CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

This qualitative research is to assess the strategic management of drug addiction treatment in fiscal year 2002 by the Rayong Provincial Health Office. Data was collected through focus groups of health personnel responsible for drug addiction treatment at the provincial, district, and *tambon* levels using the SWOT Analysis and documentary analysis. The data obtained was analyzed using four perspective of Balance Scorecard.

5.1 Conclusion and Discussion

The first drug addiction treatment program launched by the Rayong Provincial Health Office focused on health promotion and awareness campaigns for specific high risk groups; treatment was designed for addicts of heroin, opium and cannabis. Later, building life skills was incorporated; coordination with other government agencies was established; and monitoring and evaluation was done at various hospitals.

When drug addiction became a more serious problem, especially addiction to amphetamine, the program was further developed with the introduction of the Matrix Program in 2000. Health facilities in the province were upgraded and health personnel were trained to be able to provide addiction treatment under the Matrix Program. A plan was drafted for continued human resource development within the structure of the Rayong Provincial Health Office. This is based on the belief that continued professional skills building will enable health personnel to perform better, and good results in turn will lead to job satisfaction.

Coordination with the provincial level agencies of other ministries that also have a narcotics mandate was institutionalized. Most of these agencies saw the value of coordination but the challenge was in tuning their different programs, each with its own objective and methodology. The addiction programs covered prevention, detoxification/treatment, follow up (or after care) and rehabilitation.

The Rayong Provincial Health office received most of its budget from the Ministry of Public Health with additional funding from other ministries. It then allocated this budget to all health facilities under its responsibility in the province to implement their respective projects.

There were several approaches to health promotion and awareness campaigns in the community, schools and factories. At the district level, some clinics designed their approach especially to suit the problem in their area. Some trained village health volunteers to work with high risk groups within their communities. A research project was also initiated to look into the best approach possible.

As for evaluation there was no standardized monitoring and evaluation system instead it was done on a project by project basis. A meeting was also held to review problems, obstacles and solutions in 2002. Obstacles encountered in the past year include multiple duties and responsibilities for limited number of health personnel; several sets of work procedures to be followed; and unclear administrative and organizational structure as a result of civil service reform, down to the Primary Care Unit (PCU). Coordination with other government agencies was made complicated by a lack of a unified policy. Other obstacles include lack of proper space within existing health facilities for addiction treatment and insufficient funding to monitor patients. There was no standard for data collection and record keeping.

From the patients' perspective, the inability to "come out" in a society that rejects and even condemns drug addiction was a major barrier to effective treatment and rehabilitation. Some patients were uncomfortable having to wait for their turn to see their doctor in the same waiting area as patients (of other diseases), causing many to discontinue treatment.

The following is an analysis of the results of the drug treatment program implemented by the Rayong Provincial Health Office in 2002 using four perspectives of Balance Scorecard:

5.1.1 Customer Perspective

From the customer perspective, it was found that the "Strong Family-Warm School" project met the target of 100% attendance by targeted parents and students. However it was not possible to assess in percentage

point how satisfied they were because there was no monitoring of the project's outcome.

As for the community project to identify addicts to enroll in treatment programs, it was found that 80% of the targeted villages took part. The "boot camp" for addicts under legal/regulatory supervision, saw a 100% attendance by the target group, while the "school camp" saw 78.57% of youths and students participate.

For "camp" activities, it is not possible to assess the percentage of those who will kick the habit because there was no monitoring and evaluation.

There also was not evaluation of the satisfaction gained from the Matrix Program that has resulted in the formation of a team of therapist for each district (100%) and upgrading of health facilities and personnel in seven hospitals (100%) and three health centers (2.82%). It is estimated that 80% of those addicts who receive this treatment were satisfied.

As for the project to train health personnel in Matrix Program and counseling for outpatient drug addicts, it was found that 100% of the target group took part in the training. But it is not possible to assess in percentage point, their satisfaction with the training course or how much skills they have gained from the training course because there was no monitoring and evaluation.

The qualitative analysis from customer perspective done during the focus groups concluded that overall drug addiction treatment in Rayong was 60% successful with some health facilities being 100% successful. Health personnel with long time experience were satisfied and proud of their performance.

5.1.2 Internal Process Perspective

From the internal process perspective, it was found that the addiction program in Rayong covered prevention, detoxification/treatment and rehabilitation, as well as capacity building for health personnel. There were also projects to engage the community to identify drug addicts to enroll in addiction program; to treat and rehabilitate addicts carried out at health facilities; "boot camps" for the youth and student addicts under

legal/regulatory supervision; capacity building for health personnel in "Matrix Program" and counseling for outpatients.

There was collaboration with educational institutions to strengthen skills for co-habilitation between parents and students to enable parents to deal with the behavior and emotions/moods of young people in various age groups. As for the output of this project, it was found that 100% of the parents took part as planned but without a monitoring and evaluation component, it is not possible to demonstrate outcome or how many of those parents actually acquired the co-habilitation skills to deal with the behavior and emotions/mood of children of various age groups.

As for the project to engage the community to identify addicts to enroll in treatment and rehabilitation, it was found that 80% of the target villages took part. There was collaboration with those agencies involved in organizing "boot camps" for youth addicts and student addicts under legal/regulatory supervision, resulting in 100% attendance by the target group. As for "behavior change" camps for the youth and students, it was found that such camps were organized in 80% of the target area. Under the project for treatment and rehabilitation of drug addicts using "Matrix Program" at health facilities, there was upgrading of the existing health facilities and forming of a team of therapists for each district in Rayong. A "Modified Matrix Program" that is more flexible and adjustable to suit the situation in Rayong was put in place.

However there lacked a standardized archiving system and this has made it impossible to conduct a qualitative review of the strengths and waknesses of the program.

A plan was drafted to train health personnel in the implementation of the Matrix Program and in counseling at Thanyarak Hospital. This project scored 100% according to plan.

There was a process for capacity building for health personnel in "Matrix Program" in seven hospitals (100%) and three health centers (2.82%). Research found that only 2.82% of health centers were capable to implement the Matrix Program and that only 25.8% of the addicts completed their treatment, this is lower than 50% target set by the Ministry of Public Health.

The qualitative analysis done during the focus groups, both the provincial level, and district and *tambon* level health personnel responsible for addiction treatment concluded that the administrative structure was clear but that implementation could be done several ways. In terms of organization, there were clear cut regulations, duties and responsibilities, as well as well defined planning for human resource development. Both groups also concluded that there was no clear system for monitoring and evaluation which has resulted in the lack of useful data for further program development.

5.1.3 Learning and Growth Perspective

From the learning and growth perspective, it was found that in 2002 there were skills building at various levels: the family, parents, students, youths, and those addicts under legal/regulatory supervision. The community was also given the opportunity to learn and take part in the process to identify addicts to enroll in treatment programs. And health personnel learned about the Matrix Program and counseling techniques. A team of "Matrix Program" was formed in each district and health facilities have upgraded their facilities to implement treatment and rehabilitation programs to an acceptable standard.

From the perspective of learning and growth, only the output of the above can be assessed but not the level of knowledge gained from those participants in the various projects because there was no evaluation. It can be seen that upgrading of health facilities also required that health personnel there have knowledge and know-how to do the work.

From the qualitative analysis from the learning and growth perspective, the focus groups concluded that a mechanism for training has been put in place at the provincial level. Health personnel, including those at the tambon level, have the opportunity to gain more knowledge and skills. However, capacity building focused primarily on drug addiction treatment. This is because further improvement of the overall treatment work was being obstructed by the lack of reliable data resulting from inconsistent record forms, and standardized monitoring and evaluation, needed for effective strategic planning. The focus groups also found that for those health personnel with at least three years of experience in addiction treatment, further training has contributed to successful work.

It can be seen that the use of Balance Scorecard enables assessment of the organization from four important perspectives.

In addition, there are other perspectives that should be taken into account, namely, balancing between short-term and long-term perspectives. Most assessment of an organization is carried out from the financial perspective alone, which is short-term and which disregards capacity building, appropriate technology, and the overall learning and growth of the organization. This research found that only 8.7% of the budget has been allocated to capacity building which is a long-term perspective, while most of the budget or 81.19% was spent on treatment and rehabilitation, which not only is short-term but addresses the addiction problem after it was occurred. The budget for prevention was 10.10%.

There are also internal and external perspectives to be taken into account. The researcher believes that it is crucial to undertake agenda building and community engagement. Public Relations strategies should be used to build public understanding of what it takes to treat and rehabilitate drug addicts. As for the establishment of indicators for cause and effect, from the available data that 25.8% of those addicts who enrolled actually completed their treatment (which is rather low compared to the target set by the Ministry of Public Health), if there are indicators for cause, it will contribute to understanding the problems and obstacles before an addict withdraws from treatment.

5.1.4 Financial Perspective

In 2002, the Rayong Provincial Health Office received a total of 1,504,792 baht from two sources: 1,282,792 baht (85.25%) from the Ministry of Public Health, and 222,000 baht (14.75%) from the Rayong Provincial Administration Organization. Though the amount from the latter is relatively small, its significance is in the role that the local ministration has taken up in drug addiction programs.

Of this total budget, only 152,000 baht (10.10%) was spent on prevention by hosting a workshop for parents and students. This is small compared to 1,221,726 baht (81.19%) spent on treatment and rehabilitation.

The cost to identify addicts in the community was 15,154 baht, higher than estimated because only four villages took part in the project. It can be seen that from the financial perspective, it is not possible to calculate

the cost-effectiveness of this project because there was no data on the budget allocated to each district and there was no monitoring of results.

The cost of the two "boot camps" for young addicts and student addicts under legal/regulatory supervision, were 2,333 baht and 2,318 baht respectively. It can be seen that there is not much difference in the costs between the two.

This research found that the cost for treatment and rehabilitation using social psychology therapy conducted at health facilities was 7,208 baht per patient, against 3,455 baht set by the Ministry of Public Health. The cost is higher in Rayong because it covers treatment and follow-up of patients until they complete their treatment, and upgrading of health facilities to be able to support this social psychology therapy. The two were not clearly marked and thus it is not possible to calculate the real cost for only treatment and rehabilitation.

The budget for capacity building for health personnel to implement the Matrix Program and training in counseling for addicts at Thanyarak Hospital, was 131,066 baht, or 8.7% of the total budget. The cost per head of personnel trained was 3,542 baht which is very small compared to the overall budget. This figure does not include time lost of health personnel who were absent from normal daily routine in order to attend the training. As for budgetary management, it was found that there was no record keeping on budget allocation and there was no effective financial audit. This made it impossible to assess both cost-effectiveness and results of the project. And thus it was not possible to calculate cost.

It must be highlighted that the budget spent on treatment and rehabilitation is much higher than that spent on prevention and capacity building for health personnel.

The financial qualitative analysis done during the focus group of provincial level health personnel responsible for addiction treatment concluded that it was not worth the budget as compared to other health programs implemented under the Rayong Provincial Health Office. However, the focus group of district and tambon level health officials concluded that it was worth it because it was able to reduce losses of human resource to drug addiction and also to return this human resource to society. This benefit cannot be measured in financial terms.

In addition, it was found that the 2002 budget did not include monitoring activities for those addicts who have completed their treatment. This means that there was no funding for continued monitoring and evaluation.

5.2 Recommendations

1. Administrators should introduce scorecards to all health facilities in the province in order to clearly set the terms of reference for each facility. In the initial stage, suffice it to have one scorecard per facility, no need to have one for each health personnel.

2. Indicators should be established to measure the standard of facilities in relations to patient satisfaction. This might include, the space (room size) made available and conducive surrounding for drug treatment. Data in this regards could also be obtained by surveying patients.

3. Scorecards should be the basis for calculating compensation for health personnel.

4. The Rayong Provincial Health Office should adjust its budget allocation according to the BSC management model in order for funds to suit various perspectives: internal, customer, learning and growth. This should be done considering three dimensions: short-term-long-term, internal-external, and leading indicator-lagging indicator. For example, findings that only 2.82% of health centers in Rayong have the capacity to provide Matrix Program underlines the need to expand activities and increase investment, and further develop their internal structure all of these are long term perspective.

5. The Rayong Provincial Health Office should be equipped with an appropriate information management system to receive and process data from the various leading indicators to help prevent loss of follow-up. These include suitability of space allocated for treatment of drug addicts, its ambience, and the service provided by specialized doctors. The lack of timely and accurate situation analysis, the provincial health care system will not be able to prevent drop outs from treatment programs.

6. From the customer perspective, in their capacity as state employees, this perspective should be adjusted appropriately to cover the cost and benefits of the community at large. It should also include indicators of sustainable community participation and knowledge building for the

community. The government sector should have a "collaboration team" built into its system that links up and works with community-based organizations to find solutions to problems.

The researcher also proposes that the administrator should think of the cost of performance by using the principle of future list to management system for cost recovery to ensure the survival of the organization. And academics and staff members (implementers) should perform their duties considering cost and value simultaneously to ensure quality and effectiveness of their work by balancing policy, implementation, and academic considerations.

Future studies on drug addiction treatment should emphasize the following aspects:

- A comparison of strategic management by using Balance Scorecard "before and after" implementation;
- Cost analysis of the allocation of government resources to resolve drug addiction;
- Cost effectiveness analysis of the model for drug addiction treatment in Rayong Province; and,
- Research of a "Modified Matrix Program" appropriate for use in the treatment of addicts in Rayong Province.