CLEVELAND IMPACT CITIES PROGRAM

CLEVELAND DRUG ABUSE PROGRAM

EVALUATION REPORT

February 1975

OFFICE OF THE MAYOR

IMPACT CITIES

ANTI-CRIME PROGRAM

RALPH J. PERK
MAYOR

RICHARD L. BOYLAN
DIRECTOR

CLEVELAND IMPACT CITIES PROGRAM

CLEVELAND DRUG ABUSE PROGRAM

EVALUATION REPORT

February 1975

CLEVELAND DRUG ABUSE PROGRAM

(JANUARY THROUGH AUGUST 1974)

I. INTRODUCTION AND BACKGROUND

This report presents an evaluation of the Cleveland Drug Abuse Program (CDAP) for the first eight months of this year. This period is divided between the conclusion of Phase I of CDAP, January through April 1974, and the initiation of Phase II, May through August 1974.

Through a grant awarded to the City of Cleveland in November 1972, the Law Enforcement Assistance Administration (LEAA) initially committed a total of $1,600,000 to support CDAP. As a result of the publication of an evaluation report* in March of this year, assessing the first year of Phase I performance through December 1973, and the reprogramming during the spring months for the final year of the Cleveland IMPACT Cities Program, the original grant award of $1,600,000 was reduced to $1,276,000, an estimated $260,000 of which has been allocated to Phase II operations. It should be noted that CDAP Phase II operations are being supported by a joint funding arrangement negotiated between LEAA and the National Institute of Drug Abuse (NIDA).**

Phase I operations began in December 1972 and CDAP accepted its first client in March 1973. The results of the first-year evaluation, referenced above, showed that CDAP had collected reliable data on over

---

*Cleveland IMPACT Cities Program, CLEVELAND DRUG ABUSE PROGRAM EVALUATION REPORT, Office of the Mayor: Cleveland IMPACT Cities Program (March 1974).

**During 1973, federal policy guidelines, promulgated under the provisions of the Drug Abuse Office and Treatment Act of 1972, reflected a major shift in operational emphasis. The Special Action Office of Drug Abuse Prevention directed NIDA to assume principal responsiblity for clinical treatment of drug abusers and to coordinate with all existing LEAA programs which were delivering treatment services to drug abusers. The LEAA-NIDA joint funding arrangements with the City of Cleveland were finalized on May 1, 1974.

15,000 persons arrested during 1973 in the City of Cleveland and obtained over 10,000 urine samples from this arrested population. Analyses of these samples revealed that 3.6 percent were morphine positives, 3.5 percent methadone positives, 7.9 percent barbiturate positives, 2.1 percent amphetamine positives, and 7.7 percent positives for drugs other than any of the foregoing.* During the same period, CDAP accepted a total of 405 referrals from the Jail Screening Unit. A profile of CDAP clients admitted to the program during the first year yielded the following summary statistics:

- 50 percent of the Phase I CDAP client population was under 25 years of age, 25 percent was between 26 and 29 years of age, and 25 percent was 30 years of age or over;

- 24 percent of the Phase I CDAP client population was charged with IMPACT crimes at the time of referral, 35 percent was charged with other felonies, and another 29 percent was charged with misdemeanors;**

- 71 percent of the Phase I CDAP client population was unemployed;

- 71 percent of the Phase I CDAP client population was diagnosed with a primary drug problem involving heroin, 6 percent with a primary drug problem involving barbiturates, and the remaining 23 percent with a primary drug problem involving one of the following drugs: methadone, synthetic opiates, amphetamines, cocaine, marijuana, hallucinogens, or other proscribed drug substance;

- 29 percent of the Phase I CDAP client population was referred to the program from local city and county criminal courts and their respective probation departments;

- 15 percent of the average monthly Phase I CDAP client population was assigned to the detoxification treatment modality, 38 percent to the methadone maintenance modality,

---

*These analytical data are drawn from the Phase I CDAP Final Report; see Discretionary Grant Progress Report, LEAA Form 4587/1, dated June 20, 1974. Annot: The data in this report are an update to the evaluation report, cited op. cit.

**The incidence of prior or active criminal histories with respect to the remaining 12 percent of the Phase I CDAP population is unknown.

40 percent to the drug free modality, and seven percent to other chemotherapy;* and

- Nine percent of the Phase I CDAP client population, or 37 clients, were rearrested and 22 of those 37 clients remained in the program because of satisfactory performance.

On the basis of the evaluative results, the Cleveland IMPACT Planning and Evaluation Staff recommended that CDAP (1) consider during Phase II development of a juvenile treatment component based upon an analysis of relevant Juvenile Court data concerning the incidence of drug abuse among local youths, (2) establish during Phase II a "polydrug"** component to service adults who are not exclusively heroin or cocaine addicts, and (3) emphasize during Phase II more vigorous cooperation and coordination with the Adult Parole Authority, the city and county probation departments, the judges, and the prosecutors serving before both the Municipal Court and the Common Pleas Court.

Extensive management consultations between CDAP and the Cleveland IMPACT Cities Program Office resulted in a number of policy decisions during the winter months of this year which affected both the scope and resources of CDAP. First, as already noted, the grant award was reduced by $324,000. The principal reason for this reduction derived from the mass screening results of the Jail Screening Unit and

---

*CDAP definitions of these four treatment modalities are as follows: Detoxification refers to the provision of diminishing doses of methadone until the client either becomes "drug free" or is maintained at a very low dosage rate. Methadone maintenance provides methadone as an alternative to opiate usage and allows the client to stabilize himself. Drug free means the provision of a range of counseling services but no medication. Other chemotherapy refers to the provision of medication other than methadone, usually tranquilizers.

**A "polydrug" user is a simultaneous user of two or more drugs none of which is an opiate.

the fact that only 387 clients were admitted despite a projection of 1,000 addicts. The mass screening results and the drug-specific client profile indicated that the resources required for Phase II, as originally projected, were excessive and that a substantial amount of the grant funds should be reprogrammed to meet more demanding needs in the overall crime-specific program. In addition, the federal decision to commit NIDA funds to support treatment services was a major incentive to reprogram funds. Second, CDAP and the IMPACT Office together recognized that the extensive resources required for the mass screening approach of the Jail Screening Unit were not producing the number of client referrals commensurate with the expected volume of clients. Moreover, the Jail Screening Unit staff had been gaining months of experience in identifying and interviewing potential clients. This experience developed into a considerable expertise, i.e., the ability to identify a potential client without the initial screening of a urinalysis. Consequently, the decision was made to reduce the size of the Jail Screening Unit and to utilize more selective criteria in identifying potential clients. Lastly, CDAP and the IMPACT Office agreed upon the need to develop better contacts and relationships with the local criminal justice system as a whole in order to gain more referrals from judicial, probationary, parole, and custodial agencies.

The implementation of these recommendations and decisions is the subject of the remainder of this report. Section II discusses the management and performance status of CDAP over the first eight months of this year. Final Phase I performance data are presented. The results of the first four months of Phase II also are presented. Section III describes conclusions about the performance of the program through August of this year and indicates recommendations for management action

consistent with the performance conclusions.

II. MANAGEMENT AND PERFORMANCE STATUS

The performance assessment of CDAP is divided into two parts, the close-out of Phase I and the initiation of Phase II under the joint LEAA-NIDA funding arrangement. However, management and implementation aspects, which have impinged upon both phases, undoubtedly have influence performance results. Where appropriate, this influence is noted to the extent that the available data permit separation of Phase I and Phase II effects.

PHASE I: JANUARY - APRIL 1974

The concluding four-month period of Phase I CDAP operations, January through April 1974, is characterized by performance patterns similar to those reported for the preceding nine months.* Specifically, the mass screening effort by the Jail Screening Unit continued during the first four months of this year at a somewhat higher relative volume of activity; 6,473 arrestees were located in the City Jail, 4,114 of whom agreed to be tested, 1,062 of whom refused to be tested, and 1,075 of whom were found as drug positive upon test.

From this mass survey of the jail population, 61 arrestees were interviewed by the Jail Screening Unit; however, only 12 of the 61 became referrals to the program. The problem therefore of the incommensurability between the scope and cost of the jail screening effort and the number of jail-generated client referrals persisted well into 1974. Moreover, despite a recognized need to develop better referral contacts and sources

*The data summarized in the paragraphs which follow were tabulated from the January-April 1974 Performance Status Reports (PSRs). PSRs are submitted monthly to the Cleveland IMPACT Cities Program Office for the purpose of providing timely information about CDAP screening and referral activities, and summarizing aggregate performance results about program entry, program exit, and recidivism of CDAP clients.

with other local criminal justice agencies familiar with IMPACT goals and objectives, 53 percent of all referrals were either self-initiated or effectuated through a friend, relative, or other unofficial third party. The remaining 47 percent of the January-April referrals were divided as follows: seven percent from the Jail Screening Unit, 22 percent from judicial, probationary, and correctional agencies, three percent from other local drug abuse programs, and 15 percent from "other" unspecified referral sources.

From a diagnostic and treatment standpoint, there was an average of 238 active clients per month in CDAP diagnostic and treatment components during the first four months of 1974. During this same period, a total of 186 clients entered or reentered the program, 84 percent of whom were diagnosed with a primary drug problem involving opiates. This figure compares with a Phase I March-December 1973 percentage of 73 for clients diagnosed with a primary drug problem involving opiates. The remaining 16 percent of the January-April Phase I client population was a mixture of barbiturate and other, i.e., illicit methadone, cocaine, amphetamine, hallucinogen, marijuana, alcohol, and non-prescriptive substance, users. In short, the drug-specific and client-specific characteristics of the final Phase I CDAP clients do not vary significantly from those characteristics reported in the IMPACT March Phase I CDAP evaluation report.

Most of the data presented in the foregoing discussion is summarized in Table 1. The table has been organized to permit comparison between the performance results already documented for the March-December 1973 Phase I period and the performance results tabulated for the concluding January-April 1974 Phase I period.

From an examination of the two data categories set forth in the

TABLE 1

FINAL PHASE I PERFORMANCE TABULATIONS

DATA CATEGORY	PHASE I (MAR-DEC '73)	PHASE I (JAN-APR '74)
ARRESTEES TESTED	10,000 est.	4,114
CLIENTS ACCEPTED	387	186
CLIENTS IN CDAP AT END OF PHASE PERIOD	220	N/A*
CLIENTS EXITED	167	146
• Satisfactory Completion or Exit	18	37
• Dropped Out or Unsatisfactory Exit	114	102
• Rearrested	13	7
• Other	22	N/A*
CLIENT REFERRAL SOURCE DISTRIBUTION (BY PERCENT)		
• Jail Screening	N/A*	7%
• Criminal Justice Agencies	45%	22%
• Self-Referral, Friend, Etc.	28%	53%
• Other Drug Abuse Programs	17%	3%
• Other	10%	15%
CLIENT PRIMARY DRUG PROBLEM DISTRIBUTION (BY PERCENT)		
• Opiates	73%	84%
• Barbiturates	6%	5%
• All Other**	21%	11%
TREATMENT MODALITY DISTRIBUTION (BY PERCENT AVERAGE PER MONTH)		
• Detoxification	15%	16%
• Methadone Maintenance	38%	40%
• Drug Free	40%	36%
• Other Chemotherapy	7%	8%

NOTES:

*"N/A" refers to data not available at this time; in case of the Jail Screening notation, "N/A" refers to fact that data are included in the other data categories and are not broken out separately for the jail survey.

**"All Other" refers to one or a combination of the following drug types: methadone, amphetamine, cocaine, marijuana, hallucinogen, or other proscribed drug substance.

DATA SOURCES: Data used to prepare this table were drawn from the IMPACT evaluation report, cited supra; the January-April 1974 PSRs; and the January-April 1974 monthly and quarterly Discretionary Grant Progress Reports.

two bottom data aggregations in Table 1, it should be obvious that the client drug problem and the client treatment modality distributions did not change significantly between the two reporting periods of Phase I. In other words, CDAP's screening and service delivery system focused throughout both periods of Phase I on the opiate drug abuser. Fifty-three to 56 percent of the treatment modality loadings consisted of either methadone maintenance or detoxification.

This conclusion should be qualified in two respects insofar as the evaluative data discussed here contain two important information gaps which limit definitive interpretation of the results of Phase I operations. First, there are no jail screening data yet available for the final months of Phase I which would permit analysis of the drug-specific distribution of opiate and cocaine usage versus "polydrug" usage among arrestees detained in the City Jail or clients entering the program through other referral mechanisms. This information is an important supplement to the drug-specific distribution noted above in Section I for the first nine months of Phase I operations during 1973. Any changes reported in the screening distributions between 1973 and 1974 (January-April) would be helpful in completing the profile of drug abuse problems and crime in the City of Cleveland. Second, the client-specific performance data, including treatment outcome data,* which are routinely collected on the two-

*The January-April 1974 DCI data have been received from CDAP and they have been edited, keypunched, and verified preparatory to analysis by computer. Since the data are in the same format as the Phase I DCI data analyzed during December and January of 1973-1974, it should be noted that the March-December 1973 Phase I DCI data were analyzed at the Cleveland State University Computer Center by utilization of the Center's Statistical Program for the Social Sciences (SPSS) computer program package. Mr. Laurence G. Mackie, formerly of the IMPACT staff and also the CDAP staff, took responsibility for this data processing. For details concerning this processing, see the JRB Memorandum re "CDAP DCI Analysis," dated December 28, 1973.

part client entry/exit Data Collection Instrument (DCI) have not yet been analyzed. Like the drug-specific jail screening data, the DCI data are integral to any final assessment of Phase I.

Other questions concerning the Phase I performance results should be addressed such as the reasons explaining the high dropout and unsatisfactory exit rate. However, an understanding of these questions and others which might be raised is best deferred until a description of the CDAP transition from Phase I to Phase II is presented. Throughout the period November-April 1937-1974, a number of management and implementation changes were in process. A brief summary of the important changes is essential to any evaluative interpretation of Phase II operations.

PHASE II: MAY - AUGUST 1974

During the winter and spring months of this year, the CDAP management staff, in consultation with the Cleveland IMPACT Cities Program Office, made a number of extensive changes in personnel and the geographical distribution of field operations. By the beginning of the second quarter of the year, CDAP had effected numerous personnel transfers and lay-offs consistent with the recommendations of the IMPACT evaluation report and the CDAP-LEAA-NIDA fiscal negotiations regarding Phase II operations. These changes are documented in detail in the quarterly Discretionary Grant Progress Report, January-March 1974.

In addition, between April and August, there were three changes in the operations and location of CDAP treatment facilities. First, the operations of the Harper Hall inpaient treatment component at the House of Correction were terminated during April. Although the August probe into management problems at the House of Correction underscored reasons for the termination,

the spring reasons for the termination primarily related to administrative conflicts between House of Correction and CDAP managers over the objectives, purpose, and treatment philosophies underpinning delivery of Harper Hall's inpatient and clinical services. Attempts to resolve administrative issues were complicated by the LEAA-NIDA disagreement over funding jurisdictions and responsibilities. In view of these difficulties, CDAP decided simply to terminate Harper Hall operations. The events of late summer demonstrated that this decision was as anticipatory as it was wise.

Second, CDAP management decided in May to terminate the outpatient Kinsman Clinic on the East Side because (1) Kinsman was not receiving as many clients as originally anticipated in that area of the East Side, (2) the majority of clients receiving CDAP clinical services were residents of the Near West Side, (3) the Kinsman staff was considered more appropriate in terms of experience for transfer to the J. Glen Smith and the Jones Memorial Health Center at two other East Side locations, (4) Kinsman was as a consequence of the foregoing not cost-effective, and (5) the planned opening of a West Side clinic at the McCafferty Health Center, under NIDA funding, was a higher priority in terms of resource tradeoffs.

Third, in late August, the McCafferty Drug Clinic was officially opened on the West Side under NIDA funding. The McCafferty treatment staff, which between May and August had been providing services to CDAP clients at the downtown central office location at 1801 St. Clair Avenue, was transferred to the West Side location in August.

These personnel and logistical changes were made to reinforce the modified objectives which were developed as a result of the assessment of the first nine months of Phase I operations. These objectives included: (1) institution of more selective screening approaches, (2) establishment of a polydrug treatment capability, (3) establishment of a juvenile treatment

capability, and (4) development of better referral relationships between CDAP and local criminal justice agencies.

Comparison of these objectives with the performance results of the initial four months of Phase II operations reveals some significant differences between Phases I and II. From a screening standpoint, the number of Phase II arrestees or potential clients tested was 1,196 reflecting a much more selective process of both identifying potential CDAP clients and testing them through urinalysis. Moreover, the Phase II data show that CDAP's screening process, while becoming more selective, also expanded its services to other users. Over 1,000 urinalysis tests were undertaken for other drug abuse programs including Community Action Against Addiction and the Cleveland office of the Ohio Bureau of Drug Abuse. Consequently, at the same time that the scope of CDAP's screening and interviewing process was becoming more restrictive, the availability of screening services was being expanded for the benefit of other drug abuse efforts in the Greater Cleveland area.

As a result of the program's selective jail screening process, 101 arrestees were interviewed by the Jail Screening Unit. In absolute numbers, this number is 40 more clients interviewed than during the previous four-month period, January-April 1974. While the data do not permit a one-to-one correspondence through the reporting rigor of individual client tracking, they do show an increase in the percentage of the client population generated as a result of jail screening operations. Specifically, the Jail Screening Unit increased its percentage of the client population from seven percent during the January-April 1974 final Phase I period to 18 percent for the May-August initial Phase II period.

From a diagnostic and treatment standpoint, there was an average of

243 active clients per month in CDAP components during the initial Phase II period. During this same period, a total of 181 clients entered or reentered the program, 76 percent of whom were diagnosed with a primary drug problem involving opiates. This figure compares with a total Phase I percentage of 79 percent for clients diagnosed with a primary drug problem involving opiates. The remaining 24 percent of the May-August 1974 client population was a mixture of barbiturate and other, i.e., illicit methadone, cocaine, amphetamine, hallucinogen, marijuana, alcohol, and non-prescriptive substance, users. In other words, CDAP is still a program which is most responsive to opiate users. In this sense, there was no clear and present requirement for establishment of a polydrug capability as such. The treatment services available from the outpatient clinics and inpatient facilities appear to be adequate for servicing the medical and counseling needs of the clients admitted to CDAP. These service requirements of course could change if new types of drug-specific distributions appear in the client data gathered during the coming months.

Most of the data presented in the preceding discussion is summarized in Table 2. The table has been formatted in the same fashion as Table 1 to permit comparisons between commensurable aggregates of data. The two columns in Table 2 present total Phase I performance data and the initial Phase II, May through August, performance data. While the client primary drug problem and treatment modality distributions do not show significant variances, with the exception of a greater percentage of Phase II clients assigned to methadone maintenance, i.e., 39 percent in Phase I versus 52 percent in Phase II, the referral source distributions do indicate some positive changes. The jail screening activity and the criminal justice referral contacts have been responsible for generating nearly half of all client admissions, i.e., 46

TABLE 2

INITIAL PHASE II PERFORMANCE TABULATIONS

DATA CATEGORY	PHASE I (MAR '73-APR '74)	PHASE II (MAY-AUG '74)
ARRESTEES AND/OR POTENTIAL CLIENTS TESTED	14,414	1,196
CLIENTS ACCEPTED	573	181
CLIENTS IN CDAP AT END OF PHASE PERIOD	N/A*	N/A*
CLIENTS EXITED	313	183
• Satisfactory Completion or Exit	55	70
• Dropped Out or Unsatisfactory Exit	216	97
• Rearrested	20	2
• Other	22	14
CLIENT REFERRAL SOURCE DISTRIBUTION (BY PERCENT)		
• Jail Screening	N/A*	18%
• Criminal Justice Agencies	36%	28%
• Self-Referral, Friend, Etc.	41%	25%
• Other Drug Abuse Programs	10%	2%
• Other	13%	27%**
CLIENT PRIMARY DRUG PROBLEM DISTRIBUTION (BY PERCENT)		
• Opiates	79%	76%
• Barbiturates	5%	5%
• All Other***	16%	19%
TREATMENT MODALITY DISTRIBUTION (BY PERCENT AVERAGE PER MONTH)		
• Detoxification	15%	11%
• Methadone Maintenance	39%	52%
• Drug Free	38%	30%
• Other Chemotherapy	8%	7%

NOTES:

*"N/A" refers to data which are not available at this time.

**Includes all referrals from State institutions.

***"All Other" refers to one or a combination of the following drug types: methadone, amphetamine, cocaine, marijuana, hallucinogen, or other proscribed drug substance.

DATA SOURCES: Data used to prepare this table were drawn from the IMPACT evaluation report, cited supra; the May-August 1974 PSRs; and the May-August 1974 monthly and quarterly Discretionary Grant Progress Reports.

percent. The percentage of self-referrals is down from the Phase I 41 percent to 25 percent and the "Other" category, while up from 13 percent to 27 percent, reflects a substantial number of referrals from State institutions. These data point to some positive trends with respect to the intended upgrading of the client referral process involving local agencies of the criminal justice system. Judicial and probationary cooperation has been substantially improved. The data also point to some positive trends with respect to the effectiveness of the selectivity approach of the jail screening operation.

On the negative side, there are two obvious deficiencies with respect to CDAP's expected Phase II performance. First, a juvenile treatment capability was not implemented during either the closing months of Phase I or the initial period of Phase II. Despite the submission of a proposal to Juvenile Court to assist the Court and its probationary services in grappling with juvenile drug abuse problems, no firm agreement was reached between the Court and CDAP and the effort to initiate an expansion of CDAP into juvenile services was abandoned during the early spring months. Second, while the number of dropouts and unsatisfactory exits has been reduced from 216 during Phase I to only 97 during Phase II, the projection of the Phase II dropout and unsatisfactory exit rates appears capable of equaling if not surpassing the Phase I rates. Consequently, there is a need to focus analytical scrutiny upon isolation of those factors which may be influencing the high incidence of dropouts and unsatisfactory exits.

On balance, the performance data reflect some important improvements in various aspects of screening, diagnostic, and treatment service delivery.

III. CONCLUSIONS AND RECOMMENDATIONS

The Phase I-Phase II analysis is still too preliminary to point to-

ward definitive conclusions. The data must be interpreted against the administrative and operational background of important changes in both personnel and the geographical configuration of service locations.

The fact that (1) the Harper Hall operation was terminated, (2) the central office's McCafferty treatment staff was moved to the West Side, (3) a new outpatient service location was established on the West Side, and (4) that major staff changes were in process, especially the shift from Kinsman to J. Glen Smith and Jones Memorial, influenced the ability of CDAP to respond to existing demands much less new and shifting patterns in its caseload. It is still too soon, in other words, to assess the implementation of all recommendations arising out of the operational experience of Phase I.

However, the program appears to be doing as well as the milestone requirements set forth in the Phase II grant application specify concrete accomplishments. The reporting, both through the PSRs and the monthly and quarterly progress reports, has been excellent. More definitive management and performance judgments about CDAP's performance await the receipt of an additional quarter of PSR data to permit identification of specific trends and changes in the client referral, drug problem, and modality distributions depicted in Tables 1 and 2. In the meantime, the CDAP staff should be asked to develop methods for attempting to isolate those factors, i.e., independent variables, which appear to be affecting the incidence of dropouts and unsatisfactory exits, i.e, the dependent variable. Analysis of the available DCI data might permit formulation of some preliminary hypotheses which then might be tested for their explanatory power during subsequent periods of CDAP operation. The IMPACT Planning and Evaluation Staff currently has in-house a DCI data deck for clients in CDAP through March of this year. The data deck should be updated with April through

August data and some computer analysis routines should be applied to the data. These routines are described on page eight of this report. The Planning and Evaluation Staff should consider utilization of the software package described on page eight for the final Phase I and the initial Phase II analysis. One possible outcome of such an analysis is formulation of hypotheses to explain the dropout and unsatisfactory exit rates as already noted above.