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Drug Treatment Services Could Be Improved by New Accounting Program

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Human Resources Division

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The Honorable Charles B. Rangel
Chairman, Select Committee on
Narcotics Abuse and Control
House of Representatives

Dear Mr. Chairman:

Drug abuse and the need for treatment continue to be major national problems. As the federal expenditure for drug treatment increases, policymakers want assurances that federal funds are used to develop effective drug abuse treatment programs.

You asked us to review: (1) how states have implemented the 1988 legislative requirement to assess the quality and appropriateness of drug treatment services supported by the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant as specified in the Anti-Drug Abuse Act of 1988; (2) whether states are providing pertinent information for the Congress to know the effect of the federal investment in drug treatment services; and (3) how the Department of Health and Human Services's (HHS) plans to hold states more accountable for the use of ADMS funds.[1]

Background

The ADMS Block Grant is the major federal program for funding drug treatment services at the state level. In 1981, the Congress consolidated into the ADMS Block Grant seven federal programs for alcohol, drug abuse, and mental health services. This block grant provides funds to states for planning, establishing, and evaluating programs for the development of more effective prevention, treatment, and rehabilitation services. In fiscal year 1989, federal ADMS Block Grant expenditures were about $500 million. This block grant contributes to the approximately $2.4 billion spent by public sources on alcohol and drug abuse treatment and prevention services.[2]

Ensuring the effective use of ADMS funds is the shared responsibility of the federal and state governments. Since 1981, states receiving ADMS Block Grant funds have been required to provide the Secretary of HHS

[1]Accountability refers to states' obligations to the federal government to monitor, report on, explain, or justify the activities supported by the ADMS Block Grant.

[2]Public drug treatment funding comes from federal, state, and local sources.

with information on their block grant activities. During the 1980s, federal legislative requirements for information from the states have developed to include: (1) a description of the intended use of funds to be submitted as part of a state's annual application for funds; (2) a statement that, among other things, assures that the state will identify the populations and areas needing services and will use funds in accordance with the requirements of the ADMS legislation; (3) an annual report on block grant activities; and (4) a biennial audit report on program expenditures.

The Anti-Drug Abuse Act of 1988 included a new requirement that states must agree to provide for

> ". . . periodic independent peer review to assess the quality and appropriateness of treatment services provided by entities that receive funds from the State . . .."

The act did not define the terms "peer review," "quality," or "appropriateness" or specify the processes to be used to implement this requirement.

In its report accompanying H.R. 4907, a bill that resulted in the 1988 act, the House Committee on Energy and Commerce noted that because of insufficient information the success, failure, or quality of drug treatment and other services could not be determined, despite a significant investment by the federal government in state block grant funds. The Committee also noted that a contributing factor to this lack of information was HHS's unwillingness to require states to adopt a common methodology for evaluating the programs funded through the block grant.

The act also removed language that prohibited HHS from (1) prescribing the manner in which states should comply with the act's requirements and (2) establishing burdensome annual reporting requirements.[3]

HHS Oversight

HHS, through the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), oversees state administration of federal drug treatment funds. HHS, however, has provided only minimal oversight of ADMS Block Grant funds. HHS's minimal oversight reflects the Department's interpretation of the 1981 block grant legislation. This interpretation is

[3]Sections 2028 and 2037 (a)(1)(B) of the Anti-Drug Abuse Act of 1988 (P.L. 100-690).

expressed in regulation 45 C.F.R. 96.50(e). This 1982 block grant regulation provides that the agency will

"... defer to a State's interpretation of its assurances and of the provisions of the block grant statutes unless the interpretation is clearly erroneous."

HHS oversight is also influenced by Presidential Executive Order 12612 of October 26, 1987. This order advises federal agencies to be guided by the fundamental principles of federalism, and grant states the maximum administrative discretion possible. The overall effect of HHS's policy is to give states wide discretion in implementing the legislative requirements related to the grant. This means that whatever a state does in response to these legislative requirements is likely to be viewed as in compliance, unless HHS finds the state's interpretation clearly erroneous. To date, HHS has rarely issued official determinations that a state's interpretation was clearly erroneous.

To enhance the ADMS Block Grant, ADAMHA created the Office for Treatment Improvement (OTI) in early 1990. OTI is charged with helping states improve both the services supported by and the management of ADMS Block Grant funds. OTI is developing a strategy to enhance state and federal accountability for the use and oversight of drug treatment funds.

Results in Brief

The Congress receives limited information on the results of the federal investment in drug treatment services. Although most of the states we reviewed monitor administrative processes, their review activities have not provided information on the quality and appropriateness of drug treatment.

OTI has developed a program that could help better assure that the drug treatment services supported by ADMS Block Grant funds are effective in reducing drug abuse. This program would (1) develop federal drug treatment program guidelines, (2) institute federal performance reviews of state substance abuse agencies and drug treatment programs, (3) provide technical assistance to states and providers as part of these reviews, and (4) collect more detailed information on what states will do and have done with funds received through the ADMS Block Grant.

We believe OTI's program is intended to have the effect of increasing state accountability for ADMS funds. However, consistent with HHS's policy to grant states wide administrative discretion, implementation of OTI's program will be left to the states. If states choose not to implement

OTI's program, the improvements to and monitoring of drug treatment services supported by the ADMS Block Grant may be jeopardized.

Scope and Methodology

To examine how states addressed the 1988 legislative peer review requirement we selected 10 states—California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas—that received about 60 percent of the ADMS Block Grant funds appropriated for fiscal year 1990. We reviewed fiscal year 1989 ADMS annual reports and documents provided to us by each state. Subsequently, we conducted telephone interviews in January 1991 with state officials using a structured instrument. Because the states were not randomly selected, their characteristics are not representative of all 50 states. We also reviewed past GAO work on the ADMS Block Grant addressing information contained in state applications and annual reports.

To examine HHS's plans for enhancing state accountability for federally supported drug treatment services, we interviewed HHS and OTI officials and reviewed numerous documents, including regulations, policies, and reports, on HHS's drug treatment improvement program and other initiatives, such as a combined state application and plan, in addition to past efforts to oversee state administration of the uses of federal drug treatment dollars. We obtained a legal opinion from HHS's General Counsel on HHS's authority to issue regulations and impose reporting requirements on states.

Our work was performed from December 1990 to June 1991 in accordance with generally accepted government auditing standards.

State Review Activities Limited in Assessing Quality and Appropriateness

In our examination of state activities implementing the peer review requirement, we found that the 10 states we examined use licensing and certification processes that do not fully address the quality and appropriateness of drug treatment services. These processes were in place before the peer review requirement was established. The monitoring that occurs as part of these processes involves checking that providers have policies for personnel management, physical plant, and other administrative issues. States are implementing these processes in different ways in terms of the organizations conducting the reviews and how results are used. We also found that most states do not have formal definitions of quality and appropriateness. Appendix I provides more

information on how the peer review requirement has been implemented in the 10 states we reviewed.

State Reports and Applications Contain Limited Information

Information is limited not only on the implementation of the peer review requirement but also on the use of ADMS Block Grant funds for drug treatment services. ADAMHA requested that states provide information in their fiscal year 1989 annual reports on their implementation of the new requirement to conduct peer reviews of drug treatment services supported by ADMS funds. States were asked to describe their procedures, including a definition of peer review; the individuals responsible for conducting reviews; and the frequency of such reviews. In analyzing state reports to ADAMHA and information from the 10 states we reviewed, we found that these reports presented vague and incomplete information about how states were complying with the peer review requirement.

More generally, information is limited on the use of ADMS Block Grant funds for drug treatment services.[4] State annual reports vary significantly in the information provided on drug treatment services, making comparisons or assessments of federally supported drug treatment services difficult.[5]

Information from the states in their applications for ADMS Block Grant funds is also limited. ADAMHA, through the ADMS Block Grant application, requires that states provide general descriptions of the intended use of funds for drug treatment and submit various administrative assurances and certifications. ADAMHA asked states in their fiscal year 1991 application to voluntarily provide additional information in a uniform format. For example, states were asked to provide information on the populations, areas, and localities with the greatest need for drug abuse treatment services and information on the states' capability to provide treatment; that is, the states' treatment capacity. Of 26 states that voluntarily provided information in a uniform format, only 10 provided all the requested information and 16 provided incomplete information. The remaining states opted to submit the old application that did not request additional information.

[4]Section 1917(a) of the Public Health Service Act (42 U.S.C. 300x-5(a)) requires that each state prepare and submit an annual report to HHS on the use of ADMS Block Grant funds for drug treatment activities.

[5]Block Grants: Federal-State Cooperation in Developing National Data Collection Strategies (GAO/HRD-89-2, Nov. 29, 1988); and ADMS Block Grant: Women's Set-Aside Does Not Assure Drug Treatment for Pregnant Women (GAO/HRD-91-80, May 6, 1991).

Because states provide limited and diverse information in annual reports and applications, HHS does not receive the information needed to report to the Congress on the impact of the ADMS Block Grant on the nation's treatment delivery system.

OTI Program Aims to Hold States More Accountable

In mid-1990, OTI began to develop its State Systems Development Program (SSDP). This program is intended to assist states in assuring HHS and the Congress that services supported by ADMS funds are used to provide drug treatment that is effective in reducing drug abuse.

OTI Is Developing Guidance for Drug Treatment Programs

Program guidelines or performance standards are often used to ensure that programs in the various states have common procedures and goals. OTI's SSDP is expected to develop and provide states with treatment improvement protocols (TIPs), which are to be used as drug treatment program guidelines. TIPs are expected to set guidelines for clinical services, staffing requirements, program accreditation, criteria for assessing programs, and standardized program costs. OTI officials anticipate that TIPs will help policymakers, administrators, and practitioners to effectively establish, monitor, and evaluate drug treatment services.[6] In addition, federal drug treatment program guidelines could assist states in implementing the requirement to perform peer review by providing criteria for assessing the quality and appropriateness of services.

TIPs will be developed through knowledge generated from OTI demonstration projects, HHS research and epidemiological studies, and a formal consensus-development process.[7] According to OTI officials, the consensus-development process will bring together leading drug treatment experts (including clinicians, researchers, and representatives of national medical, public health, and state substance abuse officials' associations) to establish generally accepted treatment guidelines or TIPs. Once developed, OTI plans to use the drug TIPs as the basis for assessing

[6]Protocols are under development for treating addicts who are pregnant and screening drug abusers for infectious diseases. For example, draft "practice guidelines" for pregnant, drug-dependent women specify an array of services, including comprehensive medical services, parenting skills, and child care.

[7]Demonstration projects are based on OTI's Comprehensive Care Model, a drug treatment program model intended to address many of the needs of addicted individuals. This model suggests that an array of medical, psychiatric, educational, vocational, social, and aftercare intervention services should be provided directly or through referrals as part of a treatment program package.

the quality and appropriateness of drug treatment services when conducting technical performance reviews of state drug treatment activities.

OTI Plans to Assess States' Performance in Delivering Services and to Provide Technical Assistance

OTI plans to identify weaknesses in drug treatment services through its technical performance reviews of state drug treatment activities and to then improve performance by offering technical assistance. These reviews are to supplement federal compliance reviews of states and drug treatment providers.[8] The technical performance reviews are intended to be more programmatic and substantive in nature than the previous compliance reviews, which focused primarily on determining whether states adhered to the requirements of the ADMS Block Grant legislation. The reviews are planned to provide OTI with more accurate information on how states are implementing the ADMS Block Grant legislation. Based on review results, Developmental Action Plans will be provided along with technical assistance if it is needed to help states improve their services. The new review process is expected to compare state activities to TIPs and to identify areas where technical assistance is needed to improve drug treatment services. Fiscal year 1992 will be the pilot year for this process. Starting in fiscal year 1993, at least 20 state substance abuse agencies and five drug treatment service providers in each state are to be reviewed each year, pending the availability of federal resources and the states' cooperation. It is not explicit in the legislation whether the Secretary has the authority to require that states agree to technical performance reviews.

Another important element of OTI's SSDP is a proposal to offer technical assistance to states to address program management weaknesses identified by technical performance reviews. For those states that fail to meet generally accepted treatment guidelines, OTI plans to offer specific on-site technical assistance to improve the planning, resource allocation, and delivery of treatment services. Such technical assistance is expected

[8]Section 1918 (b)(1) of the Public Health Service Act (42 U.S.C. 300x-6(b)(1)) requires that the Secretary of HHS conduct investigations in several states each year of the use of the ADMS Block Grant funds to evaluate compliance with the requirements of the law. ADAMHA has addressed this requirement by requesting written information from selected states on their compliance with the legislation's requirements and conducting on-site reviews. For 1982, 5 states were visited, and for each year from 1983 to 1988, 10 states were visited. For fiscal years 1989 and 1990, written information was requested from all states followed by on-site visits to 3 states with the most significant issues of apparent noncompliance.

to be delivered through Developmental Action Plans, which are intended to help states improve their treatment services.[9]

SSDP Also Intends to Obtain Better Information

The ADMS Block Grant applications and annual reports provide information on what states will do and have done with ADMS Block Grant funds. Revisions under SSDP are intended to provide additional information to HHS and federal policymakers on the delivery of drug treatment services. In addition, OTI plans to assist states in conducting needs assessments in order to obtain data on the incidence and prevalence of substance abuse.

As part of the fiscal year 1991 ADMS Block Grant application, ADAMHA asked states, for the first time, to voluntarily submit a treatment plan.[10,11] Information required as part of the plan includes how states will direct block grant funds to provide services to intravenous drug abusers, pregnant women, and other populations at high risk for drug use, as required by the ADMS legislation. For fiscal year 1993, OTI plans to consolidate the application/plan and the annual report in order to reduce respondent burden. In the consolidated application, states will be asked to describe in a uniform format how they intend to use fiscal year 1993 funds and how they have used fiscal year 1992 funds.

As part of SSDP, OTI plans to provide states with guidance and funds to conduct needs assessments to support the preparation of the consolidated application. States would use OTI-approved needs assessment methodologies to obtain data on substance abuse incidence and prevalence. The use of common methodologies would allow for aggregation of state results at the national level. Starting in fiscal year 1992, needs assessments are expected to be funded in one-third of the states each year, with all states and jurisdictions covered within a 3-year cycle.

[9]Plans for future technical assistance efforts will be supported through information and models developed through OTI's coordination with the National Institute on Drug Abuse in its health services research study of drug abuse quality assurance in private and public sectors.

[10]ADAMHA formally invites states to submit the ADMS Block Grant application. Since 1990, OTI has worked to revise the application to obtain better information.

[11]Such a plan has been endorsed by the Office of National Drug Control Policy, in the President's drug control strategy, as an important mechanism for improving drug treatment accountability under the ADMS Block Grant. S. 1306, which passed the Senate on August 2, 1991, would prohibit block grant payments to any state that failed to submit an acceptable prevention and treatment plan starting in fiscal year 1993.

Information from states' needs assessments are intended to link with other HHS data systems to create a State Information System (SIS).[12] SIS is intended to enable OTI to monitor and assure compliance with block grant requirements and also address such issues as the appropriate distribution of substance abuse treatment funds between urban and rural areas.

HHS Policy May Limit OTI Program

OTI's program to improve drug treatment services is intended to have the effect of increasing state accountability for ADMS funds. However, as discussed earlier, HHS policy, despite 1988 legislative changes, generally defers to a state's interpretation of ADMS Block Grant requirements and does not require states to report uniform information on their planned and actual use of block grant funds. The Secretary has not exercised the authority to specify how states should comply with legislative block grant requirements and how they should report on their block grant activities.[13] If HHS policy continues, states will not be required to adopt or participate in any of the elements contained in OTI's drug treatment improvement program. In focusing on the development of standards and establishing a framework for their use in drug treatment programs and services, OTI's program represents an important step towards treatment improvement. In a 1990 report, Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed (GAO/HRD-90-104, Mar. 13, 1990), we encouraged the Secretary of HHS to develop result-oriented performance standards to be used to set expectations for federally supported treatment programs and provide a basis for assessing their results. These could include how well services are being delivered and the effectiveness of such services in reducing or eliminating an individual's drug abuse.

Our work also suggests that seeking voluntary compliance on the part of the states may impede the OTI program's attempt to strengthen reporting requirements. A recent report of ours on the ADMS Block Grant women's set-aside found that, without specific guidance from HHS, many state annual reports made no mention of drug treatment programs provided to mothers. In addition, 29 states did not report whether or not they

[12]SIS will provide a data profile for each state, encompassing treatment and prevention needs, service capacity, service utilization, state funding for services, and client characteristics.

[13]HHS recognizes the need to revise its existing block grant regulations and is considering several alternatives. In the meantime, HHS continues to follow its policy of generally deferring to a state's interpretation of the ADMS Block Grant legislative requirements.

provided new or expanded treatment programs or services for women.[14] An earlier GAO report suggested that voluntary compliance with reporting requirements without a more proactive approach by the federal government has its limitations in terms of providing information for purposes of program oversight.[15]

Our discussions with OTI officials indicate that without changes in HHS's policy, the OTI program to strengthen reporting requirements may not be successfully implemented. OTI's 1990 report to the Congress pointed out that

"given the variety of program strategies devised by the States, their annual reports in recent years have presented insightful but non-comparable data . . . despite improvements, interstate comparability is still difficult."[16]

Therefore, the report continued, it is "difficult to piece together a national picture" on the use of ADMS Block Grant funds for drug treatment services.

Conclusions

Much of the information HHS requires of the states receiving ADMS Block Grant funds relates to compliance with the grant's requirements. HHS has not required and most states have not provided information necessary to assess the impact of the federal investment in drug abuse treatment services.

OTI has established a program that is intended to develop generally accepted drug treatment guidelines and conduct performance reviews of state agencies and local treatment programs. The program is also aimed at getting more useful information from the states through a consolidated application, plan, and annual report. States will not be required under the current HHS policy, however, to undertake all or any of the elements of the OTI program. OTI's SSDP has promise for improving the quality and effectiveness of drug treatment services. But the fact that the program is voluntary may limit its success. Consequently, we believe that HHS needs to closely monitor the progress of the program and keep the Congress informed of it.

[14]ADMS Block Grant (GAO/HRD-91-80, May 6, 1991).

[15]Block Grants (GAO/HRD-89-2, Nov. 29, 1988).

[16]Report to Congress on the Alcohol and Drug Abuse and Mental Health Services Block Grant Program, Office for Treatment Improvement; Alcohol, Drug Abuse, and Mental Health Administration; Public Health Service; Department of Health and Human Services, October 1990, p. 21.

Recommendations

In order to provide the Congress with information necessary to assess the impact of ADMS-supported drug abuse treatment services, we recommend that the Secretary of Health and Human Services:

1. Establish reporting requirements for the states that will provide HHS with information to determine whether states are providing drug treatment programs and services that are effective.

2. Report to the Congress by 1995 on the progress of OTI's State Systems Development Program. The report should include information on:

- which states have implemented HHS's Treatment Improvement Protocols;
- which states have participated in a federal technical performance review and the type of problems or weaknesses identified by the reviews;
- the extent to which the states have implemented OTI Developmental Action Plans to correct identified weaknesses; and
- if applicable, the reasons why states have not participated or implemented each aspect of SSDP.

As requested, we did not obtain written agency comments on this report, but we discussed our findings with OTI officials. Where appropriate, we incorporated their comments into the report.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to other interested congressional committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. We will also make copies available to others on request.

Should you have any questions concerning this report, please call me at (202) 275-6195. Other major contributors are listed in appendix II.

Sincerely yours,

Mark V. Nadel

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Associate Director, National and
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Contents

Abbreviations

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
ADMS	Alcohol, Drug Abuse and Mental Health Services
HHS	Department of Health and Human Services
OTI	Office for Treatment Improvement
SIS	State Information System
SSDP	State Systems Development Program
TIPs	Treatment Improvement Protocols

States' Implementation of the Peer Review Requirement of the Anti-Drug Abuse Act of 1988

To examine how the 10 states we selected addressed the 1988 legislative peer review requirement, we examined such issues as how states implemented their procedures, including who is responsible for conducting such reviews, and how the results of these reviews are used. We also looked at how states define "quality" and "appropriateness" and what these states are doing to collect information on the results or outcomes of their drug treatment programs. We also reviewed a study prepared for the Office for Treatment Improvement on states' implementation of the peer review requirement.[1]

Processes Used to Respond to the Peer Review Requirement

In evaluating the fiscal year 1989 ADMS Block Grant reports to ADAMHA by the 10 states, we found that these reports presented incomplete or vague information about how states were complying with the peer review requirement. Although ADAMHA asked for a definition of peer review, who would conduct the reviews, and how often such reviews would be conducted, none of these 10 states included complete information on their procedures for implementing the requirement.

All of the states we reviewed assess drug treatment services through processes, such as a combination of licensing and certification and monitoring, that were in place before the peer review requirement was established. As of June 1991, in nine of these states, providers were required to obtain a license or certificate by developing: (1) criteria and procedures for admissions and discharges; (2) policies for types of services offered; (3) systems for managing clinical and fiscal records; and (4) policies for administrative issues, such as program planning, personnel management, physical plant, safety, and how to define the role of their governing bodies. In California, the certification of drug treatment providers occurs on a voluntary basis.

State reviews to fulfill the peer review requirement are conducted by a variety of organizations and individuals. All 10 states have policies wherein substance abuse/mental health and/or licensing/certification officials are responsible for conducting these reviews. In Massachusetts, for example, providers are responsible for interviewing clients and submitting information on the source of referrals, substance abuse history, and types of disabilities. Three of the states reviewed—Massachusetts, Ohio, and Texas—employed independent contractors to fulfill the requirement.

[1] A Survey of Peer Review: History, Literature, Issues, and Implementation of State Peer Review for ADMS Block Grants, American Medical Review Research Center, final report, August 30, 1991.

Reviews of licensing and certification processes are done by desk audits, site visits, or both. While five states—Illinois, Massachusetts, New York, Ohio, and Pennsylvania—conduct on-site visits only, the five other states—California, Florida, Michigan, New Jersey, and Texas—combine both visits and desk audits during their licensing/certification reviews of drug treatment providers.

States use the results of drug treatment reviews in different ways. Nine states—California, Florida, Illinois, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas—use the results of reviews to develop an improvement plan for the provider. These improvement plans take the form of corrective action plans or technical assistance. Although this is not state policy in Massachusetts, the state uses the results to assist the provider in improving performance in problem areas. Six states—Florida, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania—use the results of reviews to determine the providers' licensing/certification status. Seven states—California, Florida, New Jersey, New York, Ohio, Pennsylvania, and Texas—decide on the providers' level of funding based on the results of their reviews of drug treatment services. In Florida, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas, the results of state reviews are considered in establishing drug treatment policies.

Definitions of Quality and Appropriateness

Most states do not have any formal definitions of quality and appropriateness. Six state officials we interviewed (in California, Florida, Massachusetts, Michigan, New York, and Texas), interpreted quality as a drug treatment program's compliance with state standards and regulations. Officials in Florida and Michigan also interpreted quality as providing appropriate services to meet individual needs. A Texas official defined quality as treatment processes and program outcomes. Four state officials did not define quality because the state did not have an official definition or the state did not make such judgments. In terms of appropriateness, nine state officials told us that an appropriate drug treatment program is one that suits or fits the needs of clients. In Pennsylvania, an official described the need for a standardized instrument to determine whether clients had been appropriately assessed and placed in drug treatment programs. California has no consensus on how to interpret appropriateness.

Several States Collect Outcome Data

Several states have taken the initiative in collecting information on program performance that can assist in assessing the effectiveness of drug treatment programs. Two states we reviewed have moved to improve their assessments of treatment services by collecting data on outcome measures and a third state has plans to collect such data. Such measures include abstinence from mood-altering substances, employment status, and participation in self-help programs.

Ohio plans to establish a system for collecting outcome data on clients treated in drug programs as part of a cost-benefit analysis mandated by the state legislature. Ohio's client outcome evaluation data will be collected by a third-party contractor. These data will be used by the state to evaluate several client outcome variables (for example, relapse patterns, use of medical care services, employment status, and family and social relationships) and will be provided to local boards and treatment providers as a means of self-evaluation. The state plans to conduct a pilot of its client outcome data system in 1992. Ohio officials expect this system to be fully operational by January 1993.

Two other states also collect outcome data as a means of assessing treatment services. As of October 1990, Michigan began identifying measures that will enable the state to match drug abusing individuals to treatment programs. For prospective clients, the state will require its substance abuse agencies to obtain data for admissions on each applicant's medical history, alcohol use, drug use, employment status, legal status, family and social situations, and psychiatric condition. Then, the same data are collected 6 and 18 months after individuals are discharged from treatment to evaluate the effectiveness of treatment services.

Texas recently began assessing the outcomes of drug treatment services. State research analysts evaluated treatment outcomes by using a modified Client Oriented Data Acquisition Process system.[2] Providers collected uniform data on each client at admission, discharge, and 60 days after discharge. Collected data were then aggregated and reviewed. Outcome measures included: reasons for discharge, family status, employment status, legal status, current treatment status, substance abuse patterns, and frequency of drug-related problems in the last 30 days.

[2]The Client Oriented Data Acquisition Process began in 1973, and was a comprehensive federal system for collecting data on clients admitted to drug abuse treatment programs. It was terminated because states were no longer required to report such data after the enactment of the Omnibus Budget Reconciliation Act of 1981, which created the ADMS Block Grant.

On May 29, 1991, Florida enacted a law that required the state's Department of Health and Rehabilitative Services to analyze monitoring requirements, such as outcome evaluation and program effectiveness. The law also required the department to have a new drug treatment system established by July 1, 1993, that will assess client outcome measures and promote the efficient and effective use of resources to provide the most appropriate services for all clients.

OTI's Study on States' Implementation of Legislative Peer Review Requirement

A recent OTI study corroborated our work.[3] The study found that, of 32 states responding, the licensing and certification of programs was the way states opted to implement the peer review requirement. In addition, states monitored providers by conducting a utilization review—the review of data, including the number of patients enrolled, completing, and ending treatment. All of the states reviewed responded that the measurement of treatment outcomes was becoming more important. The study also found that states' interpretations of the peer review requirement varied. The study concluded that the lack of a clear definition of peer review causes confusion among the states and results in a wide variation of processes.

[3] A Study of Peer Review.

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