Implementing an Outcomes Measurement System in Substance Abuse Treatment Programs

Donna Leigh Bliss, PhD

ABSTRACT. Human services programs are increasingly being required to assess program performance and track progress in meeting outcomes in order to receive funding. This emerging trend has implications for social workers who administer substance abuse treatment programs. While larger programs can have the necessary resources to implement comprehensive outcomes measurement systems, smaller programs can be at a disadvantage when they don’t have the needed resources. This paper attempts to level the playing field by providing a model for creating an outcomes measurement system that can be used by social workers who administer small substance abuse treatment programs. The importance of logic models in developing an outcomes measurement system is discussed. A nine-step model that smaller programs can use to implement an outcomes measurement system is presented. Limitations of implementing and maintaining an outcomes measurement system using the nine-step model are discussed. doi:10.1300/J147v31n04_07 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Outcomes measurement, program evaluation, logic models, administration, substance abuse

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Mary Landers, a licensed social worker, is the director of a small substance abuse treatment program. She dreads her upcoming meeting with Councilman William Jones, someone who has a say on funding for the program and who doubts whether substance abuse treatment is worth the expense. Mary knows that Councilman Jones will ask her about the “success” rate of the program in order for him to judge how effective it is. She is concerned that funding might be cut if she cannot demonstrate that her program is achieving the results it is funded to achieve. Mary also knows that judging the effectiveness of a program such as hers based on how former clients function after discharge doesn’t make sense given that programs aren’t funded to track clients after discharge or that clients may need multiple treatment stays before achieving sobriety. Yet, despite all the beneficial aspects of her program, Mary’s mind draws a blank when she tries to imagine how she can communicate to Councilman Jones how beneficial her program actually is.

Gone are the days when human services programs could receive reliable funding from government and other sources without having to justify that the program delivered what it said it would. The era of accountability (Kettner, Moroney, & Martin, 1999) has arrived with its attendant requirement that programs assess their performance and track progress in meeting outcomes in order to continue receiving funding. Adjusting to this new reality can be challenging for social work administrators of substance abuse treatment programs that previously were not required to demonstrate their effectiveness beyond answering questions about client characteristics and treatment utilization rates.

Substance abuse treatment programs have now begun to implement outcomes measurement systems to track indicators on various treatment outcomes. Administrators of larger programs that have the necessary financial and personnel resources have found this to be a manageable task, but not necessarily so for directors of small substance abuse treatment programs that have limited budgets and small, overworked staffs. The director of a small program might look at requirements for implementing an outcomes measurement system for her program and wonder how that could be accomplished without additional time, fiscal, and personnel resources.

As social workers continue to play an increasingly important role in substance abuse treatment, program development, and administration (Straussner, 2001), the need for a social work-centered outcomes measurement system that can be applied to small substance abuse treatment programs is recognized.
programs becomes more apparent. The person-in-environment perspective of social work (Compton & Galaway, 1989) that takes into consideration the biopsychosocial functioning of clients can provide a holistic assessment of program efficacy that goes beyond information provided by individually oriented outcome indicators.

The primary purpose of this paper is to present a model of an outcomes measurement system that can be implemented by social workers who administer small substance abuse treatment programs that have limited fiscal and personnel resources.

AN EMERGING TREND

An emerging trend toward accountability that began in the latter part of the twentieth century has altered the way human service programs operate as programs increasingly have been challenged and required to demonstrate effectiveness for what they purport to do and be held accountable for what they accomplish (Kettner, Moroney, & Martin, 1999).

The roots of this revolutionary change can be traced back to the 1960s when the federal government began to allow state welfare departments to purchase services (POSC) from other state agencies, and later from private agencies (Kettner, Moroney, & Martin, 1999). More recently, the growth of managed care since the 1980s has had a major impact on the provision of human services. While POSC typically emphasized accountability in the partnerships between the public and private sectors in the provision of human services, managed care has been more concerned with containing costs by deciding the types and amount of services that can be delivered (Kettner, Moroney, & Martin, 1999).

IMPACT ON PUBLIC AND PRIVATE SECTOR

Together, these two forces have led to seismic shifts in the landscape of how human services programs are funded and services are provided. The impact of this trend toward accountability can be seen in the federal government with the passage of the Government Performance and Results Act (GPRA) in 1993 (Hatry, 1997), by state governments such as Oregon with its Benchmark program (Hatry, 1997), by local governments such as Prince William County, Virginia that included outcomes indicators in its 1995-1996 budget (Hatry), and the private sector such as the United Way (n.d.), which encourages its service agencies to collect outcomes data.
ASSESSING PROGRAM ACCOUNTABILITY

One approach to assessing program accountability is the use of performance measurement. This involves the regular collection and reporting of information on efficiency, quality, and effectiveness of the program. This multifaceted approach has become increasingly popular because it combines the three major accountability perspectives into one (Martin & Kettner, 1996).

The efficiency perspective emphasizes the degree to which outputs are maximized in relation to inputs. This is an unpopular approach as it can be used to justify cutting program funding (Martin & Kettner, 1996). The quality perspective emphasizes the use of quality benchmarks for comparing programs (Martin & Kettner, 1996). The Total Quality Management (TQM) movement maintains that productivity increases when programs provide high-quality services and decreases when program provide low-quality services (Gunther & Hawkins, 1999). The effectiveness perspective focuses on program outcomes and views accountability as the maximization of outcomes in relation to inputs. While all three approaches conceptualize accountability of program performance differently, they also give prominent roles to different types of feedback that together can provide a more comprehensive picture of program performance (Martin & Kettner, 1996).

IMPACT ON STATE AND LOCAL SUBSTANCE ABUSE AGENCIES

While publicly funded substance abuse treatment was in the past primarily funded on the basis of need, diminishing public resources have increasingly necessitated that substance abuse treatment programs evolve into performance-based systems. In order to document the performance of programs and to assess outcomes, many states have implemented new or improved management information systems (MIS). These systems are typically computer-based systems designed to collect, store, manage, analyze, and report information. The decision of states to utilize managed care has accelerated the development of MISs (Substance Abuse and Mental Health Services Administration, 2000).

Local governments have mirrored the trend of states toward developing MIS’s to collect data and assess outcomes. For example, the Cleveland Target Cities Demonstration Project, funded in 1993 by the Center for Substance Abuse Treatment (CSAT), established two central intake
units (CIU), each comprised of a multidisciplinary team of ten clinicians. An automated MIS was designed to support business and clinical procedures and is comprised of three layers of applications: (1) provider level which tracks admissions, discharges, services, staff productivity, and billing; (2) central intake unit which is a “super-agency” that provides referrals, client tracking, and billing; and (3) administrative level which views information across the system to assess productivity, utilization management, and quality improvement. Guidelines based on the experiences of the users of this system are offered to address questions about the replication of the system (Kaye, Stephens, Chen, & Bruno, 1998).

**IMPACT ON INDIVIDUAL SUBSTANCE ABUSE TREATMENT PROGRAMS**

The trend toward accountability has had a major impact on individual substance abuse treatment programs in three primary areas: (1) being required to collect more information for state agencies, (2) developing and implementing their own outcomes measurement systems, and (3) utilization of research-based findings to improve treatment.

First, while individual substance abuse treatment programs have typically been required to collect a certain amount of information on client characteristics and treatment utilization, they are increasingly collecting more specific information required by state and local agencies. There are currently two primary collection instruments in use (Substance Abuse and Health Services Administration, n.d.). First, the Alcohol and Drug Abuse Client Minimum Data Set, developed by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, provides a means of standardizing patient data that states report to the federal government. Second, the Addiction Severity Index (ASI) assesses seven areas of patient functioning. State and local governments have been increasingly mandating the use of the ASI to assess government-funded programs (Substance Abuse and Health Services Administration, n.d.).

Despite the benefits that state agencies receive from the information collected by individual programs, the collection process can be experienced as being time-consuming and not worth the effort, especially by smaller programs whose staffs are already overwhelmed with just trying to meet the clinical demands of clients they treat. Directors will mention that they see little or no specific benefit to their program from this information, yet have to devote precious time to the task of collecting and reporting it.
Second, individual programs are increasingly implementing outcomes measurement systems either out of necessity or choice. One example is the Chemical Health Case Management Program in Minnesota which developed a performance measurement system that is comprised of key components and features including (1) system variables, (2) data sources and methods of data collection, (3) management reports, and (4) system database. The system has been successfully used in a number of ways including (1) using the measurement process to highlight client needs and outcomes, (2) provide quarterly reports that summarize performance of the program, (3) conduct special statistical analyses of client characteristic and performance variables, and (4) create a composite measure to predict client performance (Dobmeyer, Woodward, & Olson, 2002).

Third, a major trend in the field of alcoholism treatment has been the growth of research on treatment outcomes, as treatment issues that were not typically addressed have now become the focus of sophisticated research efforts. These issues range from the efficacy of different types of treatment and the types of patients who respond to them to the symptoms and problem areas that can be targeted by specific modalities (Carroll, 1997).

One result of the above trend has been the use of research-based improvements in treatment. A novel approach has been the Researcher in Residence Program, a joint activity of the National Institute on Alcohol Abuse and Alcoholism, the Center for Substance Abuse Treatment, the New York State Office of Alcoholism and Substance Abuse Services, and the Alcoholism and Substance Abuse Providers of New York State. The goal of this program was to encourage alcoholism treatment providers to adopt research-based improvements in alcoholism treatment offered by a research scientist who made brief visits to treatment clinics. While a pilot study of six sites showed that these visits did stimulate adoption of research-based improvements, principal barriers to adoption included staff turnover, misperception that the project was a research study, and burden of collecting existing client information (Hilton, 2001).

**IMPLEMENTATION CONSIDERATIONS**

There is no single outcomes measurement framework that is used. Instead, different factors affect how the system is designed. For example, the Substance Abuse and Mental Health Services Administration (n.d.) states there are four factors that determine the content of an outcomes monitoring system: (1) the purpose of the system, (2) the specific ques-
tions that need to be addressed, (3) the types of programs involved, and (4) what resources are available. While there is no definitive set of variables that should be included, the system does need to describe clients or patients and the treatment they receive.

Larger programs that have the necessary resources can develop comprehensive outcomes measurement systems. Neuman (2003) discusses a ten-step process used by a hospital social work department to create an interdisciplinary, comprehensive system. While the general feedback about the system was positive, the program took a year to design and was piloted for six months.

Social workers who direct smaller substance abuse treatment programs may look at these examples and feel dismayed that they do not have the necessary time, fiscal, and personnel resources to create such comprehensive systems. Unfortunately, the literature does not provide sufficient guidance on how an administrator can develop and implement a simple system using existing resources and still gain the benefits that are delivered by more comprehensive systems.

In an attempt to address this gap in the literature, this paper presents a nine-step model that social workers that administer small substance abuse treatment programs can use to development and implement an outcomes measurement system for their program using the resources they currently have available.

**THE LOGIC MODEL:**
**KEY TO THE SYSTEM**

Comprehensive outcomes measurement systems share common features that can easily be used in less complicated systems. This is important to social workers that direct small substance abuse treatment programs that have limited resources. These features include a data system for collecting information on client characteristics, treatment services provided, and client outcomes. The key to integrating these features into a system that provides useful feedback to the social work administrator and other stakeholders is the logic model.

A logic model (CYFERNet, 2000; Harvard Family Research Project, 2003) can be thought of as a road map for showing the progress that a program is making in going from the identified problem(s) the program is designed to address to the desired outcome(s) that are supposed to result from the provision of services by the program. Just as it would be
unreasonable to know the progress one is making when driving from Washington, DC to San Francisco without a road map to provide feedback along the way, so too is it unreasonable to know if a program is effective in accomplishing its mission without a mechanism for providing ongoing feedback.

Logic models can take on different forms depending on the needs of the organizations that utilize them. Yet, many share common features. The Harvard Family Research Project (2003) offers a summary of the key elements of a logic model. “On one sheet of paper, a logic model summarizes the key elements of your program, reveals the rationale behind your approach, articulates your intended outcomes and how they can be measured, and shows the cause-and-effect relationships between your program and its intended outcomes” (p. 1).

There are four uses and benefits of such a framework: (1) strategic and program planning, (2) effective communications, (3) evaluation planning, and (4) continuous learning and improvement (Harvard Family Research Project, 2003). First, strategic and program planning involves identifying the vision and rationale behind a program and a description of how the program will work. This also helps to increase stakeholder involvement and build consensus. Second, effective communications results from providing a snapshot of the program and intended outcomes to funders, program staff, and policymakers. Third, evaluation planning is possible as a basic framework for an evaluation is provided as outcomes are identified and stated in measurable terms. Fourth, continuous learning and improvement can result since the logic model becomes a point of reference to assess progress being made toward achieving desired outcomes on an ongoing basis (Harvard Family Research Project, 2003).

**OUTCOMES MEASUREMENT SYSTEM MODEL**

Building on the strengths of logic models developed by Martin and Kettner (1996), University of Wisconsin-Extension (2003), CYFERNet (2000), and the Harvard Family Research Project (2003), a nine-step model for an outcomes measurement system was developed by a social worker who directed the kinds of smaller substance abuse treatment programs that do not have the personnel or financial resources to develop or implement more sophisticated outcomes measurement systems. The social worker was also confronted with the need to address issues around
the “success rate” of the program without knowing quite how to respond. As social workers continue to take on responsibility for directing these kinds of substance abuse programs, they will need to be able to articulate the strengths and need for their programs, especially in times of fiscal constraint or in less than supportive political environments.

While the components of the nine-step model are not new, the model was uniquely constructed with an emphasis on the need for the model to be doable and useful for social workers who direct similar kinds of substance abuse programs. This approach is enhanced by the inclusion of a user-friendly hypothetical example of how the model can be implemented using the kind of information that directors of substance abuse treatment programs can easily access. This will hopefully simplify the process of implementing an outcomes measurement system for their programs.

An important strength that derives from the feasibility of the nine-step model is that it can help empower social workers who direct smaller substance abuse treatment programs by providing them with a source of information that can be presented to external sources such as funders, state substance abuse agencies, and community stakeholders or used to provide internal feedback to other program administrators, directors, and supervisors on trends that are occurring within the program and how these trends ultimately impact client outcomes. This is a vast improvement over being put on the spot by trying to cite the “success rate” of a program or feeling defensive when the justification for a program is challenged. An additional strength is the applicability of the nine-step model in that it has been designed for application to outpatient, inpatient, and residential substance abuse treatment programs.

For the purposes of illustration, a hypothetical six-month residential substance abuse treatment program for women is used. The outcomes measurement team was comprised of the director of the New Day Addiction Treatment Center for Women, the clinical supervisor, and one primary counselor. While the state substance abuse agency was interested about the possibility of New Day developing an outcomes measurement framework, the agency did not provide additional funds for this endeavor.

What follows is a model of the nine steps the outcomes measurement team took to construct its own logic model and outcomes measurement system. In accordance with the recommendations of the Harvard Family Research Project (2003), the New Day model is summarized as shown in Appendix.
Step 1: Program Analysis

The outcomes measurement team began by using the model provided by Martin and Kettner (1996) to analyze their program in terms of how the social problem is defined, the underlying assumptions, and how the program is constructed.

First, they noted that substance abuse has become an increasingly serious problem in their community and results in lost jobs, broken families, psychiatric problems, and homelessness. The withdrawal from alcohol and drugs can be serious and requires monitoring. Yet, being safely detoxed alone is not sufficient for recovery as the relapse rate is high for persons who do not receive treatment.

Second, the outcomes measurement team began to explicitly identify the underlying assumptions that provide the basis for how their program is configured. They noted that the prevailing treatment philosophy assumes that if an addicted person is removed from the current environment that is supporting the addiction and placed in a safe treatment environment, she will be able to focus on how addiction has impacted her life and begin to make changes in her life to remain sober. A second assumption is that women will be motivated to take advantage of what the treatment environment offers and make any necessary changes in their lifestyles. A third assumption is that addiction is relapse-prone in nature and that long-term recovery necessitates ongoing support after treatment is completed.

Third, the outcomes measurement team noted that the structure of their program grows out of the assumptions they identified. The provision of a safe environment that addresses the biopsychosocial aspects of addiction, learning about addiction, examining the personal impact of addiction, and developing ongoing recovery plans are the most important aspects of the program. Yet, during this analysis the program director noted that the prevailing treatment philosophy is primarily based on the needs of middle-class males and may not be appropriate for the lower functioning women the program treats.

Step 2: Specify Inputs

The outcomes measurement team then looked at the inputs or resources it has that can be used to respond to the social problem. They noted that important inputs include: (1) staff, (2) physical infrastructure, (3) community referral sources, (4) office equipment, and (5) volunteers. While the team originally thought identifying inputs was primar-
ily a function of seeing what they already had, the program director noted that the program was missing two inputs that could be of great help to the program. First, she saw how having a computer system would facilitate much of the work the program does and save the staff time. This time could then be spent working with clients. Second, the clinical supervisor mentioned that given how many clients currently have psychiatric disorders, another needed input was a consulting psychiatrist since the treatment staff has minimal experience in treating persons with psychiatric disorders.

**Step 3: Specify Output Performance Measures**

Outputs include anything the program produces. This includes activities, services, products, and events that are targeted toward the clients the program serves (University of Wisconsin-Extension, n.d.). The outcomes measurement team identified several pertinent outputs they could easily track including (1) the number of admission assessments conducted per month, (2) the number of individual counseling sessions provided per month, (3) the number of group therapy sessions facilitated per month, and (4) the number of recovery meetings held per month. Although the team knew that it could also specify whether these outputs were intermediate or final in nature, the team decided to use the general category of outputs for the sake of simplicity, especially as it gets the outcomes measurement framework up and running.

**Step 4: Specify Quality Output Measures**

The primary counselor on the outcomes measurement team mentioned that she read an excellent book in one of her classes at the local college on how Total Quality Management (TQM) has been used in human service organizations to improve the effectiveness of programs (Gunther & Hawkins, 1999). After consulting the list of possible quality dimensions provided by Martin and Kettner (1996), the team decided that competency, responsiveness, and reliability are the most important quality dimensions for their program. They decided to measure the following quality outputs: (1) Percentage of individual counseling sessions provided each month by staff members that have certification in addictions treatment (competency dimension), (2) percentage of group therapy sessions facilitated each month that begin within five minutes of the scheduled start time (responsiveness dimension), and (3) percent-
Step 5: Specify Outcome Performance Measures

The outcomes measurement team decided to initially focus on intermediate outcomes since it is relatively simple to assess client functioning in a number of areas at the completion of treatment rather than at a later point after discharge. While the team would like to be able to track long-term outcomes, it knows that it does not have the necessary resources to do this at this time. The team decided to measure three outcomes: (1) abstinence from alcohol and illicit drugs, (2) satisfaction with learning necessary recovery skills, and (3) quality of life improvement in the areas of health, family relationships, and emotional support. The indicators of these outcomes are: (1) percentage of clients who are abstinent from alcohol and illicit drugs by completion of the six-month treatment program as measured by self-reports, (2) percentage of clients who report being satisfied with how their treatment experience helped them to learn important recovery skills as measured by a state-mandated satisfaction survey, and (3) percentage of clients who report an increase in various quality of life dimensions from the beginning to completion of treatment as measured by the Quality of Life Index Generic Version III (University of Illinois at Chicago, n.d.).

However, the social worker who directs the program mentioned the downside of using client satisfaction as a proxy for treatment outcomes based on an article she read by Outcomes Accountability Alert (1999). The paper described a study at four alcohol and drug abuse outpatient treatment programs that found that “levels of satisfaction were not well-related either to participation measures or to performance measures” (p. 1). Given that the state requires the use of an existing client satisfaction survey as part of its management information system, the team decided to use this survey, but for purposes of their outcomes measurement system, to differentiate satisfaction with aspects of service delivery (an output) from satisfaction with learning recovery skills (an outcome).

Step 6: Assess External Factors

Substance abuse treatment programs do not operate in isolation. Instead, programs operate in an environment that contains numerous external factors that interact with and influence the program. The out-
comes measurement team noted that a primary external factor that impacts New Day is the lack of resources that women can be referred to after completion of treatment in order to address their psychosocial needs. These needs include transitional housing programs, vocational training programs, and psychiatric services for women with mood, anxiety, and dissociative disorders. Another factor is the lack of political support for women-centered treatment programs by council members who think women should exercise better moral judgment toward their alcohol and drug use. The team also noted that state budget cutbacks have led to a reduction in the already meager array of community services available to their clients. In addition, there has been talk of reducing the funding of their program because it is considered a luxury that benefits only a relatively small number of persons. This sobering look at how these external factors affect their program was an eye-opening experience for the team members as they never stopped to look at how the political and social environments affect their program and the ultimate well-being of the clients.

**Step 7: Develop a Management Information System**

While management information systems are typically computer-based, given the program has minimal computer resources, the decision was made to initially collect information using paper-and-pencil forms. Because the outcomes measurement team decided to start off with just a few indicators, they realized that they could track the information they need using a notebook divided into sections for outputs and outcomes. While the team would prefer to have a computer system to keep track of this information, the team thought it could use existing resources without an undue strain.

**Step 8: Assign Responsibilities**

Once the initial management information system had been created, the program director mentioned that it was essential that responsibilities be assigned for collecting, recording, analyzing, and reporting the data. The clinical supervisor was given the primary responsibility to make sure the three counselors provide the information assigned to them in a timely manner. Each month this information is to be given to the program director that would use it as a source of feedback on program performance during treatment meetings. This will be done to help the entire staff stay involved in the outcomes measurement process and to facili-
tate team building. The program director also would have the responsibility for compiling quarterly reports on program performance and present this information to important stakeholders.

**Step 9: Implement the Outcomes Measurement System**

Once the outcomes measurement team decided on the basic elements of the outcomes measurement system, and how the information will be tracked and stored, the next step was to decide when to formally begin implementation of the system. This was an important step in the process given that premature implementation could sabotage the system while needless implementation delays might prevent the system from ever being utilized. Conducting a pilot test of the system can provide useful feedback on whether the system works as planned and whether staff members remain on task, especially when clinical demands can pull them away from their responsibilities in managing the outcomes measurement system. After any needed changes are made, the system can then be fully implemented. Regular meetings of the outcomes measurement team can help monitor the system, identify any changes needed, and begin to utilize the feedback on trends the system provides in order to assess program performance and treatment effectiveness.

The team members looked at the outcomes measurement system they developed with pride and a sense of accomplishment, as they never would have believed they could have created such a system. They realized that the one page logic model they developed was the key to the system. While the team knew this was only a start, there was a feeling of optimism that this new addition to New Day will not only provide needed information on program performance, but also stimulate innovative ways to improve the treatment outcomes of the women the program serves.

**DISCUSSION**

Substance abuse treatment programs will increasingly be required to provide outcomes data to state agencies and other funding sources, yet smaller programs may not have the personnel, expertise, and fiscal resources necessary to implement a comprehensive outcomes measurement system. Fortunately, limitations in resources no longer have to be a major hindrance to implementing an outcomes measurement system for these programs. The logic model, a road map for showing progress being made in reaching desired outcomes, is the key to developing an
outcomes measurement system. The nine-step model for implementing an outcomes measurement system utilizing existing resources can help to level the playing field by allowing social workers who administer small programs to develop their own systems.

While much of the literature on outcomes measurement discusses its role in providing information to stakeholders such as funders, one important consideration is for social workers not to lose sight of the critical role that outcomes measurement systems also play in providing internal feedback on how well their delivery of services is achieving desired outcomes. Whether the use of an outcomes measurement system is mandated or not, social workers who administer small substance abuse treatment programs have an ethical responsibility to use information from the system to improve the provision of treatment and improve client outcomes. The NASW Code of Ethics (Barker, 1999; National Association of Social Workers, 1999) calls upon social workers to help people in need, address social problems, increase their competency, and contribute to the social work knowledge base. Information from an outcomes measurement system can be used to help meet these ethical responsibilities.

Despite the benefits that an outcomes measurement system can provide, limitations in these systems need to be taken into consideration. The nine-step model was developed with these limitations in mind. First, implementing an outcomes measurement system does require an investment in potentially scarce personnel and time resources initially and over time. This may be a difficult investment to make given that staff members of smaller programs may already be stretched to the limit trying to meet day-to-day clinical responsibilities. The nine-step model was designed to be implemented on a very simple and basic level if desired to minimize these constraints. Second, resistance to implementing and maintaining a system can arise from ethical considerations, psychological factors, and organizational and operational factors (Lyons, Howard, O’Mahoney, & Lish, 1997). Administrators must be aware of sources of resistance and develop strategies for overcoming them. One important area this resistance can manifest is in investing the necessary energy to maintain the system once the initial excitement of creating it wears off. The nine-step model addresses this limitation by emphasizing the role of a team, under the direction and support of the program director, in implementing and experiencing the benefits of the system. Third, the most comprehensive outcomes measurement system is only as good as the data entered into it. Judgments made about the effectiveness of a program in achieving desired outcomes can be biased if there
are problems with the reliability or validity of data. Missing or inaccurate data for even a few clients can seriously distort the picture of how a program that has a small number of clients is functioning. In order to address this limitation, the nine-step model emphasizes starting small and pilot testing the outcomes measurement system in order to ensure that required data is accurately being collected and reported. If not, modifications in the system can be made including simplifying the system.

Social workers who administer substance abuse treatment programs with limited resources now have a new tool they can use to track treatment outcomes. Implementing an outcomes measurement system using the nine-step model can help administrators, directors, and supervisors keep their fingers on the pulse of their programs, not only to provide important feedback to stakeholders on progress being made in achieving desired outcomes, but to assess trends in the delivery of substance abuse treatment services and provide critical information on ways to help improve treatment outcomes for such a challenging population.

After implementing an outcomes measurement system for her substance abuse treatment program using the nine-step model, Mary Landers felt much more prepared and confident in her ability to address questions from Councilman Jones about the “success” rate of her program. Mary was now able to reframe what “success” meant by focusing more on the outputs her program provided such as the number of admission assessments conducted and number of group therapy sessions conducted, how they related to quality standards such as percent of treatment groups given that followed a best-practices manual, and how they linked to outcomes such as percent of clients who remained abstinent from alcohol and drugs and percent of clients who become employed upon treatment completion. She was also able to provide the Councilman a context for understanding this information by noting the difficulties that many social services programs, not only substance abuse programs, have in tracking long-term outcomes for social problems that are affected by many factors that programs are not designed to address. Mary was able to help him to see the impact of external factors in their community such as having no transitional housing resources on long-term treatment outcomes. Now, instead of being at a loss at how to respond, Mary felt empowered about her ability to advocate for her program and the clients it serves—and the Councilman had a greater understanding of the importance of substance abuse treatment in his community.
REFERENCES


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**APPENDIX**

**Logical Model for New Day Addiction Treatment Center**

**Program Analysis**

*Definition of Social Problem:* Substance abuse is a treatable disease that seriously damages biopsychosocial functioning.

*Underlying Assumptions:* Addressing the biopsychosocial aspects of addiction in a safe and supportive environment can help women begin the recovery process. Ongoing support is needed to assist long-term sobriety.

*Human Service Program:* New Day is designed to address the biopsychosocial aspects of addiction and provide women a safe and supportive environment where they can learn about addiction, see how it has impacted their lives, develop recovery skills, and create ongoing support to achieve sobriety.

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<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Quality Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Staff</td>
<td># admission assessment conducted*</td>
<td>% counseling sessions provided by counselor with addiction cert.*</td>
<td>% clients abstinent from alcohol and drugs at completion of six-month treatment*</td>
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<tr>
<td>– Physical infrastructure</td>
<td># group therapy sessions facilitated*</td>
<td>% group therapy sessions held that begin on time*</td>
<td>% clients report increase in quality of life indicators*</td>
</tr>
<tr>
<td>– Community referral sources</td>
<td># individual counseling sessions provided*</td>
<td>% relapse prevention groups given that follow format of manual*</td>
<td>% clients report satisfaction with learning recovery skills*</td>
</tr>
<tr>
<td>– Office equipment</td>
<td># Recovery meetings held*</td>
<td>(*per month)</td>
<td>(*per month)</td>
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<tr>
<td>– Volunteers</td>
<td>(*per month)</td>
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<tr>
<th>External Factors</th>
<th>Outcomes</th>
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<tr>
<td>– Less than supportive political environment</td>
<td>% clients abstinent from alcohol and drugs at completion of six-month treatment*</td>
</tr>
<tr>
<td>– Minimal services for transitional housing, vocational training</td>
<td>% clients report increase in quality of life indicators*</td>
</tr>
<tr>
<td>– Possible budget cutbacks</td>
<td>% clients report satisfaction with learning recovery skills*</td>
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