STUDY LIMITATIONS

This report presents information on 1,056 clients who received substance abuse treatment during state fiscal year 2003 in Kentucky publicly-funded treatment programs. There are several areas of limitation to the findings presented in this report. First, both the intake data and the follow-up data are self-reported. While self-reports have been shown to be valid in comparison to urinalyses (Rutherford, Cacciola, Alterman, McKay, & Cook, 2000) reliance on self-reports in this study may be an important limitation. Second, unlike many outcome studies, this study does not focus on a single treatment modality or a set of pre-selected treatment modalities such as residential treatment, or any one approach like social skills training. Likewise, this treatment outcome study is not a clinical trial that tests the efficacy of interventions. The KTOS project examines treatment outcomes from everyday clinical practice among the 14 Community Mental Health Centers who provide state and SAPT Block Grant funded services. It includes clients who have participated in many different treatment modalities including both residential and outpatient. Third, clinicians have varying interview skills and this might impact the reliability of the data they collected for the baseline. Finally, avoided cost estimates are an approximation of savings for Kentucky and are based on national cost estimate models.

Validity of Self-reports

While there can be reason to question the validity and reliability of self-reports of substance use, recent research has supported earlier findings about the reliability and accuracy of substance users’ reports (Del Boca & Noll, 2000; Rutherford, et al., 2000). Earlier studies found that the context of the interview influences reliability (Babor, Stephens, & Marlatt, 1987) and generally self-reports even at the beginning of treatment as well as during treatment have been shown to be reliable (Rutherford, et al., 2000). Concerns about deception in self-reports is most likely at baseline where information is being collected by a clinician whom clients may see as affiliated with the courts, probation or parole systems. Distortion at follow-up, when the interviewer is unknown to the client may be less likely. Overall, studies have reported little evidence to support the idea that social undesirability of substance abuse behaviors is a major contributing factor to under-reporting (Bradburn, 1983). In addition, it is important to understand the reliance on self-reports in health research as well as in substance abuse studies. For example, research on other chronic health problems such as diabetes, chronic headache, obesity, hypertension and heart disease often depends on self-reported diet, exercise, medication compliance, and weight reduction efforts (Holroyd, et al., 2001; Mokdad, et al., 2001; Pereira, et al., 2002). While there are concerns about the validity of self-reports, research in the fields of health, mental health, and substance abuse uses self-report to collect information about daily behaviors.

No Single Treatment Modality

Another study limitation is that many different modalities and clinical approaches are included as well as dual diagnosis treatment approaches that can include medication and psychiatric care along with substance abuse counseling. Most treatment outcome studies using follow-up data examine a specific type of treatment with controls over length of stay and specific interventions used. This statewide study examines clients who have received many different types of treatment with greatly varied lengths of stay in treatment.

Clinicians as Data Collectors

This study relies on clinicians for baseline data collection, including locator information from consenting clients. The baseline data are collected by clinicians with varying levels of training.
and skill with structured interviewing. Consequently, reliability for substance use and other questions may pose another limitation. Also, clinicians may have limited awareness of the importance of collecting accurate locator information, which can affect follow-up contact rates and, consequently, the sample representativeness.

Limitations in Cost Benefit Ratio Estimates

The cost benefit ratio estimates presented in this report have several limitations. First, the arrest data were self-reports. While the literature suggests that client self-reports can be valid (Del Boca & Noll, 2000; Rutherford, et al., 2000) the validity of self-reports is unknown in this study. Second, there are also limitations on access to third-party data such as paid unemployment benefits, welfare, corrections, and law enforcement, which were not used in this study. Third, national rather than specific state costs estimates were used, except for the jail costs, which were developed for Kentucky. Finally, there are potential avoided costs to society that were not included that might affect cost savings estimates. However, data presented here are an appropriate approximation of savings that result from Kentucky state-funded substance abuse treatment.
REFERENCES


REFERENCES


National Institute on Drug abuse (NIDA) and the National Institute on Alcoholism and Alcohol


