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Briefing Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives

April 1990

DRUG TREATMENT

Some Clinics Not Meeting Goal of Prompt Treatment for Intravenous Drug Users

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Human Resources Division

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April 30, 1990

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Intravenous (IV) drug abusers—drug addicts who use needles to inject themselves—on heroin, cocaine, or other illicit drugs are among those with the highest risk of contracting acquired immunodeficiency syndrome (AIDS). When seeking drug treatment, many addicts encounter lengthy waiting periods. In response to this health problem, the Congress enacted the Anti-Drug Abuse Act of 1988, which required certain state actions. In particular, for a state to receive alcohol, drug abuse, and mental health services (ADMS) block grant funds, it must provide assurance to the Department of Health and Human Services (HHS) that IV drug abusers will receive treatment from clinics within 7 days of request, to the maximum extent practicable.

At your request, we reviewed the extent to which programs receiving ADMS block grant funds in three states were providing timely treatment for IV drug abusers; we also assessed HHS's oversight of state efforts to implement these provisions.

We performed work at HHS's Alcohol, Drug Abuse and Mental Health Administration to assess federal oversight of the ADMS block grant. For California, New York, and Oregon we (1) reviewed IV drug abuse treatment policies and practices and (2) visited 14 methadone maintenance programs and 1 drug-free clinic. We selected these states based on their geographic location, organizational structure, estimated number of IV drug abusers, and amounts of ADMS block grant funding. We assessed the extent to which these states implemented the five provisions under the ADMS block grant. These provisions require states to agree to

- ensure that local providers receiving ADMS block grant funds, and nearing full capacity, will provide treatment for IV drug abusers within 7 days of request, to the maximum extent practicable;
- develop a plan, when the Secretary of HHS requests it, to provide services for all individuals seeking substance abuse treatment (including IV drug abusers) and estimate the resources needed to provide such treatment;

- target ADMS block grant funds earmarked for substance abuse treatment to communities with the greatest need for services or highest prevalence of substance abuse;
- require local providers receiving ADMS block grant funds to notify the state when they reach or exceed 90 percent of their treatment capacity for IV drug abusers; and
- require local providers receiving ADMS block grant funds to conduct outreach activities encouraging IV drug abusers to seek treatment.

Our work was conducted between September and November 1989, in accordance with generally accepted government auditing standards. We briefed your staff in November 1989 on the preliminary results of our review.

Background

The increased incidence of both IV drug abuse and AIDS in the 1980s indicated public health problems of major proportions. States estimated that in 1988, 1.3 million people were IV drug abusers. The number of treatment admissions for heroin abusers rose from about 89,000 in 1985 to about 115,000 in 1988, or 29 percent. Studies project 50,000 deaths from AIDS in 1991—more than the cumulative total since the first reported cases of AIDS in 1981. Of reported AIDS cases, about 21 percent are linked to contaminated needles shared among IV drug abusers. Thus, treating IV drug abusers has become an important strategy in reducing the spread of AIDS at the federal, state, and local levels.

The federal government recently increased its efforts to provide financial support for state-administered drug treatment programs. In November 1988, the Congress reauthorized the ADMS block grant, an important funding source for these treatment programs, as part of the Anti-Drug Abuse Act of 1988. The legislation required states to provide assurance to HHS that treatment will be provided to IV drug abusers within 7 days of request, to the maximum extent practicable, as a condition for receiving ADMS block grant funds. The Congress separately appropriated $100 million for a 2-year grant program to help states reduce waiting periods of more than 30 days for IV drug abusers seeking treatment.

Results in Brief

The three states we visited generally implemented each of the five IV drug abuse treatment provisions in section 2034 of the Anti-Drug Abuse Act of 1988. However, some clinics in two of the three states did not always provide drug treatment within 7 days to IV drug abusers requesting services. Furthermore, while the provision requiring local providers

to conduct outreach was being implemented, it was not always consistent with the approach described in the statute.

In administering the ADMS block grant program, HHS relies on the states' interpretation of the Anti-Drug Abuse Act's timely drug treatment provision. The states interpreted this provision as a broad goal, rather than a requirement, for them to provide treatment within 7 days "to the maximum extent practicable." HHS, through its current reporting system, has not required states to provide sufficient information to measure the progress they are making in reaching this goal.

Waiting Periods for Treatment Exceeded 7 Days

IV drug abusers seeking treatment waited longer than 7 days in 3 clinics in California and 2 in Oregon, of 10 we visited in those states. In 2 of the 5 clinics that exceeded the 7-day provision, waiting periods exceeded 3 months. For example, in Long Beach, California, over 200 people were on a waiting list up to 3 months at 1 clinic. Waiting periods did not exceed 7 days in the 5 New York programs we visited because when these local providers reached their capacity, they referred addicts to other treatment programs that were under capacity.

All three states had assured HHS that they would provide IV drug treatment within 7 days, to the "maximum extent practicable"—which states have interpreted as a goal, not a requirement. HHS, relying on state interpretations of the provision, approved the states' applications for ADMS block grant funds.

HHS Did Not Request State Plans, but Elements Were in Place

As a condition of receiving ADMS block grant funds, states must agree to develop a plan for treatment services, if requested by HHS. HHS did not request states to prepare separate plans to provide services to all individuals seeking substance abuse treatment. The treatment plans were to identify the magnitude of each state's substance abuse problem and the resources needed to address it. However, HHS recently began working with several states and the National Association of State Alcohol and Drug Abuse Directors to develop a survey instrument to obtain information on states' planning for and management of substance abuse services. Eight states were asked to pilot-test the instrument before HHS requests all states to voluntarily complete the survey.

We assessed whether states, on their own, were planning to meet the needs of all IV drug abusers. All three states estimated the number of IV drug abusers in their states and identified the number of treatment slots

available to serve them. California and New York, however, did not identify the financial and personnel resources required to meet these needs. Only Oregon estimated the number of illicit IV drug abusers it believed would request treatment and the financial and personnel resources that would be needed to serve those people likely to seek treatment.

States Targeted Federal Treatment Funds

The three states targeted federal drug treatment funds to communities they determined to have the greatest need for services. They based their targeting of ADMS block grant funds on such factors as clinic admissions, number of drug-related arrests, and incidence of communicable diseases. For example, California allocated its ADMS block grant funds for IV drug treatment according to the number of clinic admissions for IV drug abuse and reported AIDS cases.

Local Clinics Reported Treatment Capacity

All three states required local providers to report to the state substance abuse agency when they reached or exceeded 90 percent of treatment capacity for IV drug abusers. All providers we visited reported the required information.

Sometimes States, Not Local Providers, Conducted Outreach

All three states conducted outreach activities for IV drug abusers using an areawide or clinic-based approach to implement the federal provision contained in section 2034. Of the three states, however, only California required local clinics receiving ADMS block grant funds to conduct outreach activities. Although California requires its local providers to conduct outreach, it also conducts areawide outreach activities. New York conducted areawide instead of clinic-based outreach. For example, New York's substance abuse agency contracts with county agencies to implement regional outreach strategies. California and New York believe areawide outreach is as effective as clinic-based outreach. Oregon relied on clinic-based outreach activities that were being provided before the federal requirement. Federal and state officials believe that outreach activities conducted by agencies other than local service providers may be equally effective.

Of the 15 providers we visited across the three states, 12 either conducted their own outreach activities or relied on existing activities of other agencies to reach IV drug abusers. The other three providers had reached their treatment capacity and believed outreach activities were not necessary for them.

HHS Does Not Currently Measure States' Progress

HHS cannot presently assure that individual states are making progress toward the goal of providing IV drug abusers treatment within 7 days of request. In recent months, HHS has begun to obtain some state-reported information that could be used to generally measure some local providers' progress in providing timely IV drug abuse treatment; however, these data will not be sufficient to measure individual states' progress.

HHS currently relies heavily on state-reported data that describe procedures for implementing the federal IV drug treatment provisions. Until 1987, HHS conducted its own on-site compliance reviews annually in several states to assess their compliance with ADMS block grant requirements. It now asks selected states to assess their own compliance with federal legislation based on a checklist developed by HHS. It will conduct an on-site compliance review only if, in its judgment, state-reported information warrants such a review.

In addition, HHS requires states to provide several types of state-reported data that describe procedures for implementing substance abuse programs, such as annual applications and program reports. HHS collects data on the number of substance abusers treated and the length of waiting periods for treatment. However, these data do not specifically identify IV drug abusers. HHS also requires public and nonprofit providers receiving 1-year grants to reduce waiting periods to prepare progress reports upon termination of the grant. These reports will identify progress, but the number of grantees is too small to show state-by-state comparisons. As a result, HHS will not know whether states are making progress toward providing IV drug abusers treatment within 7 days of request in programs funded with ADMS block grant funds.

Conclusions

Because HHS has not yet obtained data needed to measure states' performance, it does not know the progress individual states are making to meet the 7-day provision. Existing reporting requirements, such as the states' annual report describing the use of ADMS block grant funds, do not provide sufficient information to measure such efforts. These reports describe procedures in place, but cannot be used to measure states' progress in reaching the goal of treatment within 7 days. We believe HHS should revise these reports so they can be used to measure states' progress in meeting this goal.

Recommendation

The Secretary of HHS should revise the Department's reporting system to ensure that it collects sufficient information that measures individual states' progress in meeting the goal of providing IV drug abusers treatment within 7 days of request.

We did not obtain written HHS comments on a draft of this report. We did, however, discuss its contents with cognizant HHS, national association, and state officials, and their comments were considered in preparing our final report. HHS officials generally agreed that the current reporting system does not provide sufficient information to measure individual states' performance in meeting the timely IV drug treatment goal.

We are sending copies of this report to the House and Senate Appropriations Committees, other interested congressional committees and members, the Secretary of HHS, state substance abuse agencies, and the National Association of State Alcohol and Drug Abuse Directors. We also will make copies available to other interested parties on request.

If you or your staff have any questions about this report, please call me on (202) 275-1655. Other major contributors are listed in appendix II.

Sincerely yours,

Linda G. Morra

Linda G. Morra
Director, Intergovernmental
and Management Issues

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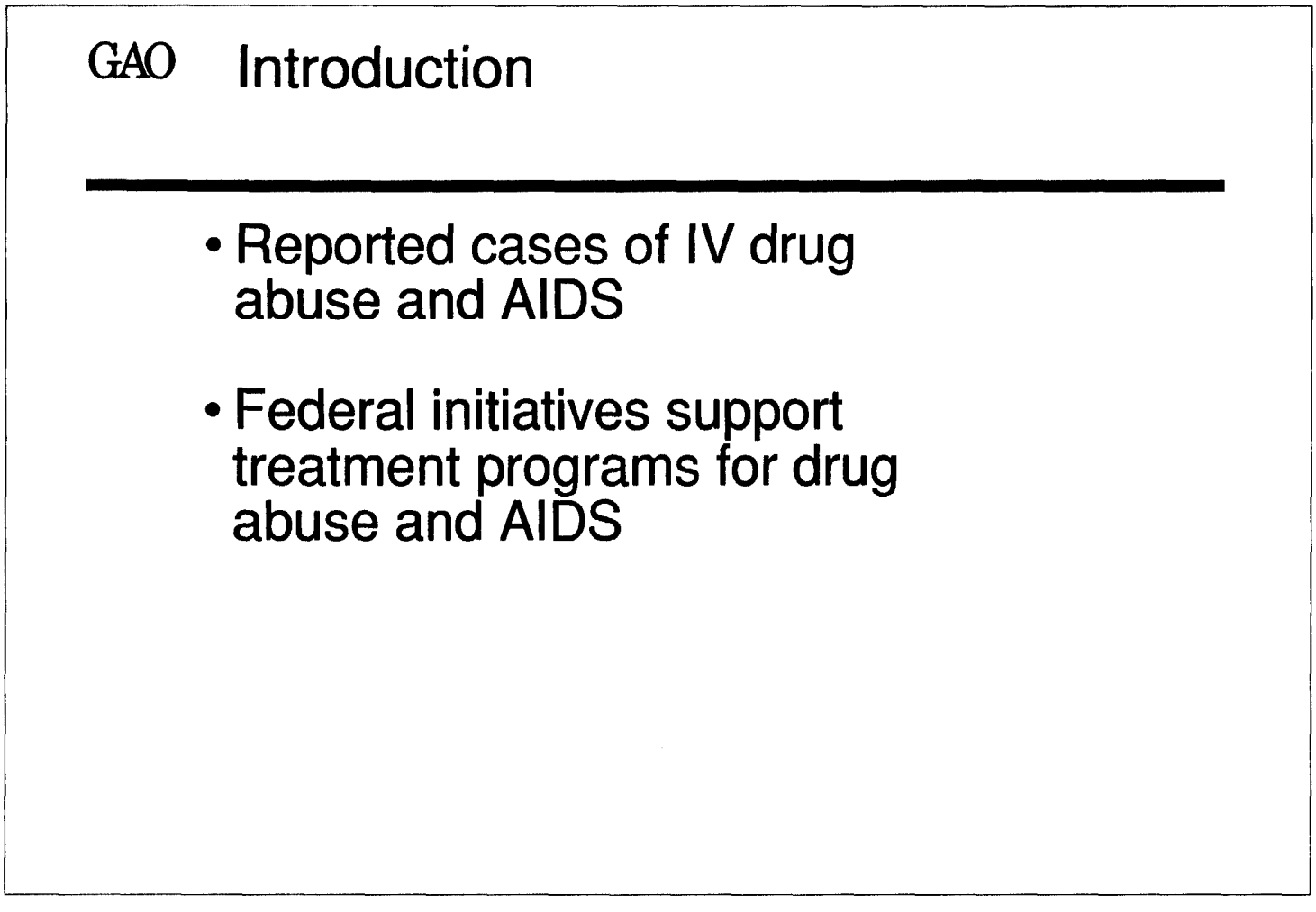
Abbreviations

ADMS	alcohol, drug abuse, and mental health services
AIDS	acquired immunodeficiency syndrome
GAO	General Accounting Office
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
IV	intravenous
NASADAD	National Association of State Alcohol and Drug Abuse Directors

Introduction

During the 1980s, intravenous (IV) drug abuse increased throughout the country, accompanied by a growing number of reported acquired immunodeficiency syndrome (AIDS) cases. Moreover, researchers estimate that more Americans will die of AIDS in 1991 than died since the first reported AIDS cases in 1981. In response to the increasing incidence of IV drug abuse and AIDS, the Congress created and funded several federal programs to treat IV drug abusers and slow the spread of AIDS (see fig. 1).

Figure 1



Reported Cases of IV Drug Abuse and AIDS

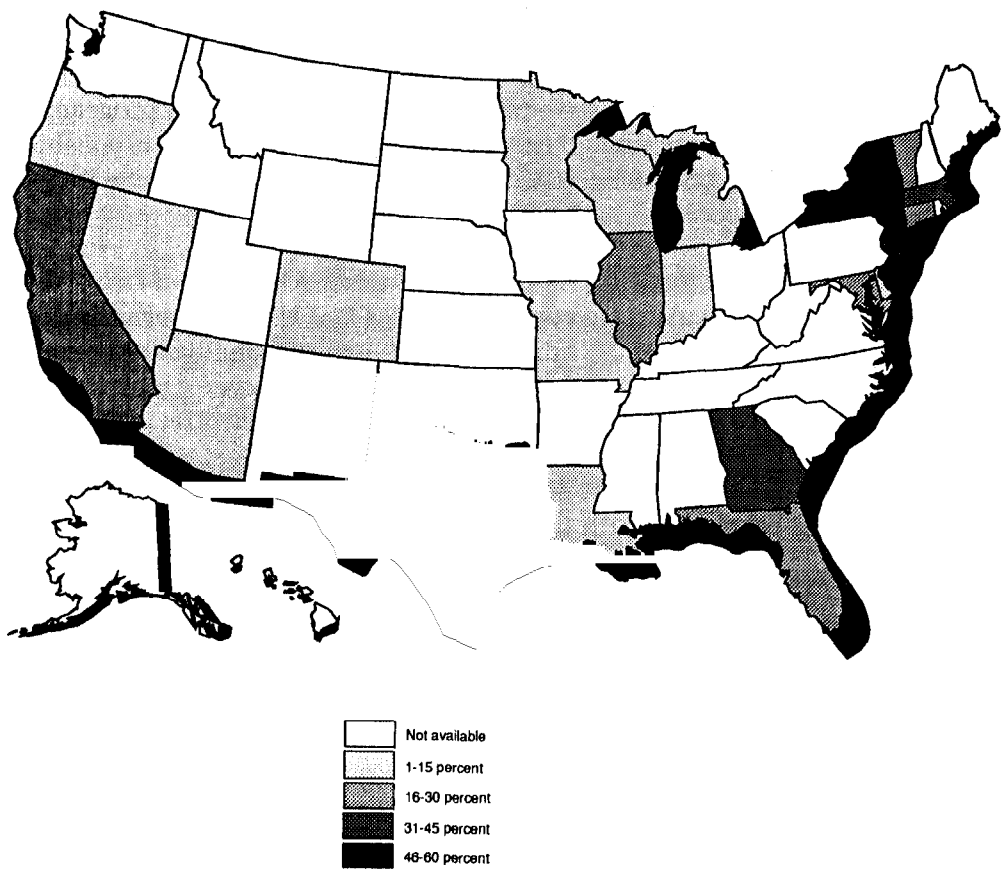
Contaminated needles, shared among IV drug abusers, contributed to the increasing incidence of AIDS. As of 1988, 21 percent of all reported AIDS victims were associated with IV drug use. Treatment admissions to clinics for heroin addiction—the most common IV drug—increased 29 percent, from about 89,000 in 1985 to about 115,000 in 1988, in part because of AIDS education and other outreach programs. Heroin users have combined heroin with other drugs, such as cocaine. Over the same 3-year period, client admissions related to cocaine increased 239 percent.

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) surveyed the states and U.S. territories in 1988 to develop estimates of IV drug use. [1] The 38 responding states estimated a total of 1.3 million IV drug abusers in 1988. [2] Several states reported that, in certain areas, most IV drug abusers were infected with the human immunodeficiency virus (HIV), generally understood to be the cause of AIDS. Of the 38 states, 24 estimated the percentage of IV drug abusers who were infected with the HIV virus. New York, New Jersey, and Puerto Rico estimated that up to 60 percent of their IV drug abusers were HIV infected. The HIV infection rate among IV drug abusers in the other 21 states that reported this information ranged up to 51 percent, with 11 of these states reporting rates of 10 percent or less.

[1] For reporting purposes, we refer to the District of Columbia, Guam, and Puerto Rico as "states."

[2] The National Institute on Drug Abuse estimates that there are approximately 500,000 heroin addicts in the United States. See Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990), p. 8.

Figure 2: Range of HIV Infection Rates Among IV Drug Abusers by State (Fiscal Year 1988)



Source: National Association of State Alcohol and Substance Abuse Directors, Inc., State Resources and Services Related to Alcohol and Drug Abuse Problems: State Alcohol and Drug Abuse Profile Data, Fiscal Year 1988, p. 50.

Federal Initiatives Support Treatment Programs for Drug Abuse and AIDS

Several federal programs have been created over the past decade to treat drug abuse and slow the spread of AIDS, particularly among populations at higher risk of contracting the virus. The higher risk population includes IV drug abusers residing in areas with higher rates of HIV infection and AIDS.[3] These federal programs established national goals and created key roles for states and local drug treatment providers. In

[3]AIDS Education: Reaching Populations at Higher Risk (GAO/PEMD-88-35, Sept. 16, 1988), p. 9.

fiscal year 1989, the Department of Health and Human Services (HHS) funded (1) a comprehensive community demonstration program to reach, communicate with, and reduce the risk-taking behavior of IV drug abusers and (2) a drug abuse information and referral hotline.

In addition, the Congress passed the Anti-Drug Abuse Act of 1988 (P.L. 100-690). In part, this act reauthorized the alcohol, drug abuse, and mental health services (ADMS) block grant. It requires states to assure that programs receiving these funds, on reaching 90 percent of their capacity, provide treatment services for IV drug abusers within 7 days of request, to the maximum extent practicable.

The Congress subsequently appropriated $765 million for the ADMS block grant in fiscal year 1989, earmarking $519 million (68 percent) for substance abuse programs. States were required to spend at least $59 million for IV drug abuse services. The Congress also appropriated $100 million for grants to public and nonprofit entities; these grants would reduce drug abuse treatment waiting lists by expanding the capacity of existing programs. Each grantee is limited to a 1-year grant.

For fiscal year 1990, the Congress appropriated $1.2 billion for the ADMS block grant, of which $895 million is earmarked for substance abuse programs. States must set aside at least 17.5 percent of their substance abuse program allocations, or $157 million, for IV drug treatment.

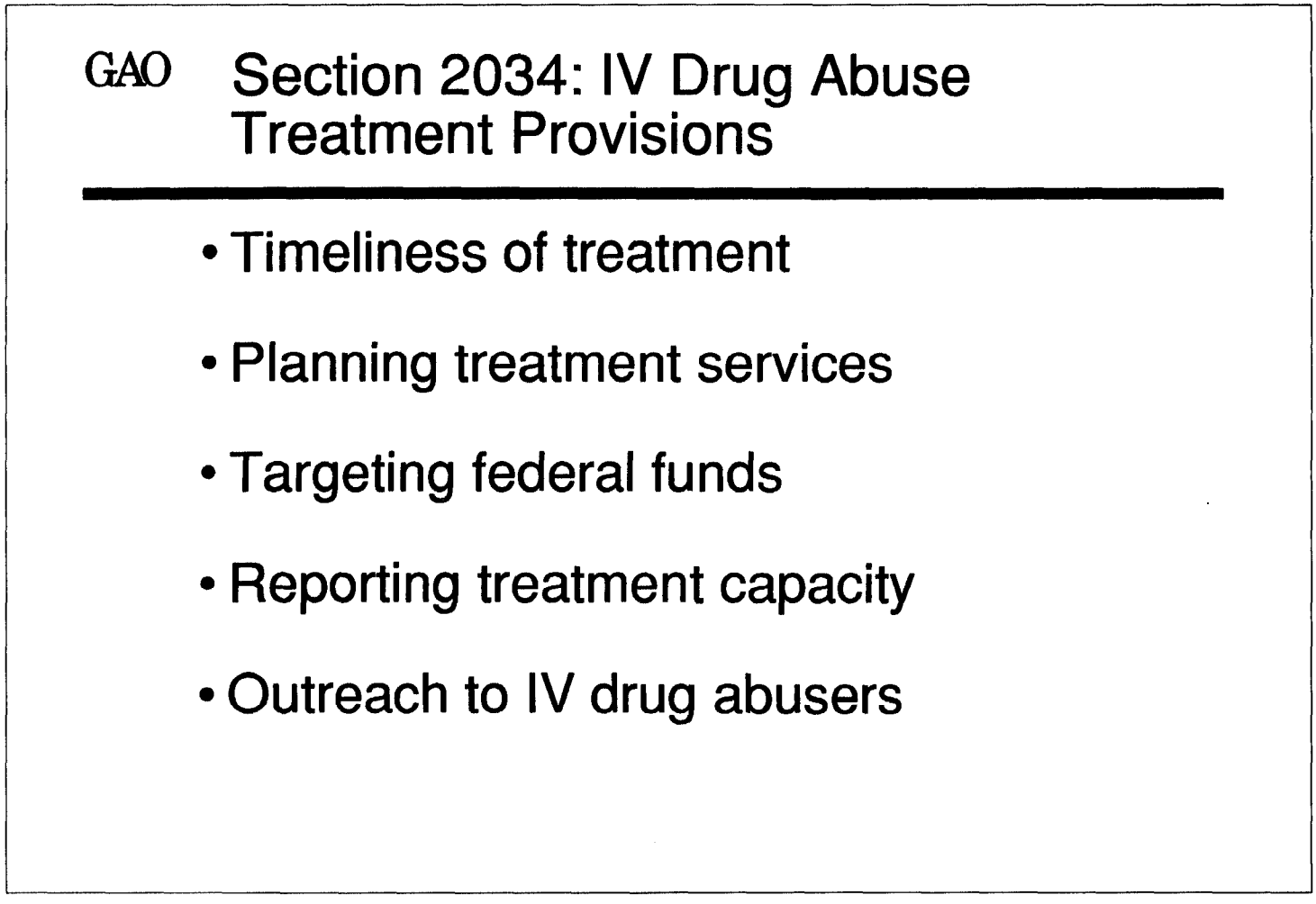
Section 2034: IV Drug Abuse Treatment Provisions

Our review focused on section 2034 of the Anti-Drug Abuse Act of 1988. Section 2034 requires states to assure HHS that IV drug abusers will be provided timely treatment in programs receiving ADMS block grant funds. Specifically, as summarized in figure 3, by statute, each state is required to agree to

- ensure that IV drug abuse treatment programs at or over 90 percent of treatment capacity that are supported with ADMS block grant funds will provide treatment for IV drug abusers within 7 days of request, to the maximum extent practicable;
- develop a plan, when the Secretary of HHS requests it, that (1) describes how the state can provide services for all substance abusers seeking treatment and (2) estimates the financial and personnel resources needed to provide such treatment;
- target the drug abuse portion of its ADMS block grant funds to communities with (1) the highest prevalence of substance abuse or (2) the greatest need for treatment services, with respect to such abuse;

- require local IV drug treatment programs supported with ADMS block grant funds to notify the state substance abuse agency when they reach or exceed 90 percent of their treatment capacity; and
- require local providers receiving ADMS block grant funds to conduct outreach activities encouraging IV drug abusers to seek treatment.

Figure 3

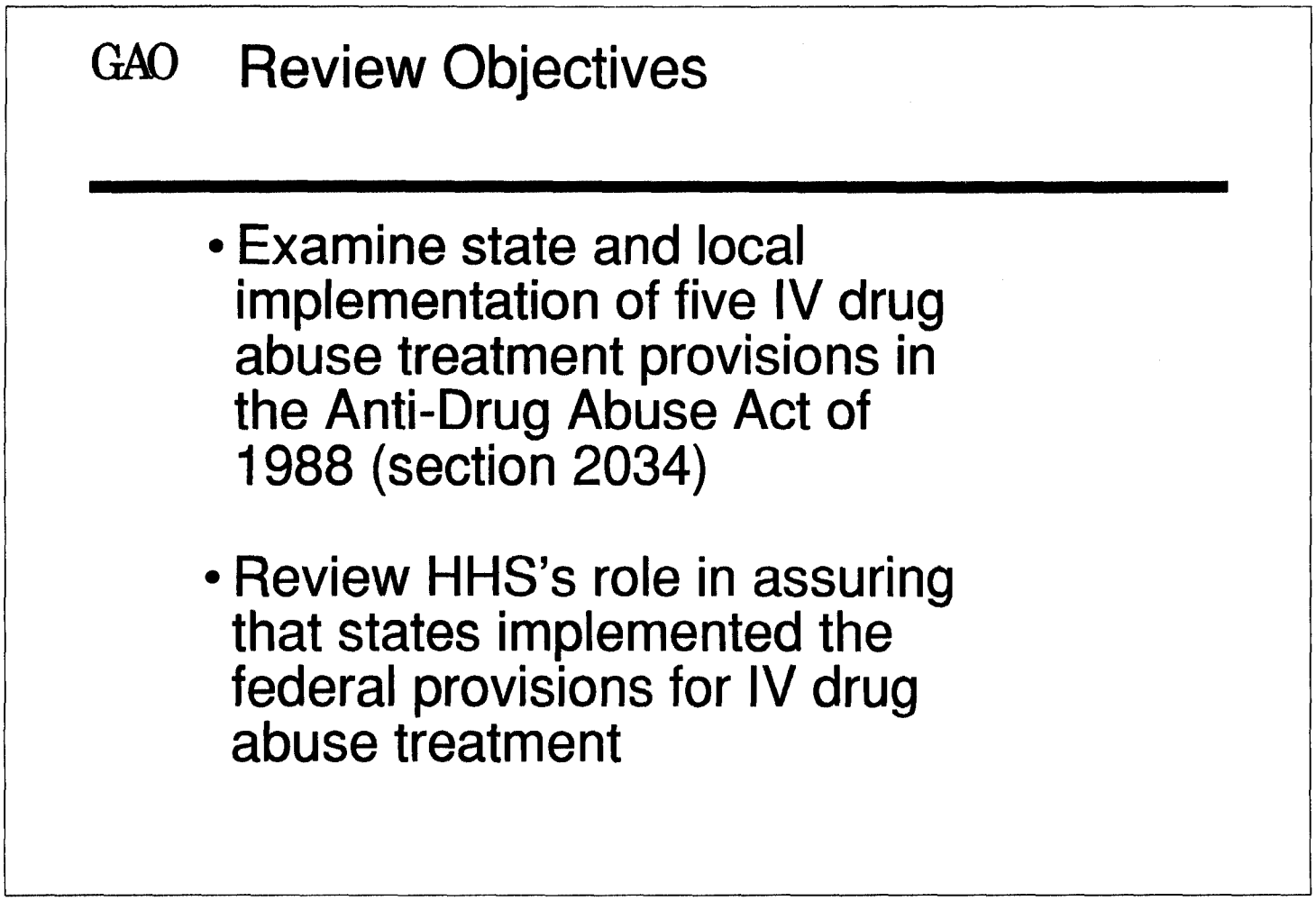


Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked us to (1) review state implementation of the ADMS block grant IV drug provisions and (2) assess local implementation of applicable reporting, timeliness, and outreach

requirements. The Chairman also asked us to review HHS's oversight of these provisions. Our review objectives are shown in figure 4.

Figure 4

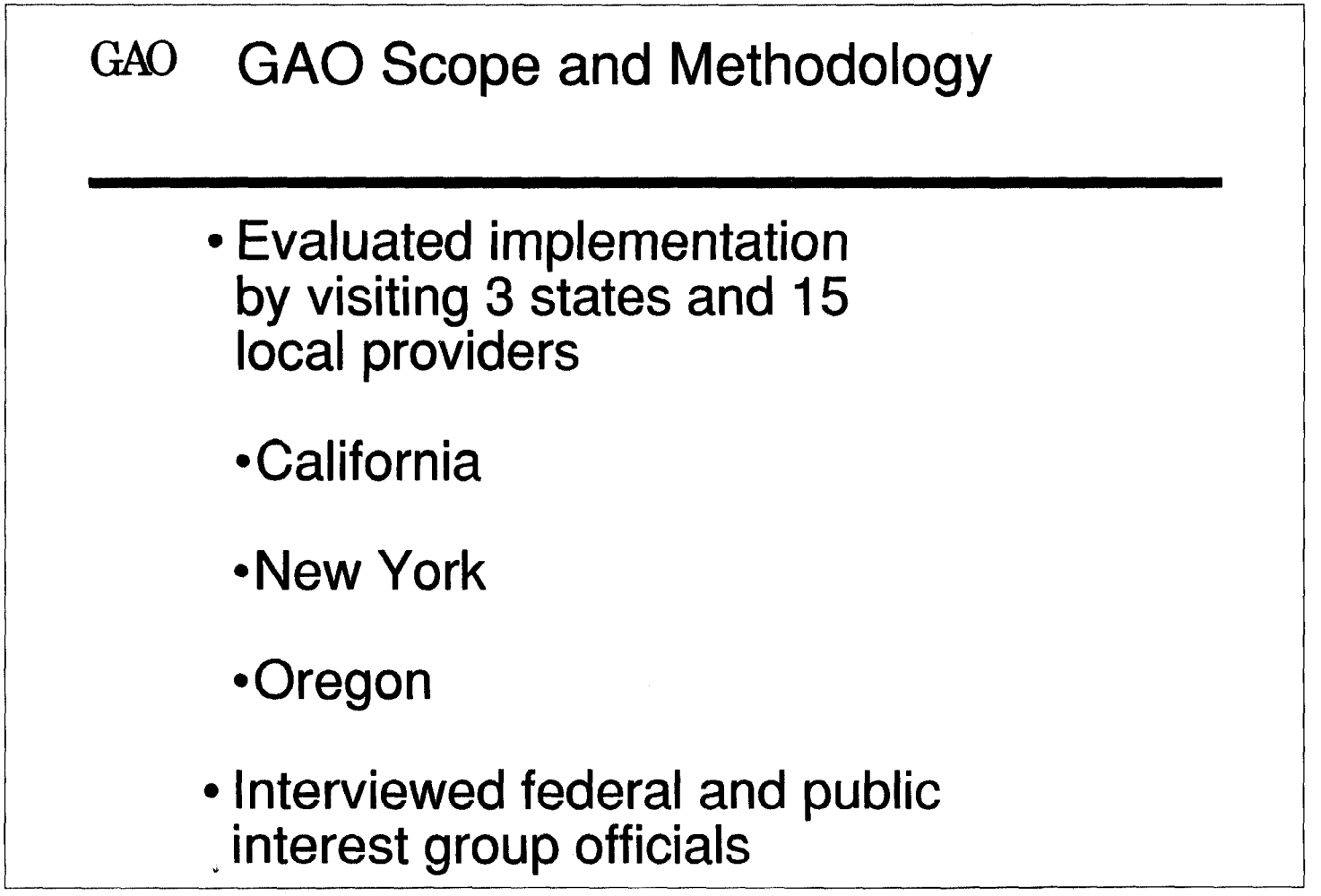


We agreed with the Subcommittee to limit our study to three states and 15 local providers (see app. I). We did not assess the effectiveness of drug treatment services or quality of care. Nor did we verify the accuracy of waiting list information or the methods states used to allocate ADMS block grant funds to their localities. Our findings are not intended to be projected to other states or local drug treatment programs.

In the three states—California, New York, and Oregon—we reviewed drug treatment policies and procedures. We selected these states because they

- represent nearly 40 percent of all estimated IV drug abusers;
- have varied levels of demand for drug treatment because of population and provider locations;
- have varied organizational structures for service delivery, such as state- and county-operated treatment programs; and
- receive different amounts of ADMS block grant funding.

Figure 5



Our review included five local IV drug treatment programs in each of the three states (see fig. 5). We visited 14 methadone maintenance clinics and 1 alcohol- and drug-free clinic. Methadone—an orally administered, synthetic narcotic used to treat heroin and other opiate addicts—is the most common form of treatment. We selected local programs that (1) received ADMS block grant funds, (2) were geographically dispersed across the three states, and (3) were at or over 90 percent of their treatment capacity. We interviewed state and local program officials to determine their policies and practices concerning waiting lists and admission procedures.

We also obtained a national perspective on IV drug abuse and HHS's oversight of state-administered treatment programs supported with ADMS block grant funds. For this, we interviewed HHS officials in the Alcohol, Drug Abuse and Mental Health Administration to (1) understand their approach to oversight of the block grant and (2) identify current policy guidance to assist states in implementing the federal IV drug provisions. We also interviewed NASADAD officials to obtain their views on state responses to these provisions.

On November 7, 1989, we briefed the Subcommittee staff on the preliminary results of our review. This report summarizes the results of our analysis and provides observations on approaches used by selected states and local clinics to provide timely IV drug abuse treatment. We conducted our work between September and November 1989, in accordance with generally accepted government auditing standards.

States Generally Implemented Federal Treatment Provisions, but Some Clinics Are Not Meeting Prompt Treatment Goal

States, including the three we visited, provided assurances in their fiscal year 1989 applications for ADMS block grant funds that programs receiving these funds would provide IV drug abuse treatment services within 7 days of request, to the maximum practicable extent. States also assured HHS that they would implement the other four IV drug treatment provisions in section 2034 by: (1) submitting a plan for treatment services if requested by HHS, (2) targeting federal drug treatment funds, (3) requiring local providers to report treatment capacities, and (4) requiring local providers to conduct outreach activities.

The three states and 15 local providers we visited generally implemented each of the provisions in section 2034. We found:

- Of the 10 local clinics we visited in California and Oregon, 5 had clients who waited longer than 7 days after their request for IV drug treatment. None of the 5 local providers we visited in New York had clients who waited longer than 7 days because programs filled to capacity referred persons seeking treatment to other programs.
- HHS did not request plans for all substance abusers seeking treatment, nor did the three states develop such plans on their own to describe how they would address the unmet needs of IV drug abusers seeking treatment. The states did, however, estimate the number of IV drug abusers they believed would seek treatment. In addition, Oregon estimated the financial and personnel resources needed to provide treatment.
- The three states targeted ADMS block grant funds to communities they determined to be in the greatest need for services or having the highest prevalence of substance abuse. These states also required local providers to report to the state when they reached or exceeded 90 percent of their treatment capacity.
- California required its local clinics to conduct outreach, but New York and Oregon did not. Of the 10 local providers we visited in these states, 8 either conducted their own outreach or used existing state and county AIDS education and awareness programs. [4]

Our analysis of state and local implementation of the five IV drug provisions in section 2034 by the three states and 15 local providers we visited are summarized in table 1.

[4]The other two clinics had exceeded their treatment capacity and they believed outreach activities were not necessary for them.

Table 1: State and Local Implementation of Five Federal IV Drug Abuse Treatment Provisions

IV drug abuse treatment provision	State implemented or required implementation			Local provider implementation[a]		
	CA	NY	OR	CA	NY	OR
Timeliness of treatment[b]	Yes	Yes	Yes	2 of 5	Yes	3 of 5
Treatment plan	Not requested	Not requested	Not requested	NA[c]	NA[c]	NA[c]
Targeting funds	Yes	Yes	Yes	NA[c]	NA[c]	NA[c]
Reporting treatment capacity	Yes	Yes	Yes	Yes	Yes	Yes
Outreach to IV drug abusers	Yes	No	No	4 of 5	4 of 5	4 of 5

[a]Of the five local providers we visited in each state, we identify the number of providers that implemented the applicable provision.

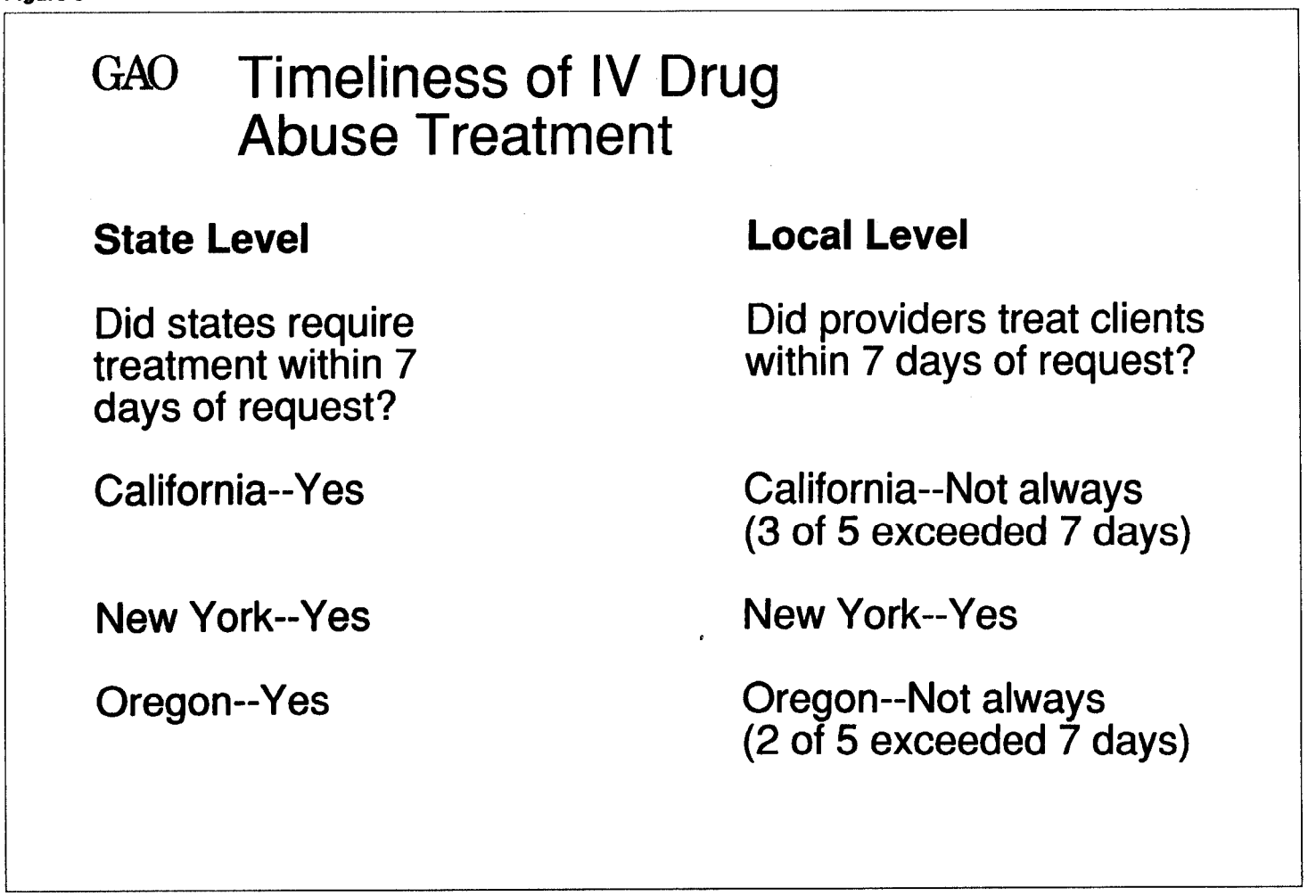
[b]The states interpret the provision to provide treatment within 7 days as a goal; we assessed whether clinics actually admitted all IV drug abusers within 7 days of their request for treatment.

[c]Not applicable because the planning and targeting provisions do not apply to local providers.

Timeliness of IV Drug Abuse Treatment

The timely treatment provision in the Anti-Drug Abuse Act of 1988 (section 2034) creates a broad goal for states to provide treatment within 7 days "to the maximum extent practicable," but does not require a 7-day period for admitting IV drug abusers to treatment. All three states required that programs supported with ADMS block grant funds provide IV drug treatment within 7 days to the maximum extent practicable (see fig. 6).

Figure 6



At the time of our visit, 5 of the 10 California and Oregon clinics did not admit some IV drug abusers into treatment programs within 7 days of request. Three of these clinics were in California; the other two were in Oregon (see fig. 6). Waiting periods in these two states were as long as 3 months at some clinics. In New York, waiting periods did not exceed 7 days in the five local programs we visited because programs filled to capacity referred persons seeking treatment elsewhere.

California

California drug abuse officials notified ADMS block grant recipients of the 7-day provision in March 1989, and it became effective in July. California surveyed local clinics in June 1989 to identify those with drug abusers waiting for treatment. The survey identified over 2,000 clients statewide waiting for methadone maintenance treatment. More than 85 percent of them had waited longer than 7 days. State alcohol and drug abuse program officials said that during the period reviewed, insufficient financial resources were the primary reason clients did not receive treatment within 7 days. California officials said other factors contributed to waiting periods longer than 7 days at the three clinics with waiting lists. These factors included barriers to developing new facilities, such as obtaining local permits.

Of the five local clinics we visited in California, three did not provide IV drug treatment within 7 days; each had a waiting list. For example, the West County Medical Clinic in Long Beach had over 200 people on a waiting list for up to 3 months. In Monterey and San Bernardino counties, waiting periods averaged at least 2 months. The clinics usually treated pregnant women and HIV-infected clients, however, within 7 days.

IV drug abusers waiting for publicly funded slots generally waited longer for treatment. This was particularly true for clients receiving Medicaid. One reason for this is that California generally does not allow Medicaid funds to be used to pay for methadone treatment.

New York

New York required all publicly funded drug treatment providers to admit IV drug abusers seeking treatment into their programs within 7 days of request. This requirement applies to those providers receiving federal funds, state funds, or both. New York officials notified ADMS block grant recipients and other state-funded treatment programs of the 7-day provision in August 1989.

Of the five local providers we visited, none had waiting periods longer than 7 days. At the time of our visit, four providers exceeded 90 percent of capacity and the other provider exceeded 100 percent. When they reached 100 percent of treatment capacity, these providers usually referred IV drug abusers to other programs with available treatment slots. For example, Lower Eastside Service Center, Inc., and Albert Einstein clinic administrators said they either try to admit drug abusers into their treatment programs within 7 days or refer them to another

local provider. These two providers did not monitor the progress of client referrals, however, to ensure timely admission to alternative programs. New York does not have a central intake system or a mechanism in place to track referrals—which is generally done informally when the provider of choice is at its capacity. New York's fiscal year 1990-91 budget proposal contained a demonstration project for central intake.

Oregon

Oregon required local clinics to admit IV drug abusers into a drug treatment program within 7 days of request, to the maximum extent practicable. The Bridgeway and Jackson County programs had waiting lists and did not provide treatment within 7 days; waiting periods ranged from 2 to 3 months at the time of our visit. In March 1990, Oregon amended all community contracts with local providers to include the federal provision for timely treatment.

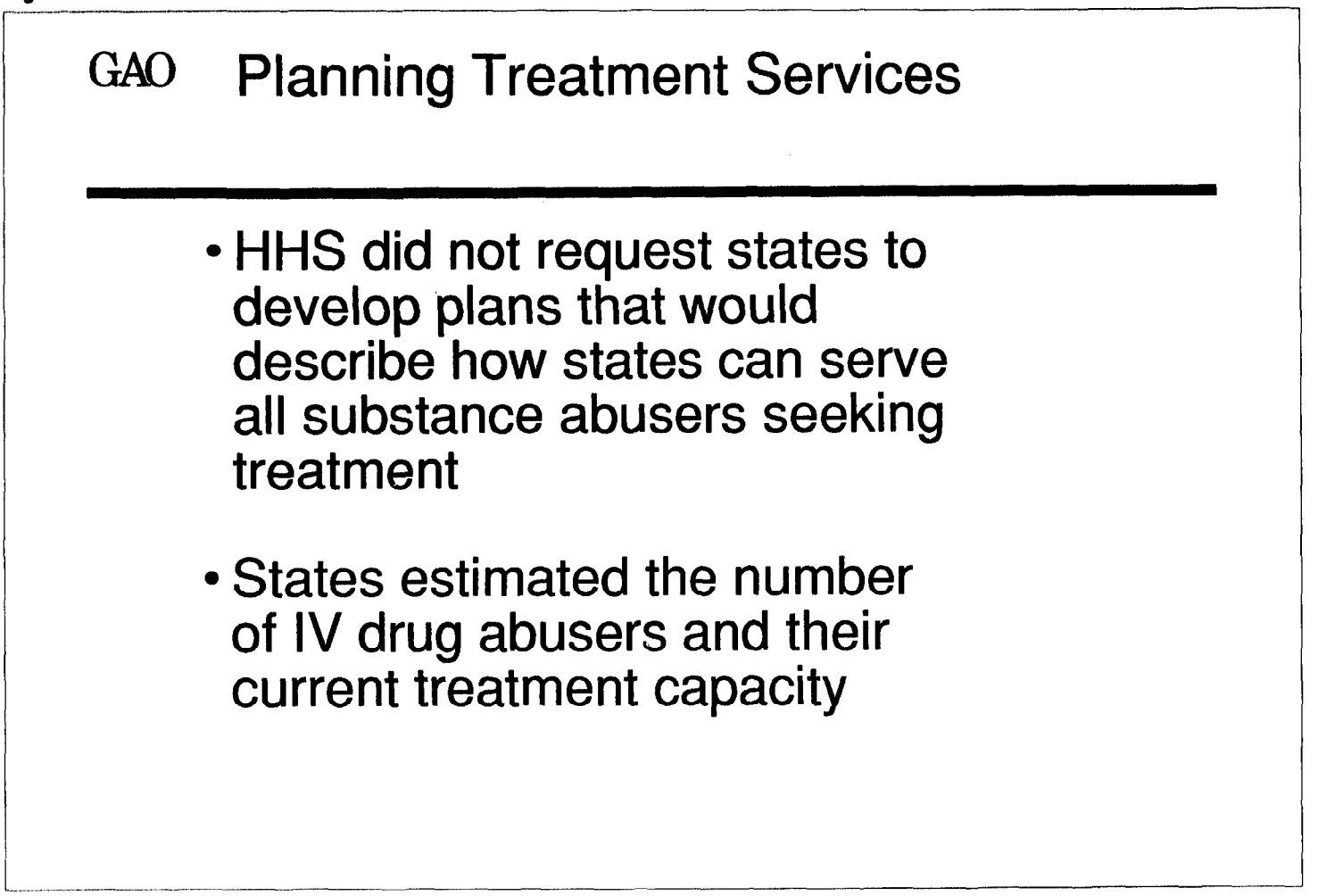
The length of waiting periods depended on the client's source of funds and ability to pay for treatment. For example, at the two clinics with waiting lists, Medicaid clients had to wait longer than clients with other funding sources.

Planning Treatment Services

The Secretary of HHS did not use his statutory authority to request states to "devise and make available" a plan that would (1) describe how states can provide services to all substance abusers seeking treatment services and (2) provide an estimate of the financial and personnel resources necessary to provide such treatment. However, HHS recently began working with several states to develop a survey instrument to obtain information on states' planning for and management of substance abuse services. Eight states were asked to pilot-test the instrument before HHS requests all states to voluntarily complete the survey.

The three states we visited did not prepare separate substance abuse plans on their own. They believed that their fiscal year 1989 ADMS block grant applications sufficiently described how the states planned to provide services for IV drug abusers. We assessed whether these applications met the spirit of the provision. Our review of the 1989 applications showed that these states did address some of the elements specified in the federal provision that were to be included in the plan. All three states estimated the total number of IV drug abusers needing treatment and the number of treatment slots available. Only Oregon, however, estimated the financial and personnel resources needed to serve those drug abusers likely to seek treatment.

Figure 7



California

At the request of the state legislature, California's Department of Alcohol and Drug Programs has begun to identify treatment needs of unserved IV drug abusers. The state intends to identify the number of additional treatment slots needed to serve eligible drug abusers. California relaxed certain treatment standards for readmission to other drug programs, such as the number of times clients have failed or dropped out of previous drug treatment programs. Because the state has not identified the number of additional treatment slots needed, it cannot estimate the financial resources needed to serve all IV drug abusers.

New York

New York estimated the number of drug abusers—including heroin addicts and other daily narcotics users—statewide and identified the state's current treatment capacity and unmet needs. New York intends to increase treatment capacity statewide from 48,000 to 65,000 drug treatment slots for all treatment methods. In March 1990, New York officials developed data to show the magnitude of the IV drug abuse problem and the treatment services needed at the county level to provide such services.

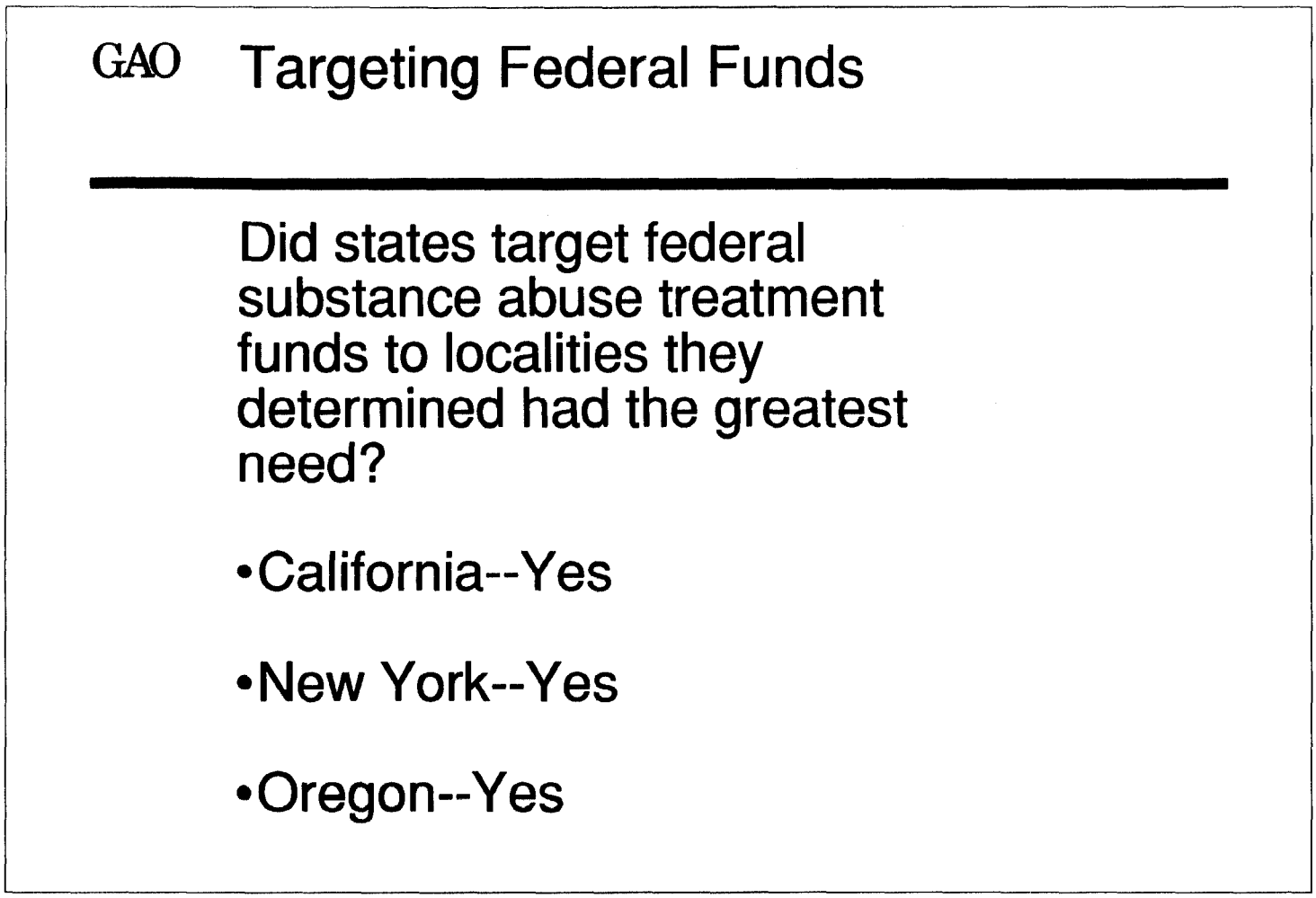
Oregon

Oregon identified IV drug abuse treatment as a "desirable" priority in its current biennial needs assessment. Oregon's substance abuse agency submits reports to its legislative and executive branches of government identifying unmet drug treatment needs. The state projects that an additional $3.5 million would be required to serve an estimated 4,500 IV drug abusers who would most likely seek treatment if it were available. Oregon estimated that additional staffing resources at both the state and local levels would be required, and included requests for these resources in its budget proposals.

Targeting Federal Substance Abuse Treatment Funds

The three states developed procedures to target ADMS block grant funds for IV drug treatment to communities they determined to have the greatest need for such services. The federal provision defines these high-demand communities as areas with the highest incidence of AIDS, drug abuse, and prevalence of drug-related crime (see fig. 8).

Figure 8



California

California allocates funds to communities based on (1) clinic admissions for IV drug treatment and (2) the number of reported AIDS cases. It also considers such factors as community income levels and number of minorities. The amount of federal ADMS block grant funds targeted to treat IV drug abusers totaled $5.7 million in fiscal year 1988 and $12.5 million in 1989.

New York

New York distributes its funds based on the number of drug-related hospital emergency room admissions and arrests, as well as clinic use rates,

among other factors. It targeted $9 million of its fiscal year 1988 ADMS block grant funds for methadone maintenance treatment. ADMS block grant funds earmarked for methadone treatment totaled $5.1 million in 1989.

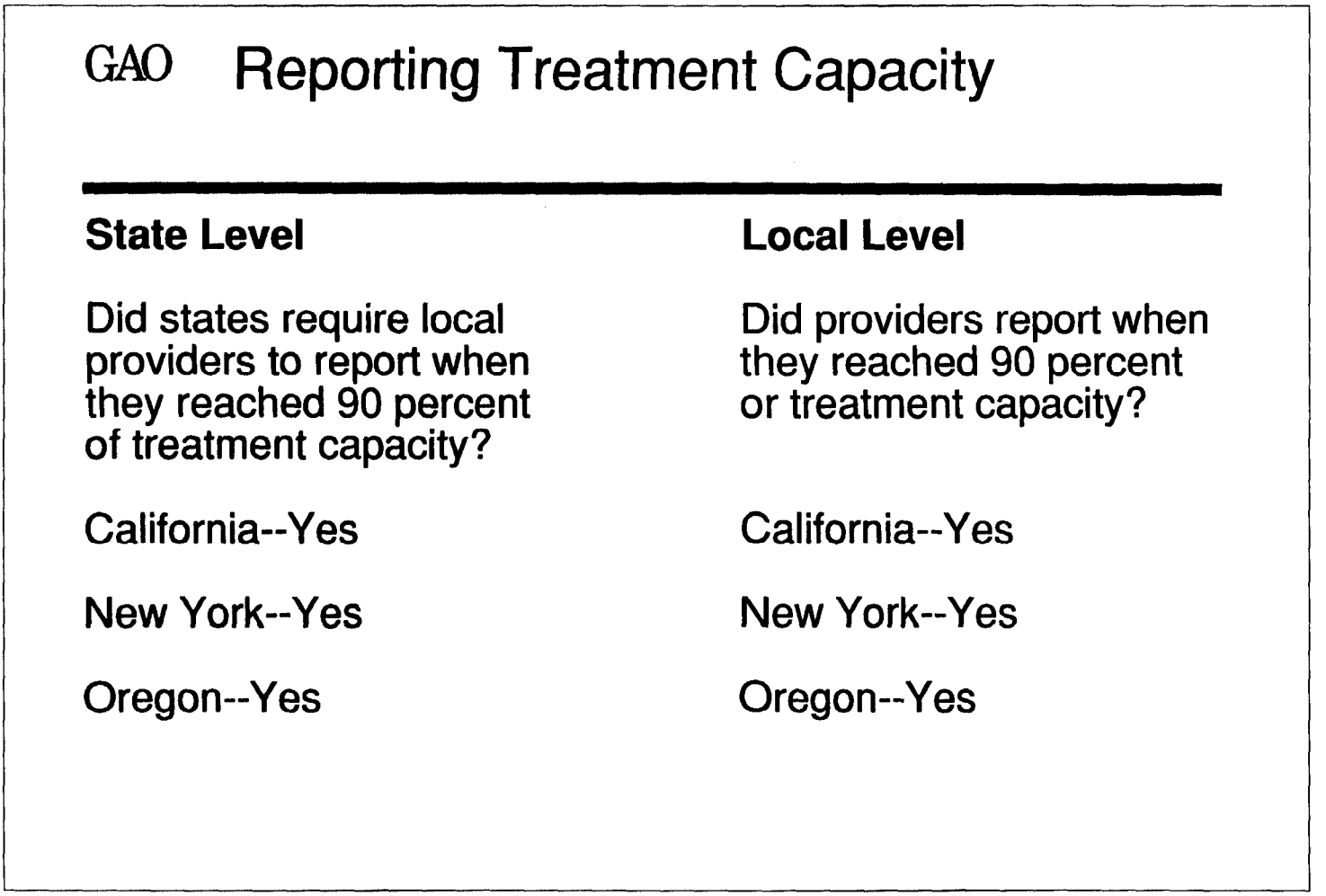
Oregon

Oregon distributes drug treatment funds based on clinic use rates and targets them to communities with high demands for services. Federal ADMS block grant funding targeted to treat IV drug abusers totaled more than $600,000 in 1988 and $1.3 million in 1989.

Reporting Treatment Capacity

The three states required local providers to notify the states' substance abuse agency when they reached or exceeded 90 percent of their treatment capacity, and all 15 providers did so. Each of the 15 providers we visited reported treatment capacity monthly (see fig. 9).

Figure 9



California

California required ADMS block grant recipients to report to the state substance abuse agency when they reach 90 percent of their treatment capacity. Although California included this requirement in grants to its counties, effective July 1989, it had a similar requirement before the Congress enacted the federal provision. The information reported, however, is not used to notify other methadone maintenance programs at or over capacity of available publicly funded treatment slots. In March 1990, a California official said, the state began collecting such data for publicly funded treatment slots.

California local clinics report treatment capacity monthly through their county governments. Of the five clinics visited, four exceeded 90 percent of their treatment capacity, and one was over 100 percent.

New York

New York has required its local providers to report treatment capacity since August 1989. New York, like California, implemented a requirement to report capacity that met or exceeded 90 percent before the federal provision. The state relies on monthly use reports from local providers to allocate its funds among other methadone maintenance programs. New York officials monitor more closely those providers that are consistently under 90 percent of their contractual capacity and inform them that they risk losing treatment slots unless they increase enrollment. Of the five providers visited, four exceeded 90 percent of their capacity, and one exceeded 100 percent.

Oregon

Oregon required local clinics to report treatment use levels before the federal reporting provision. The state required each clinic to maintain use at 100 percent or risk losing treatment slots if clinic use fell below 100 percent for 3 consecutive months.

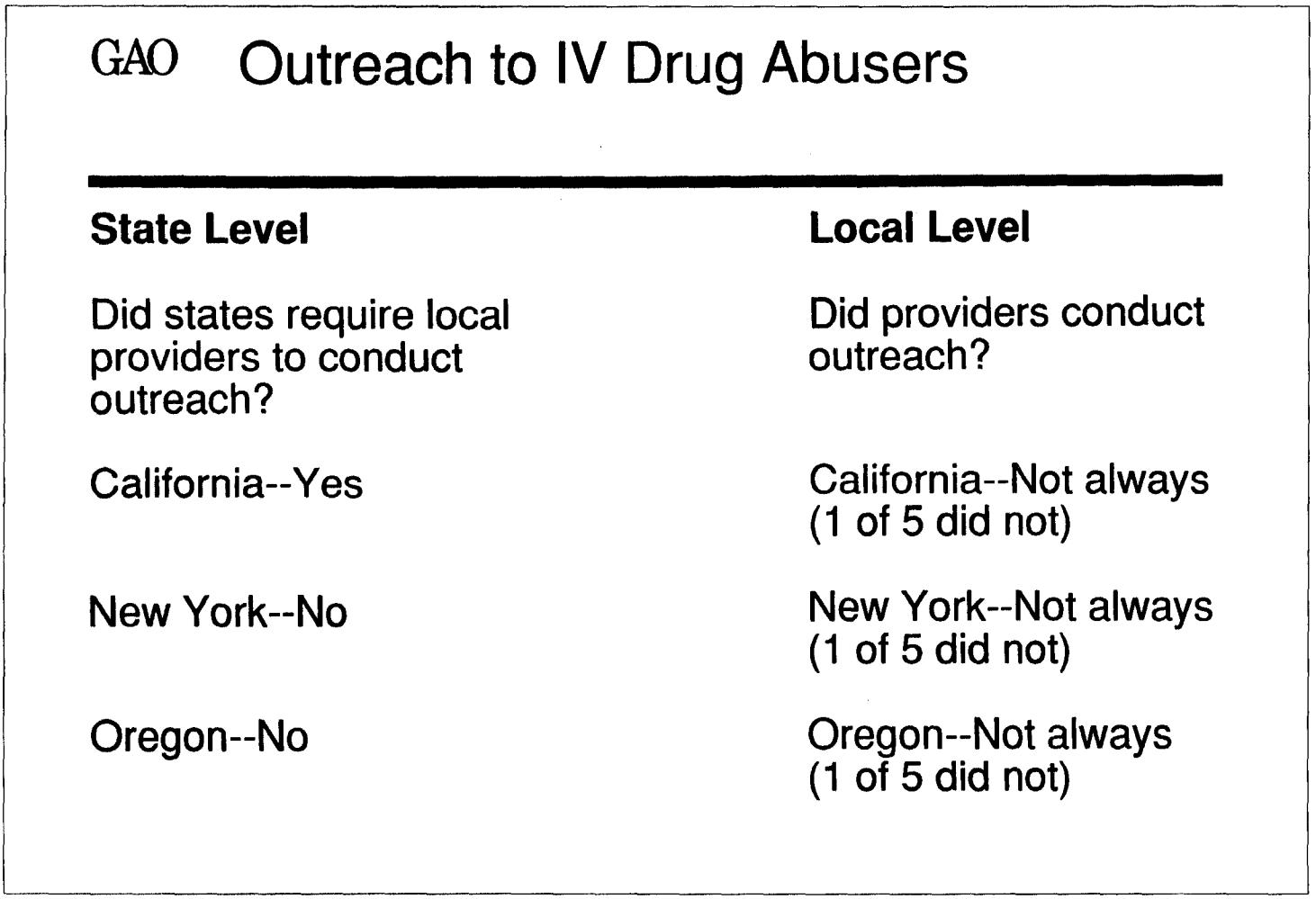
Although none of the five clinics in Oregon were aware of the federal reporting requirement, they provided monthly reports on treatment capacity to the state substance abuse agency. Of the five clinics visited, four exceeded 100 percent of their authorized capacity and the fifth was under 100 percent for about 1 month.

Outreach to IV Drug Abusers

All three states we visited conducted outreach activities to encourage IV drug abusers to seek treatment. Only California required its local clinics to conduct outreach activities for treatment programs supported with ADMS block grant funds (see fig. 10). Of the 15 local providers visited, 12 either conducted their own outreach activities for IV drug treatment services or relied on existing areawide AIDS education and awareness outreach programs rather than clinic-based outreach. [5] The three states believed that these outreach activities fulfilled the requirement.

[5]The other three clinics had exceeded their treatment capacity and believed outreach activities were not necessary for them.

Figure 10



California

California required local clinics to conduct outreach activities, and it notified the clinics by sending a letter to each county. Staff at the five local clinics we visited said that they were notified of this requirement before our visit in October 1989. Four of the five clinics conducted outreach activities before the state's notification. These activities were targeted to populations believed to be at risk of contracting AIDS, including the Hispanic community, migrant workers, and prostitutes. The clinic in Long Beach did not conduct outreach activities; it had over 200 drug abusers waiting for treatment.

New York

New York did not require local providers to conduct outreach activities for treatment programs funded with ADMS block grant money. The New York State Division of Substance Abuse Services notified all local treatment programs receiving federal or state funds of the outreach provision in January 1990, and it plans to ensure compliance during its monitoring visits. The division conducted outreach activities and contracts with county and other local agencies. These agencies conducted outreach before the federal provision was enacted. Four of the five providers visited conducted their own outreach activities; the other provider did not but was located in an area covered by the state's outreach programs. New York encourages IV drug treatment programs to conduct outreach activities as appropriate.

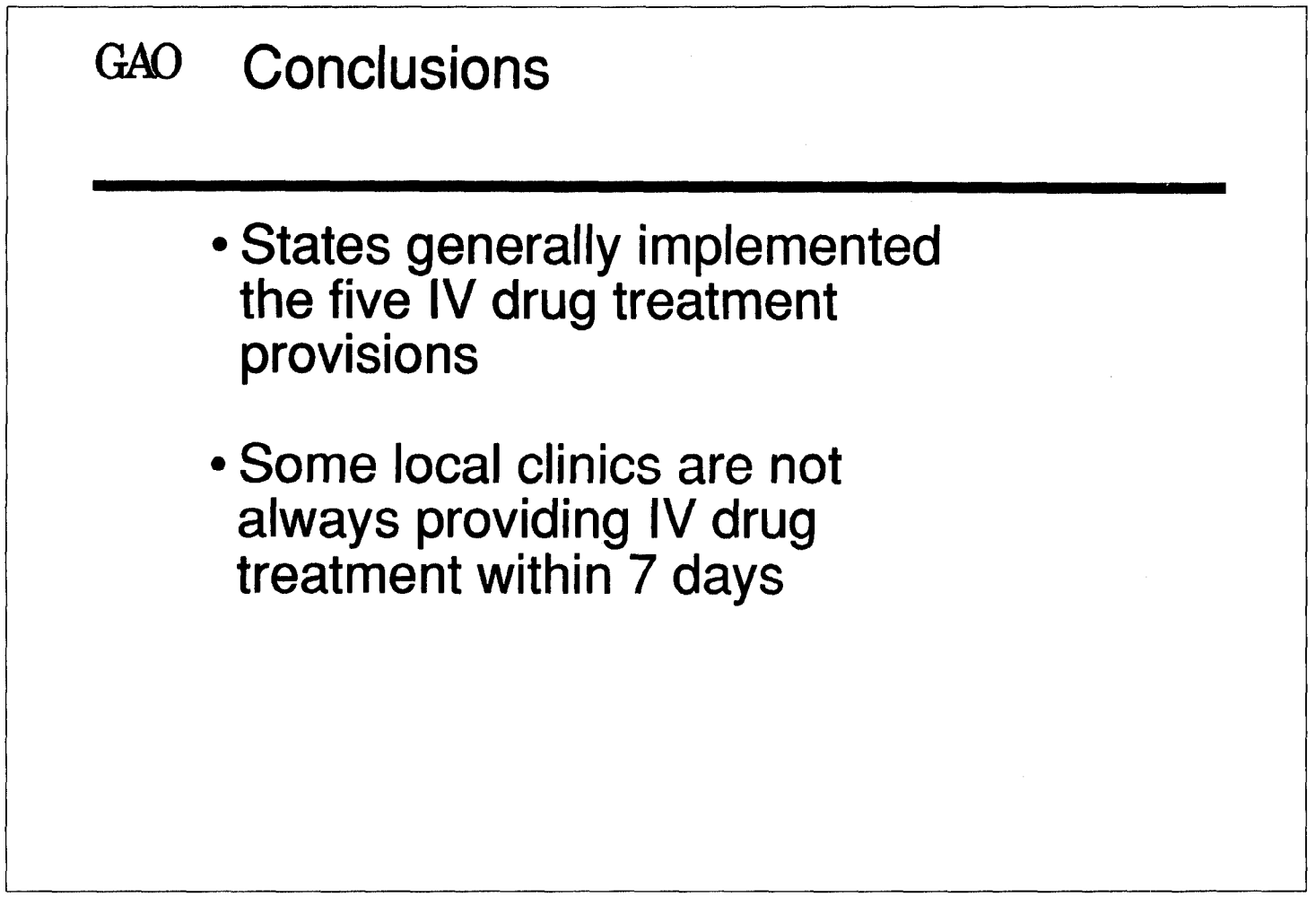
Oregon

Oregon did not require its local clinics supported with ADMS block grant funds to conduct outreach activities. Of the five clinics we visited, four conducted outreach before the federal provision, using federal- and state-funded AIDS education programs. The state and county AIDS education outreach workers target IV drug abusers and distribute coupons redeemable for free detoxification treatment. The Jackson County clinic did not accept outreach funding because, given county officials' concerns for outreach workers' safety, they were opposed to these activities. Beginning in 1990, state officials said, they plan to fund outreach activities with ADMS block grant funds.

Conclusions

States have generally implemented the IV drug treatment provisions, but some local clinics are not always providing treatment within 7 days. While two of the three states' outreach activities may not be consistent with the clinic-based approach described in statute, they do use other approaches to provide outreach, which they believe to be equally effective (see fig. 11).

Figure 11

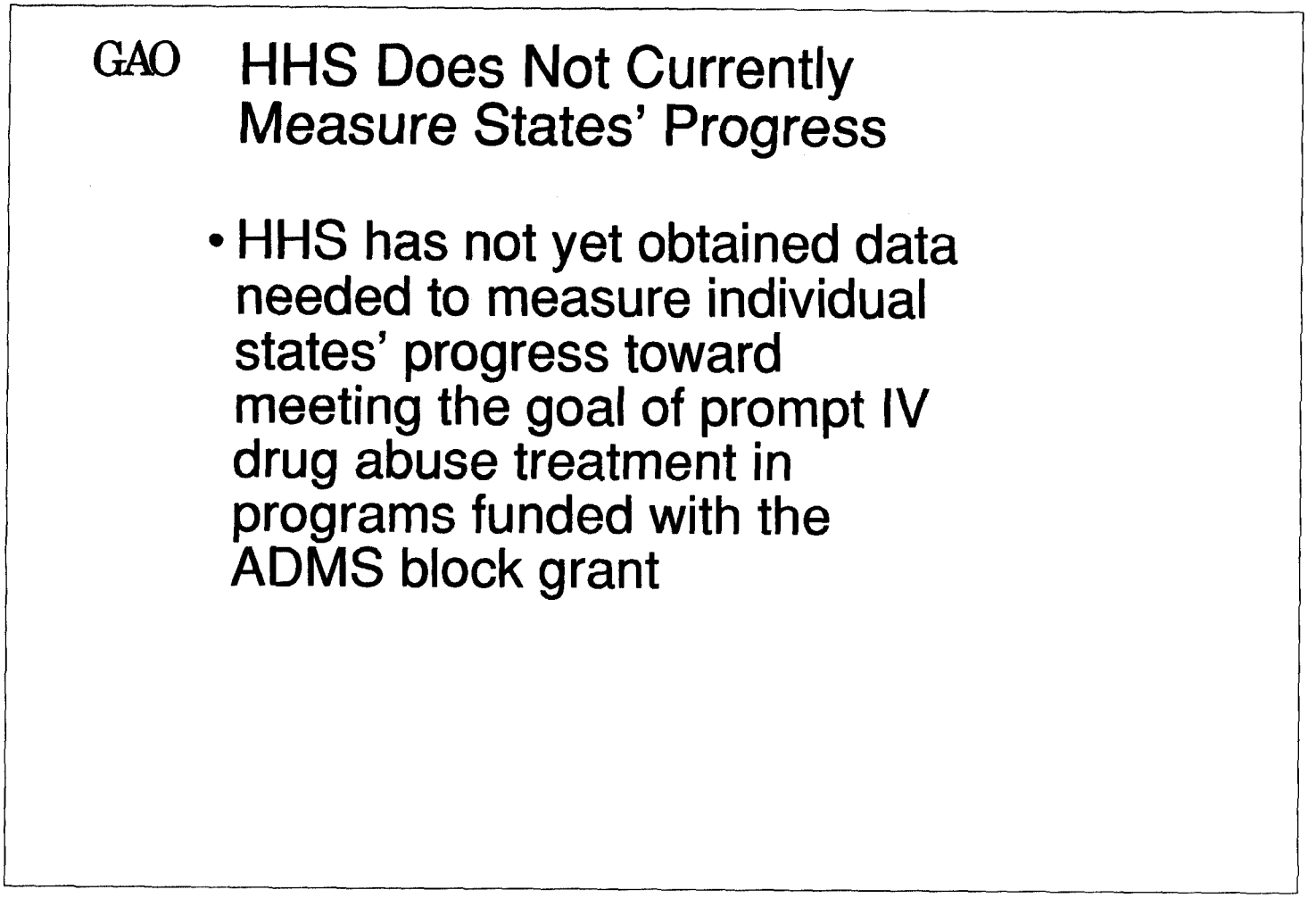

GAO
Conclusions
• States generally implemented the five IV drug treatment provisions
• Some local clinics are not always providing IV drug treatment within 7 days

HHS Does Not Currently Measure States' Progress Toward Meeting the Prompt Treatment Goal

HHS cannot currently assure that states are making progress toward the goal of providing IV drug abusers treatment within 7 days of request. However, HHS has recently increased its efforts by (1) working with states to design a national drug services research survey and (2) requiring progress reports from treatment providers receiving 1-year grants to reduce drug abuse treatment waiting lists. In addition, HHS provides some technical assistance to help states implement federal IV drug provisions affecting programs that receive ADMS block grant funds.

However, these efforts cannot be used to measure states' progress, such as changes in the length of waiting periods for IV drug abusers seeking treatment or the number of IV drug treatment slots needed. As a result, HHS will not necessarily be able to assess states' progress in implementing the federal IV drug 7-day treatment provision in all programs funded with ADMS block grant funds (see fig. 12).

Figure 12



HHS Has Not Obtained Information to Measure States' Progress

In recent months, HHS has begun to obtain some state-reported data that could be used to generally measure some local providers' progress in meeting the timely IV drug abuse treatment goal. These data, however, may not be sufficient to measure individual states' progress. HHS currently relies heavily on state-reported data to determine whether states are complying with the ADMS block grant legislation, including the IV drug treatment provisions. It does this by reviewing the periodic self-compliance review checklists, state block grant applications, and state annual program reports. In addition, HHS is developing a new national survey of substance abuse treatment services and is requiring semi-annual progress reports from those grantees receiving the 1-year drug

treatment waiting list reduction grants. These reports are to describe efforts to provide timely treatment; however, they will not measure outcomes, such as changes in the number of IV drug abusers waiting for treatment. For example, the progress reports on the waiting list grants will provide specific progress information for that program, but the number of grantees is too small to show state-by-state progress. (See p. 35.) As a result, HHS may not know the extent to which individual states are making progress in admitting IV drug abusers into treatment programs within 7 days of request.

Until 1987, HHS conducted its own compliance reviews in several states each year to determine state compliance with federal requirements. It now asks selected states to assess their own compliance with federal legislation based on a checklist developed by HHS. In 1989, HHS mailed compliance review checklists to eight states. These states provided documentation that HHS used to determine whether they were in compliance with federal requirements. For 1990, HHS plans to mail compliance review checklists to six states and conduct on-site reviews in three others based on state-reported data. HHS will conduct an on-site review only if, in its judgment, state-reported information indicates the need for such a review.

States annually submit ADMS block grant applications to HHS for review and approval. These applications describe states' intended use of ADMS block grant funds and provide assurances that they will implement federal requirements. In 1989, the three states we visited provided the required assurances that they would implement the federal provisions for IV drug abuse treatment.

Under the ADMS block grant, states agree to prepare annual program reports. These reports describe how states used ADMS block grant funds, including IV drug abuse activities. The fiscal year 1989 reports are due to HHS by May 15, 1990. In a March 1990 letter to the states, HHS described the information to be included in this report and asked the states to describe how they implemented the IV drug treatment provisions. HHS also uses the annual block grant program report as a source of information on the number of substance abusers treated and the length of waiting periods for treatment. However, HHS does not require states to identify the length of waiting periods for IV drug abusers seeking treatment.

HHS collects national data on substance abuse activities, but these data cannot be used to measure states' progress in meeting the timely IV drug

abuse treatment goal. HHS worked with the Office of National Drug Control Policy and NASADAD to develop two national data collection surveys. Since 1982, NASADAD has annually collected data from the states on substance abuse activities on a voluntary basis. Beginning in 1986, as part of its survey, NASADAD asked states to estimate the total number of IV drug abuse treatment admissions and the total number of IV drug abusers. HHS also recently initiated a survey of a national sample of substance abuse treatment programs, covering such items as the number of slots available for substance abuse treatment and how long clients would wait for such services.

In addition, HHS is requiring public and nonprofit entities receiving 1-year grants to reduce drug abuse treatment waiting periods to prepare semiannual progress reports. These reports are to include such information as the number of new treatment slots established, the type of treatment provided, the total number of persons on waiting lists on date of application and at conclusion of grant period, and problems encountered in meeting goals. When this information is reported, it will be limited to about 360 grantees receiving the $100 million to reduce waiting periods. These funds will provide 21,000 treatment slots, of which about 9,500 are for IV drug abuse treatment. In 1989, there were about 115,000 IV drug treatment admissions nationwide.

While these approaches may provide national trend data, none will provide sufficient data to measure individual states' progress in meeting the 7-day provision. For example, states' descriptions of their procedural activities cannot be used to measure their progress in reducing the length of waiting periods for IV drug abusers seeking treatment.

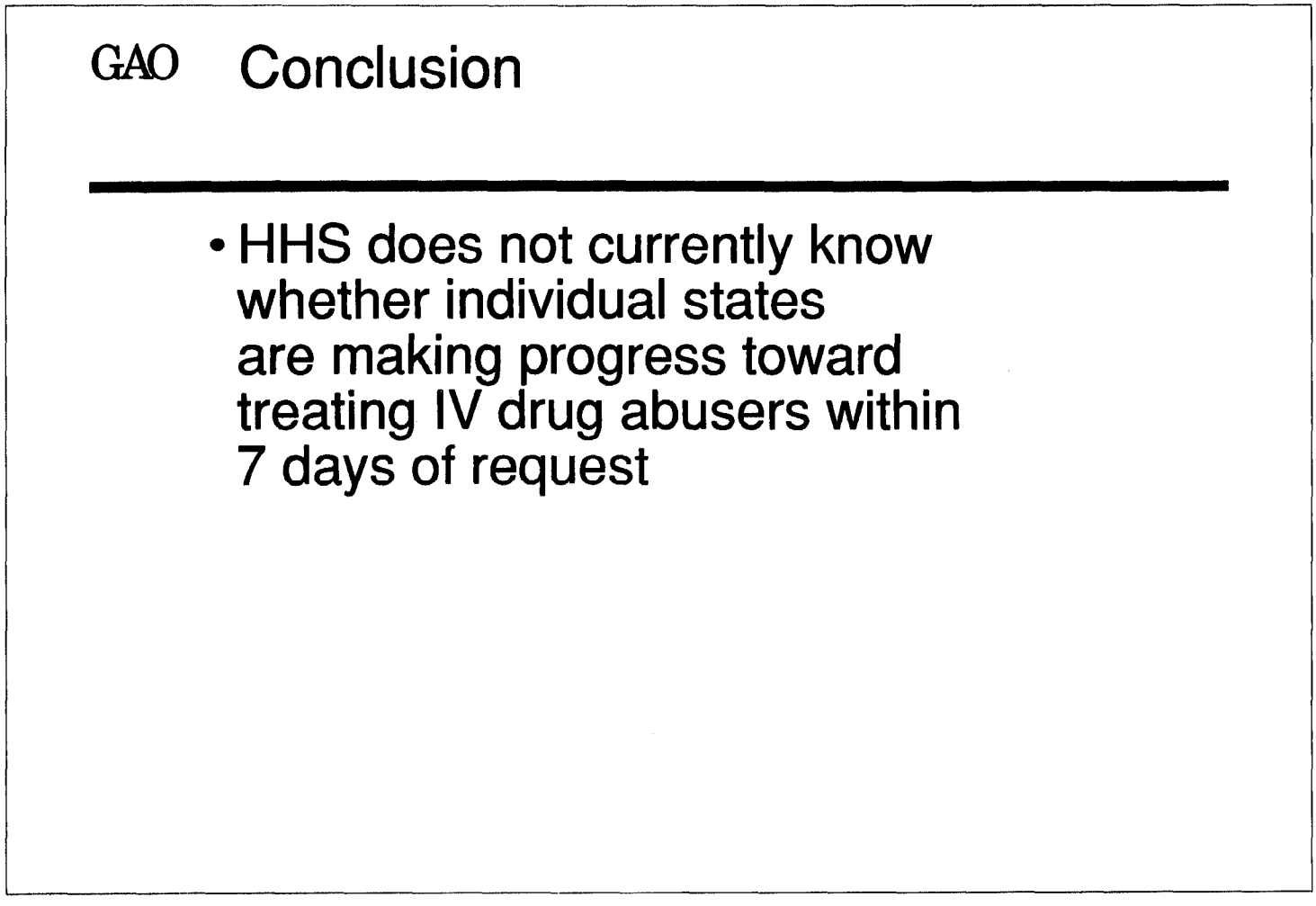
HHS Provides Some Technical Assistance

HHS focuses its technical assistance primarily on administrative procedures. For example, HHS held three regional conferences that covered several procedures, such as how to draw down ADMS block grant funds and how states can apply for waivers of federal requirements. It also sent a technical guidance letter to all states in June 1989, notifying them of new ADMS block grant requirements. In addition, HHS is pilot-testing a survey instrument to collect information on states' planning for and management of substance abuse services, and HHS is funding 41 demonstration programs to assist states in identifying appropriate outreach strategies to encourage IV drug abusers and people with AIDS to seek treatment.

Conclusions

Because HHS has not yet obtained data needed to measure states' performance, it does not know whether individual states are making progress in treating all IV drug abusers within 7 days of request. Existing reporting requirements, such as the states' annual program reports describing the use of ADMS block grant funds, do not provide sufficient information to measure such efforts. We believe HHS should revise these reports so they can be used to measure states' progress in their efforts to provide timely IV drug treatment (see fig. 13).

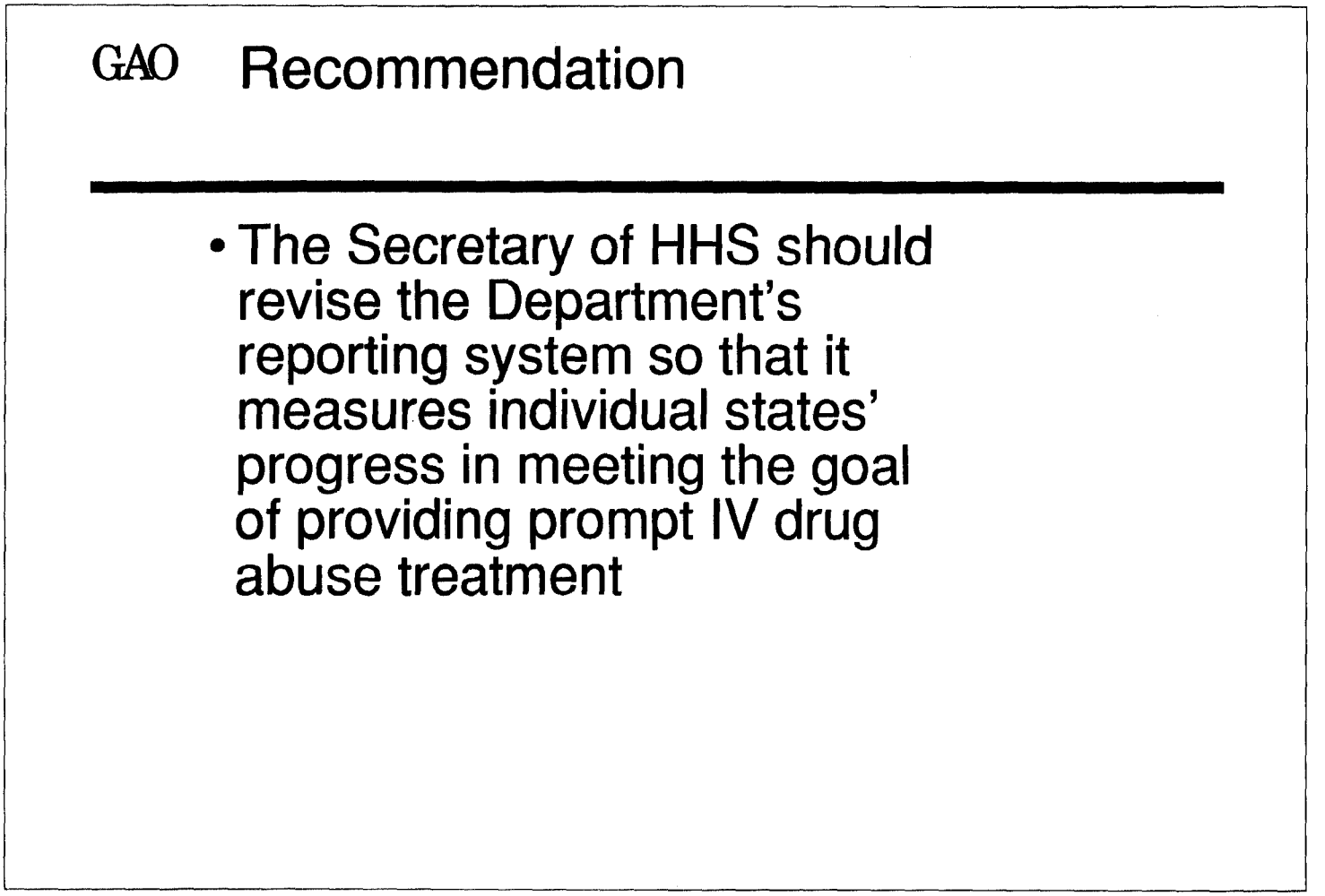
Figure 13



Recommendation to the Secretary of HHS

The Secretary of HHS should revise the Department's reporting system so that it can measure individual states' progress in meeting the goal of providing IV drug abusers treatment within 7 days of request (see fig. 14).

Figure 14



Substance Abuse Treatment Clinics Selected for Review in Three States

California

West County Medical Clinic
Long Beach (Los Angeles County)

Community Human Services, Salinas Valley
Salinas (Monterey County)

Inland Health Services (IHS) - San Bernardino
San Bernardino (San Bernardino County)

San Joaquin County Methadone Clinic
Stockton (San Joaquin County)

Moorpark Methadone Clinic
San Jose (Santa Clara County)

New York

Beekman/Trinity Downtown Hospital
New York City

Lower Eastside Service Center, Inc.
New York City

Albert Einstein College of Medicine
Division of Substance Abuse
New York City

Niagara County Drug Abuse Program
Methadone Maintenance Treatment Program
Niagara Falls (Niagara County)

Tremont Commonwealth Council, VIP, Inc.
Methadone Maintenance Treatment Program
New York City

Oregon

Bridgeway
Salem (Marion County)

Marion County Drug Treatment Program
Salem (Marion County)

CODA Methadone Treatment Service
Portland (Multnomah County)

Lane County Alcohol and Drug Offender Program:
Methadone Unit
Eugene (Lane County)

Jackson County Methadone Program
Medford (Jackson County)

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Seattle Regional Office	Patricia K. Yamane, Evaluator

Related GAO Products

HHS Cannot Currently Measure States' Progress in Meeting the Prompt Treatment Goal for Intravenous Drug Users (GAO/T-HRD-90-25, Apr. 30, 1990).

Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990).

Preliminary Findings: A Survey of Methadone Maintenance Programs (GAO/T-HRD-89-33, Aug. 2, 1989).

AIDS: Views on the Administration's Fiscal Year 1989 Public Health Service Budget (GAO/HRD-88-104BR, Jun. 2, 1988).

Controlling Drug Abuse: A Status Report (GAO/GGD-88-39, Mar. 1, 1988).

Drug Abuse Prevention: Further Efforts Needed to Identify Programs That Work (GAO/HRD-88-26, Dec. 4, 1987).

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