation, return to productive life, enhanced ego functioning, and longer periods off drugs. So long as detoxification remains the core modality, however, the de facto goal tends to revert to abstinence.

In the last few years, alternative program models have been presented which explicitly classify abstinence, detoxification, individual and group counseling, etc., along with drug maintenance as methods, not as goals or subgoals. The explicit goals, according to this rehabilitation-based model are improved social and psychological functioning and improved physical health within the limits of chronic disability (i.e., without regard to whether the patient or client is on or off drugs).[2] In such a model, explicit and implicit goals tend to merge.

Clarification of program goals must therefore take into account the possible influence of social and cultural contexts on the manner in which goals are stated and adhered to. The goals in turn will determine the criteria of success which can be logically built into the evaluation design. The goals also constitute the frame of reference in which the behavioral scientist evaluator must assess the degree of relevance of the program methods.

Since so much of the evaluation is dependent on a clarification of the goals of the program, it would appear to be incumbent upon the behavioral scientist to at least raise the question as to how well the goals are related to the kind of problem which the program is attempting to change. Evaluating a program thus begins with identifying and analyzing its goals.

What is Included and What is Excluded From Evaluation

The one question which most clearly

distinguishes the behavioral scientist role from the data analyst role in evaluation is the degree to which the evaluator participates in the decision as to what, if anything, should be excluded from the evaluation.

For a variety of reasons having to do with the original purposes of the evaluation and with the personality and attitudes of the sponsoring persons, certain aspects of the program or its outcome may not be considered appropriate objects of evaluation. The data analyst may be able to accept such limitations uncritically by applying his technical skill to evaluating only those parts of the program which have been approved for study, and either to draw limited conclusions or let someone else write the conclusions.

The scientist on the other hand will want to establish the right to include as objects of evaluation those aspects of the program which, in his professional judgement, are necessary to accomplish a meaningful evaluation. He may feel that he can conduct such an evaluation by including certain minimum aspects without necessarily including all relevant aspects. Most evaluation is no doubt partial in this sense. It is, for example, not uncommon for evaluation studies to exclude from their assessment such variables as the personalities and competence of staff and still contribute to an understanding of the program's effectiveness.

But the crucial question must be faced by the potential scientist evaluator: does the exclusion of certain aspects of the program or its outcome as proper objects of study, render a meaningful result highly unlikely? If so, then the behavioral scientist will find an appropriate way of limiting or ending his role in the proposed evaluation.

Aspects of a program which might be excluded, in spite of the efforts of the behavioral scientist to include them, are: comparison of explicit and implicit goals; a detailed description of what the actual program consists of; the relevance of methods to goals; criteria of success most directly related to goals; a system of classifying staff which is relevant to their attitudes and behavior in carrying out their activities; a system of classifying clients relevant to the problem which the program is aimed at meeting; and the relevance of the goals to the nature of the problem and its cultural context. It is likely that many if not most of these program variables are given only minimal attention in the typical approach to evaluating programs for addicts.

In a given study, the exclusion of any of these variables could jeopardize its potential value to a greater or lesser degree. Such contextual constraints on the scope and nature of the evaluation to be permitted are encountered in almost every field. Because of the peculiar historical and political context in which addiction programs have been carried out in this country in the last several decades, the seriousness of these constraints are especially visible and can serve to alert evaluators in other fields to their possible detrimental influence.

What Should Be The Criteria of Success

Because of these constraints, traditional efforts at evaluating the effectiveness of treatment programs for addicts in this country have largely consisted of follow-up studies of addicts released from a hospital or other agency to determine the percent who were still off drugs. While these studies have increasingly included non drug-use data on adjustment variables such as employment and arrests, the drug use variable has almost universally been given preeminence.

In view of the routinely high rate of failure found when the primary criterion of success is drug abstinence, other kinds of secondary criteria have occasionally been used. These include the number of contacts with the treatment agency, completion of treatment, length of time off drugs before relapse, and proportion of time off drugs out of the total time since discharge.

It was not until 1964, to our knowledge, that an evaluation of an addiction program explicitly presented social functioning variables as alternatives to the primary success criteria of abstinence. In that study, conducted by one of the authors of this paper, success was defined in terms of increased conventional behavior and reduced criminal behavior. Drug use was recorded as a possible explanatory variable but was viewed as conceptually independent of success.[3]

This approach, which we have referred to as a rehabilitation model, is now being used by a number of programs with built-in evaluation. The criteria of success, however, vary with respect to the old bugaboo -- abstinence from drugs. Most of the current programs include abstinence from drugs other than methadone as a significant criterion of success.

One exception to this use of a new abstinence criterion is the Narcotic Addiction Demonstration Center of Southwestern Fairfield County in Stamford, Conn. Use of additional drugs is viewed there primarily as a matter of general research interest and clinical concern and only secondarily as a criterion of success.

The more common pattern of using abstinence from all drugs but methadone as a criterion of success equal in importance to those of "working" and "staying out of trouble with the law" is understandable when we take into account one fact: that powerful political pressures impinge on most addiction treatment agencies which have experimented with methadone maintenance. While the evaluator may or may not be able to resist these pressures, we submit that it is his obligation nonetheless to raise questions about alternative goals, methods, and criteria of success.

How Should Success Criteria Be Measured

Once the criteria of success have been conceptualized, the evaluator must decide what observable behavior should be used to indicate or measure the degree to which each success criterion has been achieved.

If, for example, being employed has been established as one criterion of success, how shall this be measured? One might use the client's own report as to whether he is employed or not. Self reported behavior by addicts, however, is often rejected as a reliable measure of success. Thus, one might scrutinize pay checks or obtain verbal or written confirmation by employers as such a measure.

Similarly, criminal behavior is often measured by arrest records. The unapprehended crime, however, may go unmeasured if the addict is not queried about it. A methodological question underlying this dilemma is whether one can get more valuable data by establishing the kind of relationship with clients which may potentially produce full and accurate information or by relying on "objective" records of client behavior which are somewhat less than comprehensive.

Moreover, problems of professional ethics should be considered in deciding on whether to use subjective reports, objective records, or some combination of the two. The implications for the field of addiction of choosing one set of measures rather than another should be carefully thought through. For evaluation is a form of action-research and its design and implementation reflect assumptions and values regarding the nature of the problem and its treatment, whether the evaluator is aware of these reflections or not.

A most cogent and controversial illustration of these methodological and ethical problems consists of the use of urine testing to measure the success criterion of abstinence from drugs. This method, called thin layer chromotography, is typically used in programs which include as one of their goals, either abstinence from all drugs or abstinence from all drugs except legally administered methadone.

Various reasons may be cited for the use of urine testing. These include the reputed tendency of addicts to prevaricate, the reputed readiness of addicts to belittle any program which does not use urine testing, and the need for some form of coercion or rational authority in treating addicts.

Of course, the last reason is an open statement of a treatment philosophy which incorporates thin layer chromotography as a necessary treatment modality. It should be considered, in such cases, as a method of treatment to be evaluated and not simply as a method of evaluation.

When urinalysis is not directly part of the treatment program, its pros and cons as a measure of abstinence can be appropriately weighed. Its advantages are that it doesn't require development of an open relationship between client and evaluator, it may meet the expectations of most of the clients, and, at least in the short run, it may well provide more reliable information about use of most types of proscribed drugs.

The disadvantages of urinalysis are that it fails to provide information about cocaine and alcohol (which the users of these tests claim they are also concerned about) and it can, under certain circumstances, be manipulated. But most important, we submit, it constitutes a procedure in which the client participates in a process of self-degradation.

Some might take issue with this judgement by pointing to the daily weighing of overweight clients and to the periodic urine testing of diabetics. The crucial difference, as we see it, resides in the criminal stigma which adheres to addiction but not to obesity and diabetes. In the case of addiction, thin layer chromotography can truly be called "guilt by urination."

While each evaluator must make his own judgement about the ethics of this procedure, at the least the question should be raised. Eventually, of course, the effects on addict clients and on public attitudes of urine testing should be carefully assessed. In the meantime, it is sufficient to point out that there are powerful political pressures for including urinalysis in addiction treatment program evaluations. This is perhaps the most telling argument in favor of its use. Nonetheless it is significant to note that the one program we know of which is evaluating a methadone maintenance program without thin layer chromotography reveals a higher rate of illegal cocaine use as measured by self-reported drug use than does a major program which depends on urinalysis which does not test for cocaine.

How Should Recipients Be Classified

The aim of evaluation, according to one research evaluator, is as follows: "As diagnostic classifications and treatment goals and methods are more sharply defined . . . the focus of the evaluative question is likely to be sharpened so that we may no longer be asking, how effective is psychotherapy . . ." -- (or, we might add here, any kind of intervention) -- ". . . but rather, how effective is such-and-such kind of treatment in producing such-and-such changes in such-and-such kinds of people."[4]

An evaluator is generally alert to the possibility that the rate of program success, whether high or low, may be to a significant degree the result of a skewed sample. The difficulty arises in determining the most appropriate systems for classifying the clients. Clients may, of course, include such diverse targets as persons with a problem, the general public, agency personnel, decision makers, etc.

In the addiction field in this country,

programs for the most part have been aimed at addicts. The classification systems used have typically been of personality variables of these recipients of program efforts. These classes are generally presented as predisposing factors in addiction.

If one assumes that treatment of the predisposing conditions in the host is an effective approach to curing a chronic problem, then psychiatric classifications offer one logical approach to characterizing clients. However, that assumption does not always hold. In the field of medicine, for example, progress in controlling disease is sometimes achieved without a clear understanding of its etiology.

Moreover, addiction is a complex sociomedical problem which involves deep social as well as psychological roots and resultants. We believe it is primarily because cultural constraints have dictated for so long that the de facto goal of treatment be complete cure -- that is, abstinence -- that classification systems have almost exclusively focussed on psychological variables. While this is one legitimate approach, it tends to preclude innovative approaches to treatment and alternative goals in place of abstinence.

Once a rehabilitation model is used to establish improved functioning as a goal of treatment, then the shortcomings of an exclusively psychiatric approach are apparent. When high priority is assigned to the goal of improved social functioning (for example, increased involvement in conventional areas of living and decreased involvement in criminality), then relevant new social classifications are essential.

Such an approach has been followed in two evaluation studies in which one of the authors has served as director. A classification of addict life style adaptation was developed based on two independent social characteristics -- the degree of an individual's involvement in the conventional world and in the criminal world.

A typology was established consisting of four distinguishable life styles: "Hustlers" -- those who conform to the stereotype of the addict as high in criminality and low in conventionality; "Conformists" who are low in criminality and high in conventionality; and two mixed groups -- "Two-Worlders" who are high in both criminality and conventionality, and the "Uninvolved" who score low on both of these dimensions.

The value of such classification is twofold. First it assigns addicts to groups which present very different types of problems for the community and for the treatment agency. Second, the typology provides a key set of criteria for measuring success in terms of improved functioning and more positive adaptation by addicted persons. Since improved physical and mental health are also goals of a comprehensive rehabilitation program, there is need for additional classifications of addicts in terms of their patterns of drug use and their psychological adjustment.

Our point, however, is not that the above classification of life-style adaptation should be universally used in evaluating addicts. More effective classifying schemes are sure to emerge. The important point is that the choice of an exclusively psychological approach to classifying addicts tends to place the evaluator in the role of a passive data analyst unless he is fully aware of the influence of the ambivalent cultural context on the goals, methods, and success criteria which form the basis of his evaluation and unless he is prepared to raise relevant questions about alternatives. One group of evaluators of California's civil commitment program did just that in stating that: ". . . commitment programs for addicts can be considered at this time an interim procedure between a totally punitive and evolving non-punitive approaches to the issues of drug dependence, though perhaps they will persist as an alternative for those who are not helped by other programs. Implicit in this view is the expectation that alternative approaches will be explored and encouraged."[5]

As we suggested earlier, addicts are only one target of intervention for programs of addiction control. Other targets, perhaps of equal or greater importance at certain points in time, are professional attitudes, agency postures, and public policies themselves. Measuring the success of such efforts is far removed from testing the urine of individual addicts. How we define the problem to be attacked is the ultimate yardstick which we must apply in evaluating programs aimed at the problem.

Other Contextual Considerations

Other questions involving the contexts in which treatment and evaluation are carried out should be raised by a conscientious evaluator. Time allows but brief mention of two of the more important inquiries. Who should do the evaluation is a question of obvious importance. Our own answer is that it is more important that the evaluator assume the role of behavioral scientist than whether the evaluator is an "insider" or an "outsider." We have seen situations in which both inside and outside evaluators of addiction programs have served solely as data analysts and other situations in which each have served as behavioral scientists.

Another source of difficulty might be avoided if the evaluator ascertains ahead of time how the findings of the evaluation will likely be disseminated. While acceptable reasons may exist for limiting the scope and nature of the distribution of results, implicit reasons which appear unjustified to the evaluator should be elicited and challenged.

The purposes of evaluation should generally include the feedback of findings -- both positive and negative -- to the program personnel. Here the evaluator-scientist role is most clearly that of an action-researcher. This phase of

evaluation calls for interpretation by the evaluator and may culminate in specific recommendations for modifying the program's goals, methods or procedures.

Summary

In this paper we have tried essentially to make three interrelated points about evaluation. First, we submit that the case of narcotic addiction points up the degree to which the social and cultural context, -- in this case, in terms of punitive public policies and ambivalent community attitudes, -- can narrow the range of permissible goals and methods of treatment and the purposes and design of evaluation as well.

Given the criminal status assigned to narcotic drug use by our society, it is logical to aim programs at stopping the criminal behavior of drug use and to utilize involuntary methods of treatment and of measuring success. When addiction programs are, to a greater or less degree, shown to fail, the availability of psychiatric classifications of clients, legitimate as they might be, can too easily suggest that inadequate personalities are the major factor in this failure and thus divert attention from basic contextual sources of failure external to the individual.

This leads to our second point. Evaluators in designing their studies of programs in addiction, and no doubt in other fields, are inevitably and deeply involved in the action arena. Their evaluation designs and the criteria and measures they select will tend to reinforce the basic assumption of the addict as a criminal (regardless of any mental health facade) or, conversely, to challenge that assumption. These action consequences of seemingly objective research decisions can not be easily avoided. They are likely to characterize program evaluation in other fields as well.

Our third point, then, is that it is a basic obligation of the evaluator to consider the impact of the community context in which programs operate, to challenge basic assumptions which may have no foundation in fact, and to raise questions about alternative formulations of the problem and alternative approaches to controlling it. The evaluator, in short, if he is indeed to evaluate meaningfully, must assume -- regardless of his professional discipline and training -- the role of behavioral scientist.

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