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DRUG ABUSE TREATMENT: A REVIEW OF CURRENT FEDERAL PROGRAMS AND POLICIES

155045

DRUGS & CRIME CLEARINGHOUSE

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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HEARING ON DRUG ABUSE TREATMENT: A REVIEW OF CURRENT FEDERAL PROGRAMS AND POLICIES

THURSDAY, OCTOBER 17, 1991

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The select committee met, pursuant to call, at 1:30 p.m., in room 2203, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the committee) presiding.

Members present: Lawrence Coughlin, Robert K. Dornan, Howard Coble, Benjamin A. Gilman, George J. Hochbrueckner, James H. Scheuer, James M. Inhofe, Jim Ramstad, Ed Towns, and Donald M. Payne.

Staff present: Edward Jurith, staff director; Peter Coniglio, minority staff director; James Alexander, press secretary; George Gilbert, staff counsel; David Goodfriend, staff assistant; Marianne Koepf, staff assistant; Christina Stavros, administrative assistant; and Mary Frances Valentino, minority staff assistant.

OPENING STATEMENT OF HON. CHARLES B. RANGEL, CHAIRMAN

Mr. RANGEL. Today, the select committee is conducting this hearing on drug abuse treatment. I think it's become abundantly clear that if we're going to win the battle against drugs, the area that we have to concentrate in most will be demand reduction.

The question is whether or not the Federal investment in anti-drug programs is being used effectively to reduce the tremendous costs of drugs to our society. I recently had a meeting with a well-known White House official who shared with me the results of his preliminary evaluation of the social costs of drug abuse.

The White House specialist conservatively estimated that drugs are costing the United States of America over a quarter of a trillion dollars a year in Federal, State, and local government expenditures for drug-related health, welfare, criminal justice, and other programs and in lost productivity and lost revenue.

So, therefore, while we have to do all we can to reduce the supply and distribution of drugs and enforce the laws vigorously against drug traffickers who would abuse our society, we have to really find out what drug abuse treatment is effective. Because we find more and more Federal dollars being spent and much more local and State dollars being spent for treatment, I asked the General Accounting Office to review the Alcohol, Drug Abuse and Mental Health Services block grant, which is the primary vehicle

the Federal Government uses to support drug abuse treatment, and to find out exactly how effective the programs are that Federal dollars fund.

The GAO is the investigative arm of the United States Congress and does an outstanding job with the many tasks and burdens that we continuously place upon them. GAO conducted this study and unfortunately their findings are not very encouraging, because it appears that despite the remarkable increase in Federal spending on drug treatment, there is very little information available on the results of this Federal investment. GAO's report notes that the Office for Treatment Improvement, which administers the block grant, is taking very important steps to help the States assess their needs and improve the delivery of effective treatment service.

But the GAO concludes that efforts to increase accountability for block grant funds will be difficult to achieve because the Secretary of Health and Human Services has not exercised the authority granted by the Congress to establish reporting requirements for the States that will provide the information needed to determine if block grants are being used for effective programs and services.

The need for effective drug abuse treatment has never been greater. This is especially so when we see the dramatic impact of the AIDS epidemic. It's good to see that Beny Primm is here because he was the Paul Revere for the United States to tell us the epidemic was coming, and people in his home town, as well as Washington, had no idea as to how true his predictions were.

In the interest of time, I will ask unanimous consent that the remainder of my opening statement be included in the record, and then I'll yield to Mr. Coughlin, the ranking minority member of the committee, for any statement he would like to make.

OPENING STATEMENT OF HON. LAWRENCE COUGHLIN

Mr. COUGHLIN. Thank you very much, Mr. Chairman. I do want to thank every one of our witnesses for taking the time today to testify before our committee. I do think it's appropriate that the Committee hold a hearing focusing specifically on drug treatment programs and policies and perhaps it's time that we do give some credit where credit is due. Under President Bush, drug treatment spending for the Department of Health and Human Services, which includes the Office for Substance Abuse Prevention, the Office for Treatment Improvement and the National Institute of Drug Abuse, has been increased very significantly. As you know, President Bush has overseen drug prevention spending increases of approximately $345 million since 1989. Treatment spending increased by roughly $309.2 million, for a total increase of $654.5 million for drug treatment and prevention spending.

The administration's funding requests haven't leveled off either. For fiscal year 1992, the President has requested treatment and prevention funding at $1.47 billion, which is a $107.3 million increase over fiscal year 1991 estimates. More money does not always guarantee success. As you all know, you must have a plan of action. The administration's plan of action is the national drug control strategy as mandated by the Omnibus Drug Bill of 1988. It was first formulated in 1989 and it's been updated annually since then.

It's the Federal Government's comprehensive and coordinated battle plan to combat illicit drug use and trafficking in this country.

So, we do have a battle plan. It may not be like the one we had in the Persian Gulf, but it's important to remember that we're fighting a different kind of war. Our aim is not to destroy our cities, like it was to destroy the Iraqi Army occupying Kuwait, but our objective is to restore and rebuild our cities. Naturally, a Persian Gulf type strategy would be the wrong one for our fight against drugs.

From the very beginning, the national drug control strategy has included a major initiative to expand drug treatment and improve drug treatment services. This initiative is embodied in H.R. 2810, the Drug Treatment and Prevention Act of 1991, which I introduced earlier this year with the distinguished House Republican leader, and which is cosponsored by the distinguished chairman of the select committee. Unfortunately, the committees to which the bill has been referred have not yet acted upon it.

The bill provides for accountability in the way Federal funds are spent by requiring States to develop statewide treatment and prevention plans as a condition of receiving the drug portion of the Federal Alcohol, Drug Abuse and Mental Health Administration block grant funding. In addition, it prevents States receiving ADAMHA grants from reducing their own expenditures for drug-related activities. Unfortunately, action has not been taken on these so far.

What we are trying to achieve with this bill is accountability in our treatment system to ensure that the Federal dollars in our States we are spending for treatment and prevention are being spent efficiently and wisely. The GAO report requested by the chairman supports this position.

H.R. 2810 also establishes a new competitive grant program with the authorization of $99 million for fiscal year 1991 that will expand our present ability to treat drug addicts who seek to end their substance abuse. The capacity expansion program will increase the number of treatment slots especially in areas of the country where there is a shortage of such capacity.

As I stated earlier, money does not always mean success, but all you have to do today is to look at the major drug indicators such as the high school survey and the household survey to see that the President's national drug control strategy has netted some positive results. Granted, there is still an unacceptable number of our fellow Americans who are substance abusers, but the objective evidence indicates that significant progress has indeed been made. We are having success in reducing the demand for drugs in this country.

The President's proposed drug budgets have consistently called for spending increases in treatment and prevention for every fiscal year since 1989. I support the Federal Government's strong role in drug treatment, but like all of you, I want more and so does the President. For instance, I know the administration would like to see, and so would I, the passage of legislation that would require States to be held accountable for their treatment and spending of Federal treatment funds as provided in H.R. 2810.

Again, I want to thank our witnesses for coming today to testify. I look forward to hearing your views and ideas on drug treatment.

Mr. RANGEL. Larry, you sound like you just came out of a White House pep talk.

Mr. COUGHLIN. The White House is always full of pep, Mr. Chairman.

Mr. RANGEL. You're ready to go here.

Well, anyway, that's some pretty exciting news and I'm glad to hear that we're winning.

We'll hear now from the witness from GAO.

TESTIMONY OF MARK V. NAGEL, ASSOCIATE DIRECTOR, NATIONAL AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. NADEL. Mr. Chairman and members of the committee, I'm pleased to be here to discuss our report that is being issued today on oversight of the drug abuse treatment services supported by the ADMS block grant. I will further summarize my statement in the interest of time.

Mr. RANGEL. Your full statement, by unanimous consent, will be entered into the record.

Mr. NADEL. Thank you.

At issue is whether States are spending these block grant funds on drug abuse treatment programs that work and whether the Congress receives the information it needs to assess the impact of the Federal investment in treatment services. I think it would be useful, therefore, to set some context by providing a little background on several changes to the ADMS block grant legislation and its implementation.

Since 1981, the States have been required to provide HHS with information on their ADMS block grant activities. The Anti-Drug Abuse Act of 1988 contained a new requirement that the States must agree to provide for periodic independent peer review to assess the quality and appropriateness of treatment services provided by entities that receive funds from the State. Now, the act did not, however, define the terms "peer review," "quality," or "appropriateness" or specify the processes to be used to implement that requirement. In addition, the act removed language that previously prohibited HHS from prescribing the manner in which States should comply with the act's requirements and establishing burdensome annual reporting requirements. In summary, the block grant requirements have been gradually tightened in the direction of more mandatory reporting and giving the Secretary greater discretion.

HHS, through its Alcohol, Drug Abuse and Mental Health Administration, has provided minimal oversight of ADMS block grant funds which reflects the Department's interpretation of the 1981 block grant legislation. This interpretation is expressed in a regulation which states that the agency will defer to a State's interpretation of its assurances and of the provisions of the block grant statutes unless the interpretation is clearly erroneous.

Now, the overall effect of the HHS policy has been to give the States wide discretion in implementing the legislative require-

ments related to the grant. This means that whatever a State does in response to these legislative requirements is likely to be viewed as in compliance unless HHS finds a State's interpretation clearly erroneous. To date, HHS has rarely issued an official determination that a State's interpretation was clearly erroneous.

To examine how the States have implemented the 1988 legislative peer review requirement, we visited 10 States: California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania and Texas, and these States collectively, received about 60 percent of the ADMS block grant funds appropriated for 1990. We also reviewed fiscal year 1989 annual reports on all States' ADMS block grant activities.

In our review of State activities implementing the peer review requirement, we found that the 10 States we examined use licensing and certification processes that do not fully address the quality and appropriateness of treatment services. These processes were in place before the peer review requirement was established. The monitoring that occurs as part of these processes involves checking that providers have policies for personnel management, physical plant and other administrative issues. States are implementing these processes in different ways in terms of the organizations that conduct the reviews and how the results are used. We also found that most States do not have formal definitions of quality and appropriateness. Most of the State officials we interviewed interpreted quality as a drug treatment's compliance with State standards and regulations. In terms of appropriateness, 9 State officials told us that an appropriate drug treatment program is one that suits or fits the needs of clients. But there are no other sorts of criteria.

I'd like to turn now to some of the information that's provided HHS in applications for the block grant and in annual reports. Under HHS' voluntary compliance policy, the Secretary has not exercised his authority to specify how States should comply with legislative block grant requirements nor how they should report on their block grant activities. As a result, States provide HHS with limited and diverse information on their ADMS block grant annual reports and applications. The annual reports vary significantly on the information provided on drug treatment services which makes comparisons or assessments very difficult.

For the 1989 annual reports from the States, ADAMHA asks the States to describe their peer review procedures. But we found that these reports presented vague and incomplete information about how the States were complying with the requirement. We also found that information is limited, not only on the implementation of the peer review requirement but also on the intended use of ADMS block grant funds generally. In States' block grant applications, ADAMHA requires that States provide general descriptions of the intended use of funds for drug treatment and submit various administrative assurances and certifications. ADAMHA asked the States in their fiscal year 1991 applications to voluntarily provide additional information in a uniform format.

For example, States were asked to provide information on populations, areas and localities with the greatest need for drug abuse services and information on the State's capability to provide treatment. In other words, their capacity. Of the 26 States that have

voluntarily provided information in a uniformed format, only 10 provided all the requested information and 16 provided incomplete information. The remaining States opted to submit the old application that did not request additional information.

Recently, ADAMHA's newly created Office of Treatment Improvement has taken steps to hold the States more accountable. In mid-1990, OTI began to develop its State systems development program. This program is intended to provide assurance that services supported by the ADMS funds are used to provide drug treatment that is effective in reducing drug abuse. Specifically, the OTI initiative is expected to develop and provide States with treatment improvement protocols, to identify weaknesses in drug treatment services through technical performance reviews, and to improve performance by offering technical assistance to the States and to the programs. Third, to provide additional uniform information to HHS and Federal policymakers on the delivery of drug treatment services, and to assist States in conducting needs assessments.

OTI's program is intended not only to improve drug treatment services, but also to have the effect of increasing State accountability for ADMS funds by improving the quality of information provided by the States. However, as mentioned earlier, HHS' voluntary compliance policy generally defers to a State's interpretation of the block grant requirements and does not require States to report uniform information on their planned and actual use of block grant funds.

With the development of treatment standards and a framework for their use in drug treatment programs and services, OTI's program represents an important step toward treatment improvement. While we believe that the SSDP has promise for improving the quality and effectiveness of drug treatment services, as well as providing better information on services, States will not be required under the current HHS policy to undertake all or any of the elements of the OTI Program. Our recent work suggests that relying on voluntary compliance on the part of the States may limit the program's effectiveness.

In conclusion, the Federal Government does not have the information necessary to assess the impact of its investment in drug abuse treatment services. Moreover, OTI's program to obtain better information from the States and to improve treatment programs may not be fully effective because of HHS' policy to make implementation of the program voluntary for the States. We believe that HHS needs to closely monitor the progress of the OTI program and to keep Congress informed of it. Specifically, we are recommending that the Secretary of Health and Human Services first establish reporting requirements for the States that will provide HHS with information to determine whether States are providing effective drug treatment programs, and second, to report to the Congress by 1995 on the progress of OTI's State systems development program.

That concludes my statement, Mr. Chairman.

Mr. RANGEL. Thank you.

[The statement of Mark V. Nadel follows:]

United States General Accounting Office

GAO Testimony

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ADMS BLOCK GRANT: Drug Treatment Services Could Be Improved by New Accountability Program

Statement of Mark V. Nadel
Associate Director for National
and Public Health Issues

Before the
Select Committee on Narcotics
Abuse and Control
House of Representatives

SUMMARY

The Congress receives limited information on the results of states' drug abuse treatment services funded by the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant. In examining how states implemented a 1988 ADMS requirement to obtain peer reviews of their drug treatment services, GAO reviewed 10 states' ADMS-related documents and interviewed federal and state officials involved in administering ADMS funds. The states selected received about 60 percent of the ADMS funds appropriated for fiscal year 1990.

State annual reports and block grant applications provide limited information on the nature of state drug abuse treatment activities or on the quality and appropriateness of services. The Department of Health and Human Services (HHS), through the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), oversees the state administration of drug treatment funds. HHS provides minimal oversight of state activities because of a departmental policy that it will defer to states' interpretation of block grant statutes unless it finds the interpretation to be clearly erroneous.

To enhance states' use of the ADMS Block Grant, ADAMHA created the Office for Treatment Improvement (OTI) in 1990. OTI has developed a program that could help assure that drug treatment services supported by ADMS funds are effective in reducing drug abuse. The program is designed to provide technical assistance, monitoring, and collect data.

OTI's program is intended to improve services and increase state accountability for ADMS funds. Consistent with HHS's policy to grant states wide administrative discretion, however, implementation of OTI's program will be left to the states. If states choose not to implement OTI program improvements and monitoring activities, the full potential of the OTI program may not be realized.

GAO recommends that HHS establish reporting requirements that will provide HHS with information to determine whether states are providing drug treatment programs and services that are effective. GAO also recommends that HHS report to the Congress by 1995 on the progress of OTI's program.

Mr. Chairman and Members of the Committee:

I am pleased to be here to summarize our report that is being issued today on the Department of Health and Human Services's (HHS) oversight of drug abuse treatment services supported by the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant.[1] At issue is whether states are spending these block grant funds on drug abuse treatment programs that work and whether the Congress receives the information it needs to assess the impact of the federal investment in drug abuse treatment services. I think it will be useful, therefore, to first provide some background on several changes to the ADMS Block Grant legislation that occurred in 1988, HHS's block grant policy, and a new federal accountability program designed to improve and monitor the delivery of drug treatment services and obtain better information on what states will do and have done with ADMS Block Grant funds[2]. Then, I will discuss our methodology, findings, and recommendations.

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[1]ADMS Block Grant: Drug Treatment Services Could Be Improved by New Accountability Program, GAO/HRD-92-27.

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

BACKGROUND

Since 1981, states have been required to provide the Secretary of HHS with information on their ADMS Block Grant activities. The Anti-Drug Abuse Act of 1988 contained a new requirement that states must agree to provide for

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

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

In addition, the act removed language that previously prohibited HHS from (1) prescribing the manner in which states should comply with the act's requirements and (2) establishing burdensome annual reporting requirements.

HHS OVERSIGHT

HHS, through its Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) has provided minimal oversight of ADMS Block Grant funds. This minimal oversight reflects the Department's interpretation of the 1981 block grant legislation.

This interpretation is expressed in regulation 45 C.F.R. 96.50(e) which states that the agency will

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

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

In early 1990, ADAMHA created the Office for Treatment Improvement (OTI) to help states improve the services supported by ADMS Block Grant funds and better manage these funds. OTI is developing a program to enhance state and federal accountability for the use and oversight of drug treatment funds.

SCOPE AND METHODOLOGY

To examine how states have implemented the 1988 legislative peer review requirement we selected 10 states--California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania and Texas--that received about 60 percent of the ADMS Block Grant funds appropriated for fiscal year 1990. We also reviewed fiscal year 1989 annual reports on states' ADMS Block Grant activities and used a structured instrument to conduct telephone interviews in January 1991 with state substance abuse officials. To examine HHS's plans for enhancing state accountability for federally supported drug treatment services, we interviewed HHS and OTI officials and reviewed numerous documents.

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

STATE REVIEW ACTIVITIES LIMITED
IN ASSESSING QUALITY AND APPROPRIATENESS

In our review of state activities implementing the peer review requirement, we found that the 10 states we examined use licensing and certification processes that do not fully address the quality and appropriateness of drug treatment services. These processes were in place before the peer review requirement

was established. The monitoring that occurs as part of these processes involves checking that providers have policies for personnel management, physical plant, and other administrative issues. States are implementing these processes in different ways in terms of the organizations conducting the reviews and how results are used. We also found that most states do not have formal definitions of quality and appropriateness. Most of the state officials we interviewed interpreted quality as a drug treatment program's compliance with state standards and regulations. Some state officials did not define quality because either the state did not have an official definition or the state did not make such judgments. In terms of appropriateness, nine state officials told us that an appropriate drug treatment program is one that suits or fits the needs of clients.

STATE REPORTS AND APPLICATIONS CONTAIN LIMITED INFORMATION

Under HHS's voluntary compliance policy, the Secretary has not exercised his authority to specify how states should comply with legislative block grant requirements nor how they should report on their block grant activities. As a result, states provide HHS with limited and diverse information in their ADMS Block Grant annual reports and applications. State annual reports vary significantly in the information provided on drug

treatment services, making comparisons or assessments of federally supported drug treatment services difficult.

For the fiscal year 1989 annual reports from the states, ADAMHA asked states to describe their peer review procedures, including a definition of peer review; the individuals responsible for conducting reviews; and the frequency of such reviews. In analyzing state reports to ADAMHA and information from the 10 states we reviewed, we found that these reports presented vague and incomplete information about how states were complying with the peer review requirement.

We found that information is limited not only on the implementation of the peer review requirement but also on the intended use of ADMS Block Grant funds for drug treatment services. In states' ADMS Block Grant applications, ADAMHA requires that states provide general descriptions of the intended use of funds for drug treatment and submit various administrative assurances and certifications. ADAMHA asked states in their fiscal year 1991 application to voluntarily provide additional information in a uniform format. For example, states were asked to provided information on the populations, areas, and localities with the greatest need for drug abuse services and information on the states' capability to provide treatment; that is, the states' treatment capacity. Of 26 states that voluntarily provided information in a uniform format, only 10 provided all the

requested information and 16 provided incomplete information. The remaining states opted to submit the old application that did not request additional information.

OTI'S PROGRAM AIMS TO HOLD STATES MORE ACCOUNTABLE

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

-- develop and provide states with treatment improvement protocols (TIPs), which are to be used as drug treatment program guidelines[3];

-- identify weaknesses in drug treatment services through technical performance reviews of state drug treatment activities and to then improve performance by offering technical assistance;

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[3]In addition, federal drug treatment program guidelines could assist states in implementing the requirement to perform peer review by providing criteria for assessing the quality and appropriateness of services.

-- provide additional uniform information to HHS and federal policymakers on the delivery of drug treatment services through ADMS Block Grant applications and annual reports; and

-- assist states in conducting needs assessments in order to obtain data on the incidence and prevalence of substance abuse.

HHS POLICY MAY LIMIT OTI PROGRAM

OTI's program is intended not only to improve drug treatment services but also to have the effect of increasing state accountability for ADMS funds by improving the quality of information provided by the states. However, as mentioned earlier, HHS's voluntary compliance policy generally defers to a state's interpretation of ADMS Block Grant requirements and does not require states to report uniform information on their planned and actual use of block grant funds.

With the development of treatment standards and a framework for their use in drug treatment programs and services, OTI's State Systems Development Program (SSDP) represents an important step towards treatment improvement. While we believe the SSDP has promise for improving the quality and effectiveness of drug treatment services as well as providing better information on

drug treatment services, states will not be required under the current HHS policy to undertake all or any of the elements of the OTI program. Our recent work suggests that relying on voluntary compliance on the part of the states may limit the program's effectiveness.

CONCLUSIONS AND RECOMMENDATIONS

The federal government does not have the information necessary to assess the impact of its investment in drug abuse treatment services. Moreover, OTI's program to obtain better information from the states and to improve treatment programs may not be fully effective because of HHS's policy to make implementation of the program voluntary for the states. We believe that HHS needs to closely monitor the progress of the OTI program and keep the Congress informed of it. Specifically, we are recommending that the Secretary of Health and Human Services:

-- establish reporting requirements for the states that will provide HHS with information to determine whether states are providing drug treatment programs and services that are effective, and

-- report to the Congress by 1995 on the progress of OTI's State Systems Development Program. The report should

include information on states' implementation of OTI's treatment improvement protocols, state participation in federal technical performance reviews and the weaknesses identified, states' implementation of OTI Developmental Action Plans, and if applicable, the reasons for states not participating in the OTI program.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

Mr. RANGEL. We'll now hear from Dr. June Osborn, who is the Chair of the National Commission on Acquired Immune Deficiency Syndrome and dean of the School of Public Health, University of Michigan.

TESTIMONY OF DR. JUNE E. OSBORN, CHAIRMAN, NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME AND DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN, ACCOMPANIED BY DON C. DES JARLAIS, PH.D., COMMISSIONER, NATIONAL COMMISSION ON AIDS AND DIRECTOR OF RESEARCH, CHEMICAL DEPENDENCY INSTITUTE, BETH ISRAEL MEDICAL CENTER

Dr. OSBORN. Good afternoon, Mr. Chairman and Members of the Select Committee. Thank you for giving me the opportunity to speak and I'm pleased to have joining with me today Dr. Don Des Jarlais, director of research for the Chemical Dependency Institute of the Beth Israel Medical Center and a fellow member of the Commission on whom I rely very heavily for his deep expertise in the areas that we're discussing.

Mr. RANGEL. We welcome Dr. Des Jarlais.

Dr. OSBORN. In its recent report, which we entitled "The Twin Epidemics of HIV and Substance Use," the Commission made five recommendations. The first, and I think most important, of these is related to drug treatment and an issue I know is of special concern to you. The recommendation states that we must expand drug treatment so that all who apply for it can be accepted into treatment programs. The recommendation also cites the importance of continually working to improve the quality and effectiveness of that treatment. It is difficult to overstate the importance of this recommendation in combating the transmission of HIV related to substance use, for the sharing of injection equipment is a very efficient mode of transmission relative to others. HIV, once introduced into a drug-injecting population, can result in rapid transmission with half or more of the population of drug users infected over a period of years and from there it has proved to be inexorable in disseminating to steady sexual partners, to noninjecting drug users trading sex for drugs and onward from there.

That's been the story, as you know, in New York and New Jersey, in Edinburgh and recently and rather dramatically in Bangkok where IV drug users flared from less than 1 percent infected at the beginning of 1988 to nearly 50 percent of the estimated 80,000 injecting drug users infected just 18 months later. From there, it has raced across the Thai countryside to the sex industry and rapidly across borders in ever-expanding circles.

Here at home, the effects of HIV related to substance use of all kinds are felt in ever-increasing numbers in communities of color, among women and in infants and children. I won't tire you with a long list of statistics, but it is shocking to note that over 70 percent of AIDS cases in women are directly or indirectly linked to IV drug use and that 70 percent of children with AIDS whose mothers have or are at risk for HIV infection are related to maternal exposure through IV drug use or sex with an IV drug user. African-Ameri-

cans account for 45 percent of AIDS cases related to IV drug use. Hispanics account for 26 percent.

These twin epidemics of HIV and substance use are a public health threat of massive proportions. Drug treatment is an essential component of the public health response to these epidemics. Treatment is the best way to permanently break the link between HIV and drugs and immediately accessible treatment is, of course, not a new idea. We are very much beholden and related to a recommendation made strongly by our predecessor commission in 1988. Although it is not a new idea, it is a crucial one. By giving individuals immediate access to treatment, we can help them to change permanently behavior which threatens their health and the health of their sexual partners and children.

As highlighted in our report, substance use enhances the spread of HIV not only through the sharing of injection equipment, but also through the practice of unsafe sex related to crack, alcohol and other substances. This particular link was dramatically illustrated to the Commission when we visited South Georgia and saw very much the synergy of crack and HIV and syphilis, an awesome engine that was driving future trouble.

Many have said that since treatment isn't completely effective, the development of new, more effective treatment methods should take precedence over expansion of treatment slots which use current methods. Improving quality and effectiveness is essential. As was noted earlier, the Commission recommends that work on the improvement of the quality and effectiveness of treatment be ongoing. But improving quality should not be used as an excuse for not expanding treatment programs which use current methods. They may be imperfect, but they do get results and those results are crucial to saving lives. As my colleague and the Commission's Vice Chairman David Rogers said:

> We don't use the excuse in the context of heart failure or cancer that we don't know how to treat you perfectly. We must take the same committed approach to people who are caught up in the substance abuse epidemic.

While evidence is mixed, it is also important to note that some studies have shown a positive correlation between retention in drug treatment programs and a reduction in AIDS-related mortality and disease progression. Thus, drug treatment not only helps to reduce the transmission of HIV, it may also help the health of those living with the virus.

Expanding treatment so that all who apply can be accepted into programs is an intelligent, humane, cost-effective and appropriate public health response to the twin epidemics. Sadly, despite the overwhelming need for immediately accessible treatment, the Federal Government has yet to make the funding and policy commitments necessary to achieve it. Instead, the Office of National Drug Control Policy continues to focus on interdiction, neglecting the substantial gains which could be made against HIV related to substance use if a real commitment and acknowledgement of the issue were made. That office, the Office of National Drug Control Policy, has stated that Congress has yet to fully fund the President's request for treatment under its budget. This is true and it's a problem which must be remedied. Nevertheless, that lopsided budget

which emphasizes enforcement over treatment, should be reassessed in response to the desperate need to fulfill the goal of readily accessible treatment. Those who seek drug treatment should not be turned away to face a future of disease and death while they "wait their turn."

The Commission's second recommendation is to remove the legal barriers to the purchase and possession of injection equipment. As mentioned earlier, treatment is the best way to reduce transmission through IV drug use, but given the huge numbers of individuals on waiting lists for drug treatment in this country—the National Institute on Drug Abuse's preliminary estimates in July place that number at around 107,000—something must be done now to safeguard the health of injection drug users in the rest of the population.

For those who are on waiting lists for treatment, in relapse or not ready or able to stop injecting drugs, the provision of clean injection equipment can break the link between injection drugs and HIV. The legal barriers to the purchase and possession of injection equipment have not been shown to reduce illicit drug use. Instead, these barriers serve to limit the availability of new clean injection equipment and encourage the sharing of injection equipment which results in an increase in HIV transmission. Studies have shown that needle exchange programs can successfully reduce the transmission of blood-borne viruses in injection drug-using communities. In addition, we must look closely at the success of outreach of all kinds in providing education on HIV transmission and prevention, and in referring injection drug users to treatment.

The Tacoma, WA syringe exchange program became the largest referral source to treatment in that county very soon after it was established. Outreach workers have told the Commission of the gratifying response of addicts to the hope offered by new drug treatment slots. They have also told us of the anxiety of the conscientious health professionals at drug treatment clinics who worry how they will cope when the single year demonstration project funds run out and newly recruited addicts in treatment can no longer be accommodated.

Education and outreach do make a real difference in our fight against AIDS and substance abuse. Prevention is possible. Many people, including me in earlier years, assumed that drug users were beyond the pale, that they had already somehow embarked on what I once perceived as a road to chemical suicide and therefore were not reachable. But that turns out to be patently untrue. Drug users have heard about HIV and they know that they are squarely in its path. Furthermore, many want desperately to escape the dangers of both drugs and AIDS and yet we have blocked their way by failure to provide treatment for their addiction.

I was very struck by some data presented at one of the Commission's hearings by street outreach workers in San Francisco. They had managed to reach directly about 25 percent of injecting drug users in a given district with their bleach instruction program. Yet followup showed that over 90 percent of those addicts were using or trying to use bleach in the district, the majority having learned from those who were initially instructed. That's not only not suici-

dal behavior, I believe it is an all-time record success in the annals of health education.

Our third recommendation focuses on leadership. The Federal Government must take the lead in developing and maintaining programs to prevent HIV transmission related to substance use. You asked me to address the impact of HIV disease on the treatment system and the adequacy of Federal efforts to meet this growing public health crisis. AIDS and HIV related to substance use have had an enormous impact on the treatment system. There are new demands being made on both the public health and treatment communities because of the growing linkage of these twin epidemics.

There are a number of steps which need to be taken by both communities in response to the changes which HIV has wrought. We need to change the scope of activities in both public health clinics and drug treatment centers. For example, programs to provide HIV prevention and primary care health services in drug treatment centers should be developed and enhanced. In addition, more services should be available to substance users in public health care settings and training and cross training should be provided for staff in both settings. An easy first step which can be taken is simply a recognition in both settings of the link between HIV and substance use so that health care providers and drug treatment providers can help their clients as much and as soon as possible.

Although the National Conference on HIV and Substance Abuse: State/Federal Strategies, sponsored by the Alcohol, Drug Abuse and Mental Health Administration and other State and Federal agencies last year was an excellent step—

Mr. RANGEL. Doctor, I'm afraid that I'm going to have to interrupt. The second bells that you heard meant that we then had 10 minutes to respond to a vote.

Dr. OSBORN. Sure.

Mr. RANGEL. So, we're going to recess for 10 minutes. The committee has been joined by Mr. Dornan, Mr. Coble, Mr. Gilman, Mr. Hochbrueckner, as well as Mr. Scheuer, and I think it would be fair to say that we will start our inquiries based on the order of the members' return to the committee.

So, we'll adjourn for 10 minutes to vote and then we'll be right back. I'm sorry for the interruption.

[Recess.]

Mr. RANGEL.The committee will come to order again. I ask now whether you would complete your testimony.

Dr. OSBORN. Thank you, Mr. Chairman. I'm nearly done and I certainly understand.

In commenting, the recent discussion or the discussion last year in the national conference was an excellent step, but the response of the Federal Government in this area has been mixed. While some agencies have tried to be proactive in the fight against HIV and substance use, there's been a real lack of leadership on the Federal level which perpetuates the lack of direction and will on the part of public health care and drug treatment communities. Some agency or group must be designed to provide leadership in the specific area of HIV and substance use so that the needed

funds can be rallied and the needed changes and expansions to treatment made.

In order for the coordination and cooperation suggested by the national conference to work, incentives must be established for public health and drug treatment providers to work together in seeking grants and Federal moneys. Cooperation must be made easy and beneficial.

The Commission's fourth recommendation focuses on research and epidemiologic studies on the relationship between substance use and HIV transmission. The Commission strongly believes that the funding for these studies must be expanded and not reduced or merely held constant. Research in these areas can help us to ensure that the prevention and treatment of HIV related to substance use is effective. Research on injection drug-using behaviors and other substance use and sexual practices have been invaluable in our understanding of HIV related to substance use. The findings of these studies can help to control this epidemic which is a national public health problem. It is appropriate and necessary for the Federal Government to fund and support them.

Of special concern to the Commission are possible cuts in funding for investigator-initiated grants and the loss of successful demonstration projects because there is no mechanism to convert them into ongoing Federal projects. Lastly, but certainly not least, the Commission has recommended that all levels of government and the private sector mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society. This is obviously a long-term goal which isn't easily attained, but I think you would understand its importance if you'd heard, as you have, I'm sure, the devastating testimony of people who live without hope or opportunity.

It's long past time to attack the social problems that provide a medium in which drug use and HIV disease thrive. Relapse is a common part of the treatment process, but relapse aggravated by a return to life without hope may end in disease and death. I can think of little more cruel than sending individuals who have gone through drug treatment back to the neighborhoods, which one sociologist who testified before the Commission called, the neighborhoods which promote drug addiction.

I've spoken throughout this testimony of the importance of immediately accessible treatment, but to individuals who are homeless, sick or hungry, drug treatment and HIV education often seem like luxuries. There were a few simple words given by one of the witnesses to the Commission that moved us powerfully. That is, it is hard to educate a woman who is homeless and hungry. While continuing to develop and institute programs to combat HIV and substance use in the short term, the Federal Government must lead the way in the long-term attack on these larger social issues which remain as barriers to effective prevention and treatment.

Thank you for your attention.

Mr. RANGEL. Thank you, Doctor.

[The statement of Dr. Osborn follows:]

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TESTIMONY

before the

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

U.S. HOUSE OF REPRESENTATIVES

October 17, 1991

by

JUNE E. OSBORN, M.D.

Chairman

Good afternoon, Mr. Chairman and members of the Select Committee. I am Dr. June Osborn, Dean of the School of Public Health at the University of Michigan and Chairman of the National Commission on Acquired Immune Deficiency Syndrome (AIDS). Joining me today is Dr. Don Des Jarlais, Director of Research for the Chemical Dependency Institute of Beth Israel Medical Center and fellow member of the Commission. I would like to thank you for inviting me to testify before you today on this crucial aspect of the AIDS epidemic: HIV and substance use.

In its recent report, "The Twin Epidemics of HIV and Substance Use," the Commission made five recommendations. The first of these is related to drug treatment -- an issue which I know is of special concern to you today. The recommendation states that we must expand drug treatment so that all who apply for it can be accepted into treatment programs. The recommendation also cites the importance of continually working to improve the quality and effectiveness of that treatment. I cannot overstate the importance of this recommendation in combatting the transmission of HIV related to substance use. The sharing of injection equipment is a relatively efficient mode of transmission. HIV, once introduced into a drug-injecting population, can result in rapid transmission with half or more of the population infected over a period of years; from there it is inexorably disseminated to steady sexual partners, to non-injecting drug users trading sex for drugs, and onward. That has been the story in New York and New Jersey, in Edinburgh, and more recently in Bangkok where seroprevalence among

IV drug users flared from 1% at the beginning of 1988 to nearly 50% of the estimated 80,000 injecting drug users eighteen months later -- and from there it has raced to the countryside, to the sex industry, and rapidly across borders in ever-expanding circles.

Here at home, the effects of HIV related to substance use of all kinds are felt in ever-increasing numbers in communities of color, among women, and in infants and children. I will not tire you with a long list of statistics, but it is shocking to note that over 70% of AIDS cases in women are directly or indirectly linked to IV drug use and that 70% of children with AIDS, whose mothers have or are at risk for HIV infection, are related to maternal exposure through IV drug use or sex with an IV drug user. African-Americans account for 45% of AIDS cases related to IV drug use; Hispanics account for 26%!

These twin epidemics of HIV and substance use are a public health threat of massive proportions. Drug treatment is an essential component of the public health response to these epidemics. Treatment is the best way to permanently break the link between HIV and drugs. Immediately accessible treatment is not a new idea. We are to a great degree repeating a recommendation made by our predecessor Commission in 1988. Although it is not a new idea it <u>is</u> a crucial one. By giving individuals immediate access to treatment we can help them to change permanently behavior which threatens their health and the health of their sexual partners and children. As highlighted in our report, substance use enhances the spread of HIV, not only through the sharing of injection equipment,

but also through the practice of unsafe sex related to crack, alcohol and other substances. This particular link was dramatically illustrated for me on the Commission's visit to South Georgia where we saw the synergy of crack and HIV and syphilis -- an awesome engine driving future trouble!

Many have said that since treatment isn't completely effective the development of new, more effective treatment methods should take precedence over expansion of treatment slots which use current methods. Improving quality and effectiveness is essential, (as I noted earlier the Commission recommends that work on the improvement of the quality and effectiveness of treatment be on-going); but improving quality should not be used as an excuse for not expanding treatment programs which use current methods. Current methods may be imperfect, but they do get results; results which are crucial to saving lives. As my colleague, the Commission's vice chairman David Rogers has said, "We don't use the excuse of, 'We don't know quite how to treat you...' to people with congestive heart failure...[or]..cancer."

While evidence is mixed, it is also important to note that some studies have shown a positive correlation between retention in drug treatment programs and a reduction in AIDS-related mortality and disease progression. Thus, drug treatment not only helps to reduce the transmission of HIV, it may also help the health of those living with the virus.

Expanding treatment so that all who apply can be accepted into programs is an intelligent, humane, cost-effective and appropriate

public health response to these twin epidemics. Sadly, despite the overwhelming need for immediately accessible treatment, the federal government has yet to make the funding and policy commitments necessary to achieve it. Instead the Office of National Drug Control Policy (ONDCP) continues to focus on interdiction, neglecting the substantial gains which could be made against HIV related to substance use if a real commitment and acknowledgement of the issue were made. The ONDCP has stated that Congress has yet to fund fully the President's requests for treatment under its budget -- this is true and it is a problem which must be remedied. Nevertheless, the ONDCP's lop-sided budget which emphasizes enforcement over treatment should be reassessed in response to the desperate need to fulfill the goal of readily accessible treatment. Those who seek drug treatment should not be turned away to face a future of disease and death while they "wait their turn."

The Commission's second recommendation is to remove the legal barriers to the purchase and possession of injection equipment. As mentioned earlier, treatment is the best way to reduce transmission through IV drug use, but given the huge numbers of individuals on waiting lists for drug treatment in this country (the National Institute on Drug Abuse's preliminary estimates in July placed the number around 107,000) something must be done now to safeguard the health of injection drug users and the rest of the population. For those who are on waiting lists for treatment, in relapse, or not ready or able to stop injecting drugs, the provision of clean injection equipment can break the link between injection drugs and

HIV. The legal barriers to the purchase and possession of injection equipment have not been shown to reduce illicit drug use. Instead these barriers serve to limit the availability of new, clean injection equipment and encourage the sharing of injection equipment which results in an increase in HIV transmission.

Studies have shown that needle exchange programs can successfully reduce the transmission of blood-borne viruses in injection drug-using communities. In addition, we must look closely at the success of outreach of all kinds in providing education on HIV transmission and prevention and in referring injection drug users to treatment. The Tacoma, Washington syringe exchange project became the largest referral source to treatment in that county very soon after it was established. Outreach workers have told the Commission of the gratifying response of addicts to the hope offered by new drug treatment slots. They have also told the Commission of the anxiety of the conscientious health professionals at drug treatment clinics who worry how they will cope when the single year demonstration project funds run out and newly recruited addicts in treatment can no longer be accommodated.

Education and outreach do make a real difference in our fight against AIDS and substance use. Prevention is possible. Many people -- including me in earlier years -- assume that drug users are "beyond the pale," that they have already embarked on what I once perceived as a road to chemical suicide and therefore were not reachable. But that turns out to be patently untrue! Drug users have heard about HIV and know they are squarely in its path.

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Furthermore, many want desperately to escape the dangers of both drugs and AIDS, and yet we have blocked their way by failure to provide treatment for their addiction.

I was very struck by some data presented at one of the Commission's hearings by street outreach workers in San Francisco. They had managed to reach directly about 25% of injecting drug users in a given district with their bleach instruction program, and yet follow-up showed that over 90% of addicts were using -- or trying to use -- bleach, the majority having learned from those who were initially instructed. That is not suicidal behavior. Indeed, it may be an all-time record success in the annals of health education!

Our third recommendation focuses on leadership. The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to substance use. You asked me to address the impact of HIV disease on the treatment system and the adequacy of federal efforts to meet this growing public health crisis. AIDS and HIV related to substance use have had an enormous impact on the treatment system. HIV has added another strain to an already overburdened system. There are new demands being made on both the public health and treatment communities because of the growing linkage of these twin epidemics.

There are a number of steps which need to be taken by both communities in response to the changes which HIV has wrought. We need to change the scope of activities in both public health clinics and drug treatment centers. For example, programs to

provide HIV prevention and primary care health services in drug treatment centers should be developed and enhanced. In addition, more services should be available to substance users in public health care settings and training and cross-training should be provided for staff in both settings. An easy first step which can be taken is simply a recognition in both settings of the link between HIV and substance use so that health care providers and drug treatment providers can help their clients as much, and as soon, as possible.

Although the "National Conference on HIV and Substance Abuse: State/Federal Strategies" sponsored by the Alcohol, Drug Abuse, and Mental Health Administration and other state and federal agencies last year was an excellent step, the response of the federal government in this area has been mixed. While some agencies have tried to be proactive in the fight against HIV and substance use, there has been a real lack of leadership on the federal level which perpetuates the lack of direction and will on the part of the public health, health care and drug treatment communities. Some agency or group must be designated to provide leadership in the specific area of HIV and substance use so that the needed funds can be rallied and the needed changes and expansions to treatment made. In order for the coordination and cooperation suggested by the "National Conference" to work, incentives must be established for public health and drug treatment providers to work together in seeking grants and federal monies -- cooperation must be easy and beneficial.

The Commission's fourth recommendation focuses on research and epidemiologic studies on the relationship between substance use and HIV transmission. The Commission strongly believes that funding for these studies must be expanded and not reduced or merely held constant. Research in these areas can help us to ensure that the prevention and treatment of HIV related to substance use is effective. Research on injection drug-using behaviors and other substance use and sexual practices have been invaluable in our understanding of HIV related to substance use. The findings of these studies can help to control this epidemic which is a national public health problem -- it is appropriate and necessary for the federal government to fund and support them. Of special concern to the Commission are possible cuts in funding for investigator-initiated grants and the loss of successful demonstration projects because their is no mechanism to convert them into on-going federal projects.

Lastly, but certainly not least, the Commission has recommended that all levels of government and the private sector mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society. This is obviously a long-term goal which is not easily attained, but I think you would understand its importance if you had heard, as I have, the devastating testimony of those who live without hope or opportunity. It is long past time to attack the social problems that provide a medium in which drug use and HIV disease thrive. Relapse is a common part of the treatment process, but relapse

aggravated by a return to a life without hope may end in disease and death. I can think of little more cruel than sending individuals who have gone through drug treatment back to neighborhoods which one sociologist who testified before the Commission called "toxic agent[s] which promote drug addiction."

I have spoken throughout my testimony of the importance of immediately accessible treatment, but to individuals who are homeless, sick or hungry drug treatment and HIV education may seem like luxuries. I would like to share with you a few simple words spoken by one of the witnesses who came before the Commission -- "It is hard to educate a woman who is homeless and hungry." While continuing to develop and institute programs to combat HIV and substance use in the short-term, the federal government must lead the way in the long-term attack on these larger social issues which remain as barriers to prevention and treatment.

Mr. RANGEL. Now we'll hear from the treatment side with Arthur Webb, director of the Division of Substance Abuse Services for the State of New York, and he'll be followed by Dr. Beny Primm, who is the associate administrator for treatment improvement from the Department of Health and Human Services.

Mr. Webb.

TESTIMONY OF ARTHUR Y. WEBB, DIRECTOR, DIVISION OF SUBSTANCE ABUSE SERVICES, STATE OF NEW YORK

Mr. WEBB. Thank you very much, Mr. Chairman and Congressman Coughlin and members of the select committee. I am Arthur Webb, the head of the New York State Division of Substance Abuse Services. I will make my testimony very short. The full testimony is available and has been submitted to you.

Mr. RANGEL. That testimony will be entered into the record without objection and that will apply to Dr. Primm too.

Mr. WEBB. Thank you.

I'll try to make this very short and pointed so that we can spend the time on the questions and answers.

The GAO report and the AIDS Commission report really speak to two very important issues, quality and effectiveness, both of which have been two overriding themes in our State and headed by the Governor, Governor Cuomo. We generally accept the recommendations in both of these reports. I'll make that very simple and straightforward and up front. Indeed, effectiveness and accountability have to be part of the overall public system and we would agree that the reporting recommendations as well as the treatment expansion must happen in this field because we need to respond to treatment on demand.

You also asked for my views on the reauthorization of the ADMS block grant. We favor the reauthorization of the grant as it's currently structured. We also strongly support the targeting of additional Federal funds to areas of the greatest need that was recommended in that particular capacity expansion.

But while we accept and would like to pursue both of these recommendations of the reauthorization in both of the recommendations in the GAO report and the AIDS Commission report, the problem is that we do need to have the money to follow the mandates. It's been quite disconcerting that despite the tremendous increase over the past several years, the perspective of additional Federal funds for the subsequent years is just not going to be at our disposal.

The GAO report proposes the creation of a State systems development program which we would agree would improve our ability to understand and improve effectiveness as well as data. But we also suggest that the Federal Government, and particularly Congress, mandate these to ensure that we use current data systems which are available to the Congress and to the Federal Government and have been part of the ongoing reporting systems.

We respect the intention of OTI and Congress to increase the accountability, but from a State point of view we would strongly suggest that we build in the flexibility because every State is not the same, every community is not the same and we must have the abil-

ity to adjust and tune the data and accountability measures to fit the State's ability both to fund and to measure the outcomes of treatment.

OTI in particular and my colleague, Dr. Primm, has really demonstrated a genuine interest in working with the States to the point of where NASADAD has had a voluntary reporting system. Dr. Primm has particularly shown leadership in the critical populations, the waiting list grants and target cities, all of which I think have contributed to our ability to attain the quality and effectiveness that both of these reports address. Quality and appropriateness really in many ways have not been defined and we agree again and concur with the GAO findings that we need greater specificity.

In New York State, we have really approached quality and effectiveness from a much more comprehensive point of view than either the GAO report or even the AIDS Commission report talked to. We believe that not only is it regulatory compliance in terms of inspections and licensing and indeed when you held a hearing a year and a half ago, specifically on methadone, I think we demonstrated our ability to exercise the leadership in both of these areas.

Also, we agree that we should be measuring the efficiency and effectiveness of programs and we are moving to develop a whole new system that will begin to address on an empirical basis effectiveness of programs. This program is called the Program Assessment and Cost Efficiency System, all of which is documented in my testimony.

We believe in terms of this comprehensive approach, you also need to think about client rights and I haven't seen the kinds of issues expressed about client's rights in either of these reports and I'm sure, as Dr. Osborn pointed out, that indeed the client rights of individuals both in terms of AIDS and drugs need to be protected and we have established a client rights hotline with a high degree of confidentiality and direct followup. We think that is absolutely core to any kind of regulatory and/or quality system.

Another point is regulatory compliance. It has to be part of the comprehensive approach. Effective research allocation methodologies; that we are buying the right service at the right time at the right cost. This goes to performance standards. Access; we need to improve access which means we need to expand treatment. To ever attain the treatment on demand concept and philosophy that our Governor and our approach really attempts to achieve, we need to have a greater capacity to ensure access. Also, we need state-of-the-art knowledge deriving from the research and evaluation that is both at the State and Federal level and ultimately we need a comprehensive policy with which both Congress and the Federal Administration can concur.

The National Commission on AIDS is a very hard-hitting and a timely report, "The Twin Epidemics," one which we've lived with in the State of New York, and one which we need to really address. Indeed, regarding new AIDS cases, the proportion of heterosexual intravenous drug users in New York now surpasses that of homosexual males. Indeed, in less than 2 years, IV drug users are expected to account for half of all new AIDS cases in the city of New York, according to the New York City Health Department. The

twin epidemics are with us now and we need the kind of support to achieve and attain any of the recommendations that the AIDS Commission talks to. Estimates right now are that 30 to 60 percent of all of our clients that we see have seroprevalence.

Our approach to dealing with the twin epidemics is threefold. First, we need to expand treatment capacity. Second we need to integrate HIV services into treatment settings, and third, we need aggressive pursuit of street outreach both for families as well as the drug users. I will only highlight some of these particular initiatives for you.

As an example, we have 120 coordinator positions working in 105 programs and on 225 sites, specific and highly trained coordinators who are able to deal with individuals who are in need of both education prevention and treatment. That's only an example.

Another example, aggressive street outreach. Through our AIDS outreach program, we contacted 140,000 intravenous drug users last year by providing a variety of safety kits and referral patterns in excess to services. One of the most important ones and which is actually in jeopardy as a result of the cut by CDC, which I would like to address, and that's the HIV counseling, testing, referral and partner notification project. This is probably one of the most aggressive efforts to try to get individuals into both drug treatment as well as HIV prevention and education and treatment. We are in 15 programs and 82 sites serving 20,000 drug clients. Unfortunately, as a result of the cut, almost $4 million for the State of New York, this particular program is in jeopardy. I would strongly ask your select committee and other members in their various capacities to immediately address this issue. We believe that CDC has the flexibility of resources to hold this particular program harmless.

As Dr. Osborn pointed out, in the AIDS Commission you can't deal with the AIDS and the twin epidemics of drug addiction without dealing with the public health crisis facing all of us and indeed through an AIDS Institute in New York City Department of Health and the Bureau of Tuberculosis, we have now developed a TB prevention initiative whereby we have intervention specialists. We are making sure that most of our methadone programs have all of this.

In addition, we are using $1.4 million of our block grant to expand primary care, access to primary care services. So, indeed, what we've tried to do in addressing the twin epidemics in New York State with the AIDS Institute and my agency and the city of New York and other places in the State is really threefold. We need to expand treatment, we need to increase the access to prevention and education, and at the same time we need a very aggressive street outreach program.

So, the short of it, I accept and would strongly recommend that Congress carefully consider these recommendations of the AIDS Commission report and the GAO findings.

Thank you very much for the opportunity to testify.

Mr. RANGEL. Thank you, Mr. Webb.

[The statement of Mr. Webb follows:]

U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTIC ABUSE AND CONTROL

OVERSIGHT HEARING
ON
DRUG ABUSE TREATMENT:
A REVIEW OF CURRENT FEDERAL PROGRAMS

October 17, 1991

STATEMENT OF ARTHUR Y. WEBB, DIRECTOR, NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES

Testimony
For
U.S. House of Representatives
Select Committee on Narcotics Abuse & Control
Oversight Hearing
on
Drug Abuse Treatment: A Review of Current Federal Programs

INTRODUCTION

Good afternoon. I am Arthur Y. Webb, Director of the Division of Substance Abuse Services. I would like to thank Chairman Rangel and the other members of the Select Committee on Narcotics Abuse and Control for inviting me here today to testify before you.

You asked me to comment on the GAO and AIDS Commission reports, and to discuss what New York State is doing to improve the quality and effectiveness of publicly funded treatment programs. Both of these reports clearly emphasize the need to improve the quality and effectiveness of drug abuse treatment. The GAO report focuses on a proposed new accountability program to improve drug treatment services. The Commission report advocates the expansion of treatment as a major method of reducing the spread of AIDS, and stresses the importance of improving treatment services. These two major themes -- expansion and accountability -- have been the two overriding themes of my administration since I took over as New York State's Director of the Division of Substance Abuse Services (DSAS) nearly two years ago.

In general terms, I accept the recommendations of these reports as they echo the goals I am striving to attain as the head of the State's drug abuse services agency. I have focused the agency's efforts on the expansion of treatment and prevention services that are appropriate and necessary to address the needs of its clients and on the development of a comprehensive system for determining the accountability and quality of services offered. The Division is working to develop and maintain programs and services both so that more people can be served and that the volume of services can be expanded to assure an appropriate and timely response to people's needs. At the same time, the agency is vigilant that services are cost-effective and cost-efficient, and this concern guides expansion activities.

Especially in these difficult financial times, effective management must be brought to bear on all of our efforts, including expansion. Streamlining and simplifying intake, client assessment, client tracking, cost accounting, capital and operational finance, contract management and licensing systems and processes are critical elements in facilitating expansion. At the same time, treatment and prevention initiatives must be measured in terms of outcome for our clients. DSAS must demonstrate cost-effective and cost-efficient service development through measures such as: the economic self-

sufficiency of clients; reductions in drug-related criminal behavior; maintenance of periods of abstinence; and decreases in overall drug use.

The recommendations of the GAO and the Commission reports reinforce the goals and mission of the agency, and I support their intent. As mentioned above, however, these are difficult financial times. Although the reporting requirements raised by the GAO report are intended to assist states in complying with measures of effectiveness, and they do not seem onerous or unnecessary -- unless funding is provided to help us fulfill these requirements, they cannot be met. In the name of effectiveness and accountability, we can support additional requirements upon us -- but only if these are matched by the dollars to carry them out.

You also requested my views on the reauthorization of the ADMS Block Grant, and the proposed capacity expansion initiative. DSAS certainly favors the reauthorization of the Block Grant as it is currently structured, and we support the targeting of federal funds to areas of the greatest need, as is afforded under the proposed capital expansion program. In addition, I must be consistent with my comments expressed above on the recommendations of the GAO and Commission reports. States must get the money if they are to carry out the mandates. The president has recommended a zero increase in the Block Grant. Your own House of Representatives has recommended a $33 million reduction in funds. How can States be asked to pick-up this additional responsibility without additional support? As it is, in New York State, federal funds represent less than 18 percent of the DSAS budget for local assistance in state fiscal year 91-92. Additional funds are required if additional and improved services are to be developed.

COMMENTS ON THE GAO REPORT

The GAO report proposes the creation of a State Systems Development Program (SSDP) which will include an information system as well as treatment improvement protocols (TIPS). There are currently numerous data collection systems in place which make information available to OTI and ADAMHA, including a voluntary multistate effort coordinated through NASADAD. Prior to creating a new data collection system, it would seem that there needs to be a close examination of these existing data sources, and a crosswalk of available information prepared to ensure that the proposed new system does not duplicate ongoing efforts. There is no doubt that information must be provided for monitoring and oversight of accountability for the use of funds. However, a thorough and systematic review of current data systems should be conducted before another collection instrument is developed.

In terms of other aspects of OTI's proposed role, such as performing on-site reviews, and becoming actively involved in monitoring and technical assistance, it is not entirely clear to states how this will play out -- and therefore it is difficult to comment on the impact of such activities. We appreciate that OTI and ADAMHA have indicated that states will have maximum flexibility in assessing need for services and allocating resources, but we

are concerned that in practice this latitude will be restricted by the technical constraints imposed by OTI's need to develop a uniform information system. While we respect the intention of OTI and Congress to increase accountability and rational decision-making, we would like assurances that both OTI and Congress will remain flexible in their expectations of individual states.

In our enthusiasm to be accountable and rational, it is critical that we don't delude ourselves into thinking that we can be any more precise than existing information and scientific research methods will allow. We are interested in learning more about OTI's systems and protocols before we are asked to implement them. To be of maximum benefit, states should work in tandem with OTI in their development so that states can provide input and improve upon the product -- as is planned with New York State and the development of a needs assessment methodology.

At the recent OTI Resource Allocation and Planning Conference, it was acknowledged that New York State is in the vanguard of systems development and the technology of needs assessment. Many of the states that participated in the conference were very interested in the approach taken by DSAS. Discussions were initiated which might lead to an arrangement under which DSAS would be an active partner with OTI in the development of protocols and technical assistance to other states.

Since its inception, OTI has shown a genuine interest in working with state drug agencies in their overall mission to improve treatment. This is perhaps best demonstrated by their willingness to utilize the states' expertise in the disbursement of federal treatment dollars among qualified local provider agencies. OTI recognizes state drug agencies' role in overall comprehensive planning and fiscal control by accepting umbrella applications submitted by the states on behalf of providers. Such coordination is exemplified by the handling of the Target Cities, Critical Populations, and Waiting List Grants. New York looks forward to continuing this cooperative relationship with OTI.

New York was one of 10 states studied by the GAO in the course of preparing for its report. It was noted in the conclusion that states are not required and therefore do not provide much of the information that had been sought to assess the impact of the federal investment in drug abuse treatment. GAO's purpose in raising this point was to substantiate the necessity for mandating reporting requirements. While such requirements might better enable contract managers, providers and congress to identify and react to program strengths and weaknesses, given limited staffing, and without increased funding to match increased responsibilities, these reporting requirements could not be completed without reducing other vital staff efforts.

The study was also critical of states' interpretation of "quality" and "appropriateness" as stated in Section 2028 of the Comprehensive Alcohol Abuse, Drug Abuse and Mental Health Amendments Act of 1988 (P.L. 100-690) dealing with peer review. These terms had not been defined within the Act, therefore, each state defined them as they saw fit,

and carried out the Act accordingly. It is important to note that New York State requested approval of its protocol for meeting this requirement prior to implementing the review process. New York continues to refine its interpretation of both quality and appropriateness within its framework for improving accountability.

The GAO wants to provide Congress with the information necessary to assess the impact of ADMS-supported drug abuse services. It proposes to do this through the establishment of reporting requirements for the states that will provide HHS with information to determine whether drug treatment programs and services are effective. I do not dispute the right of Congress to know that it has spent its dollars wisely. What I question is the ability of the states to absorb the burden for the additional responsibility without increased funding.

I can appreciate the need for Congress as well as clients, the public, agency administrators and others to know that services provided with public funds are effective. I can assure you, the members of the Select Committee, that New York State is already actively pursuing an aggressive and comprehensive approach to accountability.

THE DSAS APPROACH TO ACCOUNTABILITY

The Division of Substance Abuse Services is committed to ensuring accountability and quality in the services provided to its clients, and to assuring the public's safety. This dual commitment is carried out by applying the best known technology to the delivery of services. DSAS believes this requires a comprehensive approach that must address three basic areas: cost, quality and access. These areas form the framework of accountability within which DSAS is taking specific actions to translate quality and accountability into day-to-day reality for providers and clients.

Initially, the agency's accountability efforts focused on the need for cost-efficient expenditures to maximize the development of service capacity and for the most effective targeting of resources to those with the greatest need. This demand for accountability was heightened by the public policy directive to expand programs and services as articulated in the State's Anti-Drug Abuse Strategy. Expansion of substance abuse treatment and prevention services became the major strategic theme underpinning the activities of DSAS.

Accountability also came to include a concern for the quality of care given to clients and for the effectiveness of programs both to help clients attain a state of freedom from drug dependency, and to help them attain maximum productivity as measured by employment and their exercise of family responsibility. Consequently, DSAS added these dimensions to its framework of accountability. This framework focuses on cost-effectiveness, while incorporating a commitment to quality that is reflected in the nature of services to clients and in the assurance of client safety and rights. This comprehensive approach to quality

and accountability is seen as the critical requirement supporting the expansion agenda of New York State.

From this broad framework, a variety of initiatives and changes were undertaken to allow DSAS to fulfill its commitment to public accountability, with an emphasis on the effectiveness of programs and services and on the delivery of quality care to clients. Coupled with this concern for quality, DSAS strengthened its capacity to provide inspections and reviews through both unannounced and regularly scheduled on-site visits. It has also strengthened its fiscal audit activities to better assure service provider financial accountability by implementing procedures to improve the efficient and effective recovery of funds from providers as a result of audit findings.

Consistent with its commitment to strengthen its capacity for quality assurance activities, DSAS addressed the problem of an increased influx of licensing applications resulting from the expansion effort by redeploying staff to handle the added volume, and by careful revision of the licensing process in order to streamline operations. In addition to maximizing the use of scarce staff resources, DSAS has implemented a cross-training program for all of its program review staff. This permits these staff to be able to review programs and, at the same time, review the facilities for compliance with health and safety regulations. As a result, inspection processes are expedited and program review and inspection efforts are improved through better coordination.

Ultimately, DSAS has to assure that the effectiveness of programs can be measured by the achievements of clients. These gains may be measured from a variety of perspectives. Achievement may be measured by the success of the individual in terms of exercise of family responsibility or attainment of gainful employment. The successful outcome of programs could be measured by the length of time that clients are free from drugs. Or it can simply be that client success may be measured by the retention of the individual in a drug rehabilitation and treatment program.

The substance abuse treatment system needs to be able, comprehensively and in detail, to assess needs of each client and to match, efficiently and effectively, that person, based on his/her needs, with discrete services that have been proven to provide the most cost-efficient and cost-effective treatment intervention. DSAS has decided to move toward the establishment of standards that reflect this level of precision.

DSAS is developing standards based on empirical evidence of the actual outcomes and activities that can be seen in current provider practice. DSAS will define effectiveness and efficiency evaluative concepts, and then using data from all providers, it will compare and contrast the relative experience of each provider to the mean or median experience of all providers of a similar type. In this approach, the measures will be based on what a provider has actually done and how that performance compares with the performance of other similar providers of care. In the last 18 months, DSAS has been moving to measure standards of efficiency and effectiveness in this manner. Two new

systems are now in development: Program Assessment and Cost-Efficiency (PACE) and PACE II.

PACE will provide DSAS with the opportunity to examine demographic information about the existing provider community. For each program, DSAS will be able to look at a variety of factors. These indices will permit DSAS to examine, on a relative basis, the performance of each program against all others of a given type. In the long run, as the field and DSAS gain experience with these measures of efficiency and effectiveness, DSAS can translate the criteria into regulatory requirements and begin to reflect these requirements through licensing and financing vehicles.

PACE II will take this effort to its next logical level. Specifically in PACE II, DSAS will begin to examine the relationship between the needs of clients as expressed in terms of human resource need (e.g., physical health needs, mental health needs, etc.) and the types of services that best match to those needs. PACE II will enable DSAS to more fully express efficiency and effectiveness. Getting people into those programs that best address their needs, and which most efficiently consume resources, will bring the field to a new level of understanding of the concepts of program effectiveness and cost-efficiency.

While following this empirical approach to develop cost-efficiency and cost-effectiveness standards, DSAS still has an obligation to provide state-of-the-art information for new approaches to treatment and to evaluate programs to improve our understandings about what "works." In this respect, DSAS is developing the capacity to organize the information it derives from research and program evaluation. The reason for organizing research and evaluation is to more quickly capture the new knowledge gained from existing projects, and to speed the transfer of that knowledge and information to objectives of expansion and accountability.

To restate the agency's position, DSAS believes that the challenge of accountability requires a comprehensive approach which is framed by concerns for cost, quality and access, and, within this framework, a variety of focus areas need to be addressed. These include:

- client rights;
- regulatory compliance;
- effective priority resource allocations;
- cost-efficient and cost-effective services through performance standards;
- improved access to comprehensive care through integration of service systems;
- "state-of-the-art" knowledge deriving from research and evaluation; and
- policy-driven management practices.

This concept of accountability and quality is neither simple to define nor easy to achieve. It will require a long-term, dedicated effort to assure that all of the focus areas come together in a rational way to produce a system that is truly accountable and dedicated to quality care for the individuals and families receiving substance abuse prevention and treatment services in New York State. This framework for accountability and quality is one of the Division's major strategic operating premises. Congress can be assured that New York State is in the forefront of the movement to increase the effectiveness of services, and that DSAS will continue to lead the nation in its development of a performance evaluation system.

SUBSTANCE USE AND HIV

The report prepared by the National Commission on AIDS and released this past summer is a hard-hitting document that is critical of federal programs and policies on substance use and HIV infection. The Commission, a 15-member body with expertise in both drug abuse and AIDS asserts that the link between these twin epidemics has been largely ignored in the development of the federal drug strategy. Although appointed by the President and Congress, this panel of experts chastises the Office of National Drug Control Policy for selecting interdiction and increased prison sentences over public health and treatment measures to break the deadly relationship between substance abuse and AIDS.

The link between intravenous drug use and AIDS is manifest. Among new AIDS cases in New York City, the proportion of heterosexual intravenous drug users (IVDUs) now surpasses the proportion of homosexual males. In less than two years, IVDUs are expected to account for half of all new AIDS cases in New York City, according to the City's Health Department. Nationwide, a third of all recent AIDS cases are related to intravenous drug use. The facts that confront us argue that more must be done to deal with the extremely serious spread of AIDS among drug users.

It is clear we need to provide more treatment opportunities. New York State is doing just that -- having already increased capacity to some 57,000 slots, compared with about 48,200 in early 1989. More development is in the pipeline. It should be noted here that although all 50 states were criticized by the Commission for the level of expenditures applied toward the expansion of treatment, on a per capita basis, New York State spent more than any other state -- nearly the same amount as California, Florida, Illinois, and New Jersey combined ($8.00 vs $8.13).

The HIV epidemic among intravenous drug users (IVDUs) and their families has presented an enormous challenge to DSAS and its provider network. With seroprevalence levels of 30 to 60 percent among its client population, and the intravenous drug user serving as the index case in the overwhelming majority of heterosexual and pediatric AIDS cases, the Division has been faced with a range of

critical choices to address the special needs of clients in various stages of HIV infection and to prevent further spread of the virus among substance abusers and their families. The Division's approach to meeting these critical needs is three-fold: expand treatment capacity, integrate HIV services into the treatment setting, and pursue aggressive street outreach to IVDUs, their families and other active drug users.

DSAS has responded to the HIV crisis with a series of independent and collaborative projects designed to expand and augment treatment services, develop and sustain an HIV service continuum within the provider network, and strengthen outreach. Detailed below are examples of the Division's efforts to address the need for HIV prevention, risk-reduction, and health care services within the drug treatment setting, and through an active outreach campaign.

HIV Coordinator Project -- The HIV Coordinator Project is the Division's major initiative to incorporate a comprehensive program of HIV risk-reduction and related services into ongoing drug treatment operations. The HIV Coordinator serves as an in-house resource to treatment staff on HIV issues in their caseload and as agency liaison to other HIV care-giving systems. The Coordinator also counsels HIV-positive clients on dealing with HIV within the context of drug treatment and recovery. Finally, the Coordinator is responsible for the development of a program's HIV Service Plan which is required by Division regulations.

There are currently 120 Coordinator positions working in 105 programs at 225 sites across the State. These individuals have become a vital link in the development of a comprehensive HIV service response to drug treatment clients and their families. The HIV Coordinators provide a range of clinical, administrative, and supervisory functions which enhance the integration of a comprehensive HIV service response within existing drug treatment operations.

Aggressive Street Outreach -- Any comprehensive strategy to reduce HIV transmission among drug users and their families requires an active and aggressive HIV outreach program to complement the efforts of drug treatment. In 1990, the Division-funded AIDS Outreach Project (AOP) contacted over 140,000 intravenous drug users, or their sexual partners. In addition to providing HIV information, the AOP distributes "safety kits" of bleach and condoms to at-risk substance abusers. Outreach staff also make referrals for HIV antibody testing and drug treatment. To supplement these activities, the Division awarded contracts to six community-based providers to conduct "second generation" outreach activities, i.e., services to IVDUs which guarantee ongoing support for attempts at behavior change. These programs became fully operational in 1991.

HIV Counseling, Testing, Referral and Partner Notification Project (CTRPN) -- With the advent of early intervention chemotherapies which both prolong and improve the quality of life among people with HIV infection, DSAS has encouraged programs to incorporate HIV antibody counseling and testing components into their treatment regimes. The

Division, in cooperation with the AIDS Institute of the New York State Department of Health has established confidential, on-site HIV Counseling, Testing, Referral and Partner Notification Services in 15 programs and 82 sites in New York State (11 NYC; 2 Buffalo; 1 Nassau County; 1 Westchester County). Funds for this project are from the Centers for Disease Control. Approximately 20,000 drug clients have access to these services.

Through this initiative, clients (and their significant others) in participating drug treatment programs have access to pretest counseling, HIV antibody testing, posttest counseling, risk reduction instruction, and ongoing supportive services. Additionally, clients are assisted in accessing necessary medical, social and related HIV services. While most programs serve their in-treatment population, several contain outreach components to active drug users (e.g., City of Buffalo, Staten Island University Hospital, St. Luke's/Roosevelt). An alternative consortium strategy is utilized to serve smaller drug treatment programs (e.g., Nassau County DDAA, AIDS Related Community Services). Two programs have components to serve pregnant and postpartum women (Albert Einstein and Daytop).

The Division provides necessary technical assistance to the AIDS Institute to insure the unique needs of substance abusers are addressed, and equally important, that services are provided within the context of comprehensive drug treatment services. HIV testing and related services are designed to compliment and enhance the primary role of providing drug treatment.

Tuberculosis Prevention Initiative -- The dramatic increase in tuberculosis cases in New York City in 1990 (38 percent increase over 1989; 3,520 reported cases), attributable largely to the HIV epidemic among intravenous drug users, has resulted in the development of a project to prevent the transmission or activation of the tuberculosis bacillus among drug treatment clients. This collaborative project involves DSAS, the AIDS Institute, and the New York City Department of Health's Bureau of Tuberculosis, and includes the placement of TB specialists in New York City treatment programs with CTRPN services. The Centers for Disease Control fund this initiative with an annual grant amount of $950,000.

Recognizing the increased prevalence of reactivated TB among IVDUs who are seropositive (i.e., HIV-infected), the initiative targets IVDUs who are already seropositive or at high risk of infection. Clients currently enrolled in methadone treatment programs, which are CTRPN providers receive TB testing and chemoprophylaxis based on their serostatus. Those with active tuberculosis are treated at NYC-DOH chest clinics.

Funds to participating programs provide a Disease Intervention Specialist per program and a nurse extender for each two clinics participating. The Disease Intervention Specialist provides follow-up and case management services, while the nurse extender

performs nonnursing duties to permit both the nurses to focus on the administration of medical care.

Primary Health Care Initiative -- Drug users historically have experienced serious difficulty accessing adequate health care. Even when drug users are participating in drug treatment, there is limited access to basic primary care services. This problem has been compounded by the HIV epidemic. Persons who are currently enrolled in drug treatment services often are either at risk for HIV infection or already are infected with HIV. Providing medical care to these individuals requires a wide spectrum of HIV-related services, including HIV education, counseling and testing, family planning, psychological support and medical evaluation and treatment of opportunistic infections and tumors. Concurrent epidemics of tuberculosis and sexually transmitted diseases (STDs) have further complicated matters.

With intravenous drug use accounting for almost half of AIDS cases in New York State, the importance of primary health care services for drug treatment clients takes on great urgency. The Division has moved aggressively to develop models of health care for HIV-infected clients. In 1990, the Division transferred $1.4 million in federal funds under the Alcohol, Drug Abuse and Mental Health Services Block Grant to the AIDS Institute for primary health care services. The project will fund both on-site health care teams in some programs and visiting health care services for smaller programs arranged in a consortium model. The Division has also collaborated with the AIDS Institute to establish on-site primary care teams in six New York City programs. In addition, over 25 substance abuse providers with Article 28 designation as diagnostic and treatment centers have entered agreements with the Department of Health to provide early HIV primary care services to their clients. An additional $1.5 million in NYS-DOH funds has been allocated for primary health care services in drug treatment programs.

The HIV epidemic among intravenous drug users, their life partners, and their children has not abated. While there is no guaranteed formula for preventing its spread, DSAS recognizes that treatment is the most effective means of AIDS reduction for this group. Toward this end, the agency has directed its provider network to deliver critical services in an accessible, compassionate setting, and to play a major role in finding solutions to this tragedy.

CONCLUSION

In closing, I would like to again thank Chairman Rangel for asking me here today. I also wish to thank the Committee for your overall efforts on behalf of the substance abuse treatment and prevention field, and to commend your interest in increasing the effectiveness and accountability of treatment services funded under the ADMS Block Grant. I would like to again compliment OTI for their responsiveness in working with New York State, and look forward to the continuation of our coordinated efforts. In

addition, I would like to request continued support for the expansion of treatment initiatives, especially in keeping with the trends outlined in the AIDS Commission report. The dramatic risks and consequences faced by IVDUs as well as Crack abusers who do not obtain treatment, or enter treatment after they are already infected with the AIDS virus, are particularly grim.

In terms of federal funding, the Division has made significant progress in meeting the goals it established for use of Block Grant and other federal grant funds. Currently, state funds are the primary source of the funds for New York's treatment and prevention system. Additional funds are required to add services for special, high-risk populations, to enhance services, and to strengthen accountability systems. We request increased funding to meet these needs, and recommend that the Block Grant be maintained in its present form.

New York State intends to continue its efforts to expand treatment, although limits in funding may force us to re-examine long-term expansion plans, as well as to target expansion even more strictly to high-risk population groups and geographic areas with the greatest need. As detailed in this testimony, DSAS is also dedicated to increasing the quality and accountability of existing and new substance abuse services. Through these dual commitments to expansion and accountability, the Division expects to provide greater numbers of clients with access to cost-efficient, cost-effective services, and to offer more enhanced services to those with special needs, such as clients who are HIV positive, all the while ensuring the public's safety.

Thank-you for the opportunity to discuss our progress on these goals. I would be happy to answer any further questions you may have.

Mr. RANGEL. Dr. Primm.

TESTIMONY OF BENY J. PRIMM, ASSOCIATE ADMINISTRATOR FOR TREATMENT IMPROVEMENT, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Dr. PRIMM. Thank you, Mr. Chairman. I am very elated and exceedingly happy to be here and to talk about something that you and I talked about 8 or 9 years ago. I thank you for still paying tribute to me and my foresight in warning, particularly New Yorkers, about this problem.

I want to testify today, Mr. Chairman, on something that I consider most important—increasing the State accountability for treatment efforts funded under the Alcohol, Drug Abuse and Mental Health Administration's block grant; the State systems development program that you have heard mentioned by Mr. Nadel and Mr. Webb; the efforts on the part of the Office of Treatment Improvement to combat the twin epidemics of substance abuse and HIV infection and expansion and quality improvement of treatment capacity in our Nation.

OTI's Division of State Assistance has developed a State system development program to meet the requirements of the Public Health Service Act as amended by Public Law 100-690, the Anti-Drug Abuse Act of 1988. The State system development plan will enhance Federal and State accountability for use of ADMS block grant funds, particularly through development of State treatment and prevention plans.

Additionally, it will improve State management of substance abuse treatment and prevention programs and it will also improve treatment quality overall. Once it is fully implemented, the SSDP will enable OTI to guide and to monitor addiction treatment services on a national scale. Already, Mr. Chairman, on a voluntary basis we have 26 States that have voluntarily begun to use the plan. Ten States have fully used the OTI State plan processes and 16 States have partially used this process in applying for their fiscal year 1991 ADMS block grant funds. I think that is a good sign.

We are forging ahead with the States to finalize the format for statewide drug treatment and prevention plans which will be mandatory in fiscal year 1993.

Today I would like to specifically focus on two elements of the State systems development plan which are responsive to the Committee's concerns. These are the development of treatment standards or guidelines, and assisting States to target treatment resources to the areas of greatest need.

The Office for Treatment Improvement, in conjunction with Federal and national experts, is producing a series of treatment improvement protocol statements known as TIPS. These treatment improvement protocol statements will serve as guidelines to Alcohol, Drug Abuse and Mental Health Administration block grant funded programs and State and substate agencies. These guidelines and standards of care are intended to provide state-of-the-art information for establishing funding, monitoring and evaluating drug treatment programs.

In developing the treatment improvement protocol statements, OTI sets up a Federal research panel to collect information from the literature and known experts in the field. This panel then makes recommendations to a non-Federal consensus panel comprised of recognized experts who actually develop the guidelines. OTI then puts these guidelines into the field for review and a final document is produced for public distribution. Currently, there are two TIPS in the review process. One is for pregnant and substance-abusing women. The other is for the screening for infectious diseases among substance abusers. Mr. Chairman, I would like to give you copies, for the record, of these two draft TIPS.

Mr. Chairman, without current data which indicate need at the substate level, States cannot comply with the statutory requirements that ADMS block grant dollars be targeted to areas of greatest need. To correct this deficiency, OTI is providing technical assistance to the States. For example, last September 25 through 27, OTI convened 65 of the most experienced epidemiologists to advise us on developing State capabilities to conduct these needs assessments. This group identified a core set of variables for States to measure, including the prevalence of drug use, drug-related crime, drug-related infectious diseases such as tuberculosis, hepatitis B, human immunodeficiency virus, human T-lymphotropic virus numbers 1 and 2 and other sexually transmitted diseases.

To help implement these findings, Mr. Chairman, OTI will fund needs assessments beginning in fiscal year 1992. We are also providing technical assistance to States through a 300-plus member consultant pool, national workshops and publications. This effort is called the treatment improvement exchange, or TIE. On December 11 to 13, 1991, OTI will hold a major technical assistance conference for States, in Chicago, on AIDS and HIV testing, the treatment improvement protocol statements, criminal justice and substance abuse treatment linkages, State guidelines and State plans.

Mr. Chairman, I would like now to move to a topic that you know is of great concern to me. Eight years ago I testified that the AIDS epidemic was going to sweep our Nation with very serious effects. Now, according to the Centers for Disease Control, more than 192,000 cases of AIDS have been reported in the United States and the U.S. territories by the end of August of 1991.

The prevalence of injecting and noninjecting drug abuse is a major factor in determining not only total numbers of AIDS cases but also the geographical concentration and the demographic distribution of HIV disease. New York City, as you just heard Mr. Webb state, accounts for 18 percent of the total reported AIDS cases, 25 percent of the total pediatric cases, and 21 percent of adult female AIDS cases.

The significance of injecting and noninjecting drug abuse in the development of AIDS in women and children overall is startling, Mr. Chairman. Evidence of perinatal drug use by the mother or the sex partner of the mother has been documented in the overwhelming majority of pediatric cases. The rate of serological HIV infection is rising rapidly among noninjecting drug users as well. The use of crack cocaine and smokable heroin, along with a concomitant increase in sexual activity with multiple partners that accom-

panies the use of these substances, creates a forum for transmission of the human immunodeficiency virus.

Mr. Chairman, the Office for Treatment Improvement has established a number of goals for improving services for HIV seropositive individuals and those at risk of the human immunodeficiency virus who are also addicted. As you know, my philosophy is that alcohol and drug dependency is a chronic complex bio-psycho-social disease phenomenon which cannot be treated in isolation from the person's medical, psychological and social deficit factors, all of which contribute to the onset and maintenance of addiction.

Those who suffer from addictive disorders, especially indigent and minority populations, women and children, are least likely to have access to primary health care services. As a consequence, we are seeking to provide preventive and primary medical care onsite through formal linkages with local health care providers and monitored through case management. These are also recommendations of both the President and National AIDS Commission.

Mr. Chairman, relative to the HIV epidemic, I particularly want to remind you about the Office of Treatment Improvement's Primary Care Substance Abuse Linkage Initiative, or SALI. SALI is helping to strengthen collaboration and coordination among primary care providers and the alcohol, drug abuse and mental health and HIV treatment systems. The SALI regional workshops, special issue meetings and coalition building activities that have already taken place will culminate in a national SALI conference to be held for 1,200 participants here in Washington, DC on February 26 to 28, 1992.

In addition to SALI, Mr. Chairman, the components of ADAMHA have worked together to sponsor or participate in such initiatives as the second National Conference on Preventing and Treating Alcohol and Other Drug Abuse, HIV Infections and AIDS in Black Communities: From Advocacy to Action, the National Hispanic-American Conference on Substance Abuse Prevention, and the annual meeting of the National Asian-Pacific-American Families Against Substance Abuse. OTI staff helped to ensure that these events served as forums to encourage adoption of the OTI comprehensive care model.

Mr. Chairman, OTI has also entered into discussions with the Indian Health Service to explore possible cooperative agreements that will enable us to further impact the cultural mosaic.

As the AIDS Commission report, "The Twin Epidemics of Substance Abuse and HIV," states, "We must attack the deep-rooted social and economic problems which promote and sustain substance abuse." You have often spoken of this yourself and you know I am a proponent of this.

In addition to primary medical care, patients who suffer from addictive disorders should be afforded psychological and psychiatric services, social and welfare services, legal assistance, and access to educational counseling and job training. This continuum of care is outlined in the Office for Treatment Improvement's Comprehensive Care Model, which I am providing for the record, Mr. Chairman.

The OTI model also promotes the provision of structured aftercare services. Retention and treatment and positive treatment outcome are likely to be increased if this continuum of care model can

be provided, in a one stop shopping approach, where people can get these services at one location, where all services are either provided on site or through case management. All programs that deal with populations at risk of the HIV/AIDS, should provide appropriate outreach, education, voluntary testing, pre- and post-test counseling and intervention services.

I would like to talk about what we will require States to do.

The ADMS block grant requires States to expend 50 percent of the drug abuse portion of their allotment for programs to serve injecting drug users with priority given to AIDS, to train drug abuse counselors and to conduct outreach activities. Earlier this year, the Department forwarded a legislative proposal to expand 50 percent set aside to cover all HIV-infected drug users and sexual partners of injecting drug users. Additionally, all of OTI's discretionary programs are designed to foster treatment improvement based on the OTI comprehensive care model.

These programs, which I have had the opportunity to brief the committee about previously, include Model Treatment Programs for Critical Populations; Cooperative Agreements for Drug Abuse Treatment Improvement Projects in Target Cities. There are 8 target cities in: New York, Boston, Baltimore, Atlanta, San Juan, PR, Milwaukee, Albuquerque, and Los Angeles. Also we have model drug abuse treatment programs for correctional settings and for nonincarcerated criminal justice populations. We have recently funded 28 new projects to serve high-risk adolescent juvenile justice populations.

Additionally, we have cooperative agreements for drug abuse campus treatment demonstration projects. The campus treatment project currently involves new cooperative agreements between two States: New Jersey and Texas, and the Office of Treatment Improvement, to create a setting where several providers sharing common resources deliver residential treatment services for drug use in a single large facility.

I would like talk to you briefly about expanding treatment capacity. The Department's proposed Capacity Expansion Program was designed to better target funds for capacity expansion in areas of greatest need and for patient groups at greatest risk of addiction-related diseases, including the human immunodeficiency virus. The goal of these competitive, 3-year-grants to States is to generate additional treatment slots.

Under the proposed capacity expansion program, Mr. Chairman, priority will be given to those applications which expand the capacity of comprehensive drug treatment programs providing a broad array of treatment services that have been found to be successful. Priority may be given to States that seek to increase capacity for certain high-risk groups, such as pregnant women and adolescents. The CEP provides a much needed mechanism by which we can target Federal dollars to areas of greatest need.

Additionally, OTI is also conducting training activities to ensure that there is an adequate supply of qualified treatment providers to staff additional capacity. For example, under the national training system, the Office for Treatment Improvement is expanding and enhancing the quality of training for entry level counselors. We are also offering career development and assistance to substance abuse

counselors through our minority summer fellowship in addiction treatment.

In conclusion, Mr. Chairman, the Office for Treatment Improvement, through its State Systems Development Plan, is currently increasing State accountability for drug abuse treatment services funded under the ADMS block grant. All OTI initiatives are designed to address the twin epidemics of HIV and substance abuse. OTI stands ready to implement treatment capacity expansion efforts as authorized and approved by the Congress.

I look forward to working with the select committee on each of these efforts. This concludes my testimony, Mr. Chairman. I will be glad to answer any questions that the committee may have.

Thank you very much.

Mr. RANGEL. Thank you, Dr. Primm, and I thank the entire panel.

[The statement of Dr. Primm follows:]

STATEMENT OF

BENY J. PRIMM, M.D.

ASSOCIATE ADMINISTRATOR FOR TREATMENT IMPROVEMENT

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

October 17, 1991

2203 Rayburn House Office Building

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Mr. Chairman, members of the Select Committee, I am Dr. Beny Primm, Associate Administrator for Treatment Improvement in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The Office for Treatment Improvement (OTI) has been charged with providing leadership for our national effort to improve substance abuse treatment. To accomplish this goal, OTI works with the research institutes within ADAMHA and with other Federal agencies to identify effective treatment methodologies. Additionally, OTI provides financial and technical assistance to States in order to facilitate the transfer of efficacious treatment technologies, and expand the availability of effective treatment capacity.

I would like to thank you for inviting me here today to testify before you on OTI's major initiative to increase State accountability for treatment services funded under the Alcohol, Drug Abuse and Mental Health (ADMS) Block Grant: The State Systems Development Program (SSDP); and also to talk to you about OTI's efforts to combat the twin epidemics of substance abuse and HIV infected drug abusers as well as our efforts to expand treatment capacity.

State Systems Development Program

OTI's Division of State Assistance has developed a State Systems Development Program (SSDP) to: 1) enhance Federal and State accountability for use of ADMS Block Grant funds; 2) improve

State management of substance abuse treatment and prevention programs; and 3) improve treatment quality overall. Once it is fully implemented, the SSDP will enable OTI to guide and monitor addiction treatment services on a national scale, while still allowing States latitude to design solutions to local treatment problems.

There are five components of the SSDP: 1) State development of comprehensive statewide drug treatment and prevention plans as a contingency for receiving ADMS Block Grant funds; 2) Development of a needs assessment by each State so that Federal funds can be targeted toward populations and sub-state jurisdictions most in need; 3) Comprehensive on-site reviews of State alcohol and drug abuse treatment and prevention programs; 4) Development of individual technical assistance plans for each State and provision of requisite technical assistance, as required by these plans; and 5) Creation of a centralized State Information System.

Mr. Chairman, because the SSDP is so complex, I would like to specifically focus on two elements which respond to the concerns of your committee: 1) Lack of treatment standards or guidelines; and 2) The inability to target treatment resources to the areas of greatest need.

Lack of Treatment Standards

Treatment Improvement Protocol Statements

OTI, in conjunction with Federal and national experts, is producing a series of Treatment Improvement Protocol Statements, known as TIPS, which will serve as guidelines to ADMS Block Grant funded programs and State and sub-state agencies.

These guidelines and standards of care are intended to provide state-of-the-art information for establishing, funding, monitoring, and evaluating programs. These guidelines will cover a number of subject areas such as program assessment; substance abuse treatment services; relapse prevention and aftercare; medical services; mental health services; life skills management; sociocultural aid; parenting skills and early childhood development.

TIPS are developed through OTI convening experts from the clinical and research fields. Mr. Chairman, I would like to explain this process. First, we set up a Federal research panel to collect information from the literature and known leaders in the field. This panel then makes recommendations to a non-Federal consensus panel, comprised of recognized experts, who actually develop the guidelines. OTI puts the guidelines into the field for review and a final document is produced for public distribution.

Currently, two TIPS are in the field review process: TIPS for Pregnant and Substance Abusing Women, and Screening for Infectious Diseases among Substance Abusers. These reviews are expected to be completed by early December. Janet L. Mitchell, M.D., M.P.H., Chief of Perinatology at Harlem Hospital Center, chaired the Pregnant Women Panel; and Andrea G. Barthwell, M.D., Medical Director for Interventions, a not for profit drug treatment program in Chicago, chaired the Infectious Diseases Panel. Mr. Chairman, a copy of the Pregnant and Substance Abusing Women and Screening for Infectious Disease draft TIPS are being provided for the record.

Inability to Assess Needs for Treatment Services

Mr. Chairman, currently, OTI's efforts to implement statewide drug treatment plans is hampered by the States' inability to conduct needs assessments. States lack this capability primarily because of a lack of financial resources and absence of qualified staff. Without current data which indicated "need" at the sub-state level, States cannot comply with the Statutory requirements that ADMS dollars be targeted to areas of greatest need.

In order for a State to target ADMS Block Grant funds to communities in greatest need of treatment services, they need to determine the incidence and prevalence of substance abuse and the need for treatment and prevention services in their communities.

OTI is providing technical assistance to the States so that they can collect this necessary data. This will allow states to effectively target scarce treatment resources.

Recently, OTI has made great progress working with the States to develop workable approaches they can use in targeting their ADMS Block Grant dollars to areas in greatest need.

On September 25-27, OTI convened 65 of the most experienced epidemiologists from Federal, State, academia, and hospital settings, to advise OTI on developing State capabilities to conduct needs assessments for treatment of those who abuse alcohol or other drugs. One of the major findings of this group was the identification of a core set of variables including the prevalence of drug use, drug related crime and drug related infectious diseases such as Tuberculosis, Hepatitis B, human immuno-deficiency virus (HIV), and other Sexually Transmitted Diseases. OTI will recommend that every State should employ these variables in their state drug abuse treatment needs assessment so that uniform measures are available.

OTI will fund Needs Assessments beginning in FY 1992. Meanwhile, we have forged ahead with the States to finalize the format for Statewide Drug Treatment and Prevention plans, which will be mandatory by 1993.

OTI is currently working with OSAP to develop prevention components for the State Plans and protocols for the State Technical Reviews. OTI is also involving OSAP in the development of the methodologies that we will fund in State Needs Assessment Studies.

Treatment Improvement Exchange

As part of OTI's technical assistance component of the SSDP, we are implementing a Treatment Improvement Exchange (TIE). The TIE is funded by the ADMS Block Grant technical assistance set-aside.

More than three hundred consultants have been identified to deliver program-specific consultation to the States at Federal expense. National conferences have been held on establishing linkages between the addiction treatment and criminal justice fields and on women's treatment issues. The fifth National Conference on Women's Issues, cosponsored by OTI, on May 5-8, 1991, focused on dissemination of state-of-the-art treatment practices for women. The conference included workshops on Women and AIDS, Women in the Criminal Justice System, and use of state ADMS Block Grant set-aside dollars for special women's programs. Additionally, workshops have been held, or are planned, on topics ranging from medicaid funding for substance abuse services to the ADMS Block Grant application process. On December 11-13, 1991, a SSDP Conference will be held in Chicago. Topics to be discussed

include AIDS and HIV testing, TIPS, Criminal Justice and Substance Abuse Treatment Linkages, State Guidelines and State Plans.

Additionally, the TIE publishes a communique that aims to share information between OTI and the States to assist States in improving and expanding their substance abuse and mental health treatment services. The first issue focuses on pregnant, substance abusing women, and presents information on a variety of Federal responses to problems of pregnant addicts and their children.

Mr. Chairman, when fully implemented, the SSDP will increase the effectiveness and accountability for Federal funds provided for drug abuse treatment services under the ADMS Block Grant. In the meantime, we are taking the first steps to strengthen States data collection systems to determine the incidence and prevalence of substance abuse and the need for services in their communities; the development of the Treatment Improvement Protocol Statements and improving state-of-the-art information dissemination to the States through the Treatment Improvement Exchange program; and the development of state needs assessment protocols for use in the implementation of Statewide Drug Treatment and Prevention plans.

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AIDS

Statement of the Problem

Mr. Chairman, as you mentioned during my testimony before the Select Committee, during Congressional Black Caucus Legislative Weekend last month, eight years ago I testified that the AIDS epidemic was going to sweep our Nation with very serious effects. Now, according to the Centers for Disease Control (CDC), more than 191,601 cases of AIDS had been reported in the United States and U.S. Territories by the end of August 1991.

The incidence of reported AIDS cases among homosexual and bisexual men, while still increasing, is experiencing a slower rate of increase compared to diagnosed cases of AIDS for injecting drug users, their hetero-sexual partners, and children.

The prevalence of injecting and non-injecting drug abuse is a major factor in determining not only total numbers of AIDS cases, but also the geographic concentration and the demographic distribution of HIV disease. New York City, for instance, accounts for 18 percent of the total reported AIDS cases, 25 percent of total pediatric cases, and 21 percent of adult female AIDS cases, a phenomena thought to be attributed largely to New York's large community of substance abusers.

The National significance of injecting and other drug abuse in the development of AIDS in women and children is startling.

Approximately 51 percent of reported AIDS cases among adult and adolescent females can be traced to intravenous drug use, with approximately another 21 percent of female AIDS cases attributed to heterosexual contact with a drug user. Evidence of perinatal drug use by the mother or the sex partner of the mother has been documented in the overwhelming majority of pediatric AIDS cases.

In addition, the prevalence of AIDS and its relationship to drug abuse cannot be fully limited to injecting drug use only. The rate of serological HIV Infection is rising rapidly among non-injecting drug users. The use of crack cocaine and smokable heroin, along with the concomitant increase in sexual activity with multiple partners, that accompanies use of this substance, creates an increased risk for transmission of the HIV.

Outreach programs which encourage drug users to change risk behaviors and enter treatment can greatly reduce the spread of AIDS. I would like to share with you a demonstration program funded by the National Institute on Drug Abuse (NIDA).

The National AIDS Demonstration Research Projects combine aggressive outreach with innovative behavior-change strategies to prevent AIDS in injecting and non-injecting drugs users and their sex partners. Under this program, outreach was conducted to locate injecting drug users and their sex partners in the communities in which they live and provide them with AIDS

counseling, testing and prevention information. Providing referrals to and encouragement regarding treatment was one program goal. In fact, twenty-eight percent of the injection drug using participants who had never sought treatment before, sought treatment; 36 percent of those who had received treatment in the past, reentered treatment after participating these programs. The NADR program also recognized that many users are unwilling or unable to enter formal treatment programs. It was highly successful in altering the behavior of those individuals in community settings.

NIDA has also launched a research program known as the Cooperative Agreement Program for AIDS Community-Based Outreach/Intervention Research. This program will evaluate the efficacy of behavior change strategies aimed at reducing the risk of HIV among injecting drug users and their sexual partners.

NIDA has initiated major programs to develop state-of-the-art treatment for drug abusers at high risk for HIV infection and for pregnant women and their children. Under the HIV program, eight Treatment Research Units have been established to permit rapid investigations of promising therapeutic approaches, including interventions for minority inner-city addicts, interventions for female addicts, and the development of new medications. Twelve demonstration projects are conducting careful research into a variety of interventions for high-risk drug users, including new

pharmacotherapies; counseling, psychotherapy, and neurobehavioral therapy; vocational training; and enhancing the effectiveness of treatment. For pregnant addicts and their offspring, NIDA has established 20 demonstration projects to provide drug abuse treatment coupled with a broad array of ancillary supportive services, including parent skills training, safe housing, and educational and employment training. These demonstrations, which will treat an estimated 5,000 women, employ case management and intensive outreach during and after treatment.

In addition to NIDA, the Office for Substance Abuse Prevention is assisting national efforts to combat AIDS through its prevention and early intervention programs aimed at curbing alcohol and other drug use. Prevention initiatives are directed particularly at youth living in high-risk environments whose widespread alcohol and other drug use, including injecting drug use and needle sharing, as well as unsafe sexual activity makes them vulnerable to HIV Infection. Among the high-risk youth OSAP has targeted for special efforts are runaways, abused or neglected youngsters, pregnant teens, those who suffer from mental disorders, and children of substance abusers.

OSAP also targets its alcohol and other drug abuse prevention initiatives to women at high-risk, including pregnant and postpartum women and their infants. These women and their infants are among the most vulnerable to HIV/AIDS. OSAP also

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disseminates information about AIDS through its National Clearinghouse for Alcohol and Drug Information (NCADI), and through the work of a special Task Force on Women and AIDS.

Last May, OTI, along with the Office for Substance Abuse Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and The Office of Minority Health, sponsored the Second National Conference on Preventing and Treating Alcohol and other Drug Abuse, HIV Infection and AIDS in Black Communities: From Advocacy to Action. Considered by many to be a highly successful conference, it focused on fostering greater community and individual empowerment to address alcohol and other drug abuse in the Black community and to disseminate state-of-the-art information on alcohol and other drug abuse prevention and treatment approaches.

OTI Goals and Programs

OTI has established a number of goals for improving services for HIV seropositive individuals, and those at-risk of HIV Infection, who are also addicted. The goals are consistent with our greatest imperative: to increase access to a wide spectrum of high quality addiction treatment, health and human services for those who suffer from addiction and addiction-related disorders. It is OTI's philosophy that alcohol and drug dependency is a chronic, complex bio-psycho-social disease phenomena which cannot be treated in isolation from a person's medical, psychological

and social deficits--factors which contribute to the onset and maintenance of addiction.

Those who suffer from addictive disorders, especially indigent and minority populations, women and children, are least likely to have access to primary health care services. As a consequence, we are seeking to provide preventive and primary medical care on-site through formal linkages with local health care providers, and monitored through case management. HIV testing and treatment, including the provision of prophylactic medication for asymptomatic patients, are included in the array of services which comprise the OTI health care continuum.

The AIDS Commission report, "The Twin Epidemics of Substance Abuse and HIV" states that we "must attack the deep-rooted social and economic problems which promote and sustain substance abuse." As outlined in the OTI Continuum of Care Model, in addition to primary medical care, patients who suffer from addictive disorders should be afforded psychological and psychiatric services, social and welfare services, legal assistance, and access to educational counseling and job training. OTI also promotes the provision of intense aftercare services. Retention in treatment and positive treatment outcome are likely to be increased if this comprehensive continuum of health and human services can be provided in a "one-stop shopping" approach, where all services are either provided on-site, or through case

management.

All programs that deal with populations at-risk of HIV/AIDS, should provide the following:

- o HIV/AIDS prevention and education;
- o Accurate and confidential testing done on a voluntary basis;
- o Post-test counseling;
- o Appropriate outreach
- o Partner notification and referral conducted by both the patient and the treatment provider;
- o Continuous monitoring of CD4 T-cell counts;
- o Provision of prophylactic medications including pentamidine, AZT, and tuberculosis prophylaxis, and;
- o Treatment of related primary health disorders such as herpes and sexually transmitted diseases.

Treatment programs may choose to provide all of these services in-house or to ensure, through case management, that selected services are provided by local primary health care providers. In those cases where the disease has progressed significantly and patients require acute care, programs should have established linkages with acute care providers to ensure that patients will have access to these services.

OTI's Programs

Mr. Chairman, drug treatment programs represent the greatest opportunity to reach drug users at-risk of the HIV and their families. However, we need to increase access to drug treatment programs and also expand treatment capacity and enhance the overall quality of that treatment. These programs need to be improved to the level where they are offering all of the services mentioned above, as appropriate for individual patient needs. Provision of these services will enhance our ability to provide earlier detection and intervention for HIV infected individuals.

The ADMS Block Grant requires States to expend 50% of the drug abuse portion of their allotment for programs for injecting drug users with priority given to AIDS, to train drug abuse counselors, and to conduct outreach activities. Earlier this year, the Department forwarded a legislative proposal to expand the 50% set-aside to cover all HIV infected drug abusers, and sex partners of injecting drug users.

Additionally, All of OTI's programs are designed to foster treatment improvement based on this Continuum of Care model, and we require the provision of HIV/AIDS testing, pre- and post-test counseling, education, and primary health care in all of our demonstration grant programs. These programs include: 1) Model Treatment Programs for Critical Populations, which targets

services to at-risk populations including racial and ethnic minorities, adolescents, and residents of public housing; 2) Cooperative Agreements for Drug Abuse Treatment Improvement Projects in Target Cities; 3) Model Drug Abuse Treatment Programs for Correctional Settings and for Non-Incarcerated Criminal Justice Populations and; 4) Cooperative Agreements for Drug Abuse Campus Treatment Demonstration Projects.

Under the Critical Populations program, provision of HIV testing, pre and post test counseling, treatment, and appropriate staff training programs are encouraged. A total of 95 projects were funded under this program in FY 1990 and FY 1991. Under the Target Cities program, which supports overall systemic improvements to the city-wide treatment delivery infrastructure, once an HIV infected patient is identified, they are referred to appropriate medical care.

OTI's Model Drug Abuse Programs for Correctional Settings and for Non-Incarcerated Populations fund demonstrations for prison and jail based treatment programs and diversion-to-treatment for arrestees, probationers and parolees, all sub-groups at very high risk for HIV. AIDS testing, counseling, education and prevention are components of these programs. Twenty-eight new projects were recently funded to serve the adolescent juvenile justice population; a population whose risk-taking behavior puts them at very high risk for addiction-related diseases.

The Campus Treatment Project involves cooperative agreements between States and OTI to create a setting where several providers, sharing common resources, deliver residential treatment services for drug use in a single large facility. The goal of this project is three-fold: 1) to enhance treatment capacity; 2) to improve the quality of treatment, especially through the provision of primary medical care and HIV/AIDS testing, counseling and prevention; and 3) to create a controlled environment for assessment and evaluation of the efficacy of different treatment approaches.

Another one of OTI's projects, The Primary Care/Substance Abuse Linkage Initiative (SALI), will help strengthen collaboration and coordination among primary health care providers and the alcohol, drug abuse, mental health and HIV treatment systems. The activities of this Initiative include Regional Workgroups, Special Issues Meetings and Coalition Building, culminating in a national SALI conference to be held here in Washington February 26-28, 1992.

Capacity Expansion Program

The proposed OTI Capacity Expansion Program is designed to target funds for capacity expansion in areas of greatest need and for patient groups at greatest risk of addiction-related diseases including the HIV. The goal of the CEP is to generate additional treatment slots. As envisioned by HHS, the Capacity Expansion

Program represents an updated, improved version of the Waiting List Reduction Program.

The CEP directs the Secretary to determine appropriate criteria for the States to determine shortages and coordinate services. Priority is to be given to those applications which expand the capacity of comprehensive drug treatment programs and provide a broad array of treatment services found to be successful. Priority may be given to States that seek to increase capacity for certain high risk groups such as pregnant women and adolescents.

The CEP provides a much-needed mechanism by which to target Federal dollars to areas of greatest need. We hope the Congress will act to approve the President's request to authorize and fund this program for FY 1992.

In conclusion, Mr. Chairman, OTI, through its SSDP, is currently increasing State accountability for drug abuse treatment services funded under the ADMS Block Grant. In addition, all OTI initiatives are designed to address the twin epidemics of HIV and substance abuse. We stand ready to implement treatment capacity expansion efforts as authorized by the Congress. I look forward to working with the Select Committee on each of these efforts. This concludes my testimony. I will be glad to answer any questions the committee may have.

Mr. RANGEL. My colleagues are here. Congressman Coughlin—I don't have the new date—Congressman Scheuer, Congressman Gilman, Congressman Towns, Congressman Payne.

What I'd like to do is to start off being brief and giving everyone an opportunity to have a first go-round, and then we will stay as long as the members and the panel can stay with us.

Dr. Primm, how long have you been involved in providing treatment or directing treatment for drug addicts?

Dr. PRIMM. Since 1966, Mr. Chairman. I began at Harlem Hospital Center, as you know, and my career has——

Mr. RANGEL. And how long have I been working with you on this subject?

Dr. PRIMM. At least that length of time, at least since 1967. In 1968 we began working very closely together.

Mr. RANGEL. So, the questions that I'm going to ask the General Accounting Office you would have heard before. I've been asking these questions because I just wanted to set the time frame.

How many drug addicts do we have in the United States, multidrug addicts?

Mr. NADEL. I think I'd rather have Dr. Primm answer that. I don't think——

Mr. RANGEL. That's good. How many addicts do we have under treatment and how much of that treatment involves Federal dollars?

Mr. NADEL. Well, the Federal dollars is roughly about 20 percent of the total.

Mr. RANGEL. What's the total?

Mr. NADEL. The total is——

Mr. RANGEL. With me you can guess. These figures, you and I know——

Mr. NADEL. The total is about, I think, roughly $2½ billion.

Mr. RANGEL. That's the Federal part of it, right?

Mr. NADEL. Well, the overall block grant is about $1.1 billion, but that also includes the mental health part of it. The Federal dollars actually going to drug abuse treatment or substance abuse is about $500 million.

Mr. RANGEL. That's not the figure my staff has given me. But you worked on those figures. With the drug addicted and multidrug addicted population, how many of these programs have proven to be successful, success meaning that after the conclusion of the treatment the person refrained from the use of drugs for more than 2 years?

Mr. NADEL. Well, ideally we could provide you with such information. But as we found in our report, because uniform information is not being collected, we are unable to provide you with that information.

Mr. RANGEL. How many different types of treatment do we have for the different types of drug addicts?

Mr. NADEL. Well, there are several different modalities in terms of information which would allow us to say specifically how many people are in what kind of program. That is also unavailable.

Mr. RANGEL. How can we compare the success of one modality compared to another modality?

Mr. NADEL. If you had good uniform data and outcome data on a continuing basis, you would be able to do so. We don't have such data now.

Mr. RANGEL. So what you're saying is that these figures that my friend and colleague, Mr. Coughlin, is so proud of as relates to the Federal investment and treatment, you haven't the slightest idea as to whether any of these treatments are working.

Mr. NADEL. We are unable to determine that. That's right, Mr. Chairman.

Mr. RANGEL. OK. Now, Mr. Webb, could you provide any answers to the questions that the General Accounting Office could not answer?

Mr. WEBB. Sure. In this same kind of, how would you call it, imprecise way, but I will give you the best guess. In the State of New York, we have what we would consider to be approximately 500,000 heavy drug users, 250,000 of which we're trying to target our resources to. They show up in a variety of different systems in terms of criminal justice and the mental health system and other systems. We are treating in any single day about 57,000 individuals in a variety of different settings; residential, therapeutic community settings, methadone maintenance programs, a significant amount of outpatient programs. Then, if you combine what's going on in criminal justice with the mental health system and the health care system, we're reaching close to 130,000 to 140,000 of those individuals at one time or another in any single year.

In terms of Federal dollars, only 18 percent of all dollars spent in the State of New York for treatment and prevention, are Federal dollars. All the rest are State and local dollars.

Just a footnote. As Congress thinks about all these mandates, let's make sure that we're just not mandating for 18 percent and imposing on the State a set of requirements that, in fact, predict or proscribe or prescribe State and local dollars which should be at the discretion of State and local government.

Successful programs on empirical basis——

Mr. RANGEL. Talk slowly now.

Mr. WEBB. OK. I'm trying to get everything in that you want here.

Mr. RANGEL. No, no, no. You're reaching the part that I'm very interested in.

Mr. WEBB. OK. I have to admit, this is based upon empirical evidence——

Mr. RANGEL. I don't care what it's based on.

Mr. WEBB. Well, it's not personal experience.

Mr. RANGEL. That's all right.

Mr. WEBB. OK. I don't have the distinguished experience that Dr. Primm has.

Mr. RANGEL. No one does. That's why he's in charge nationally.

Mr. WEBB. That's right.

Mr. RANGEL. Let me hear just from a guy from New York who has been running the program——

Mr. WEBB. Asking the same questions.

Mr. RANGEL. I want to know roughly how many people have gone through programs and how many have come out and for a year or two have remained drug free.

Mr. WEBB. Two key variables to keep in mind as I give you these statistics. The longer someone is in treatment the greater the likelihood of remaining, as they say in the field, sober.

Mr. RANGEL. I'm only talking about those that remain in treatment.

Mr. WEBB. OK. In therapeutic communities, if you deal with and exclude the first 30 days, because a good deal of the turning process——

Mr. RANGEL. Forget the first 30 days.

Mr. WEBB. We are now talking anywhere from one out of four to one out of five individuals successfully complete a residential intensive program.

Mr. RANGEL. Now, how long is that?

Mr. WEBB. It ranges anywhere from approximately 9 months to 18 months.

Mr. RANGEL. And how much does that cost per patient?

Mr. WEBB. It is approximately $55 a day. What is that, about $17,000, $16,000 a year? That's for all services. That's a total comprehensive set of services.

Mr. RANGEL. And can you identify the organizations that provide this type of comprehensive service?

Mr. WEBB. Yes.

Mr. RANGEL. And what percentage of the total drug treatment programs that you have in the State of New York are these types?

Mr. WEBB. More than half fit that kind of dimension of that success rate.

Mr. RANGEL. So that you would be able on any given day to give at least the number of people that have gone through the New York State system and those who have completed it, pardon the expression, successfully?

Mr. WEBB. Absolutely. Yes; in fact, our new program, Program Assessment Cost Effectiveness, called PACE, has been put into place.

Mr. RANGEL. So, because we don't have a federal system, then it means that the Federal Government would have no idea really as to which programs are working in New York State, at least these treatment programs.

Mr. WEBB. I have to say, though, Dr. Primm's staff has been working with our staff and we have a number of exchanges specifically on the PACE.

Mr. RANGEL. Let me rephrase it. As a Federal office holder, if somebody were to ask me, "Rangel, what are you doing with treatment?" then I would grab the figures from Larry Coughlin that the President gave him, and say, "We've put $1.4 billion in treatment." Then the questioner would say, "Well, how's it working?" Now, what would I say?

Mr. WEBB. I would say, from my perspective and——

Mr. RANGEL. No, from the Federal Government's perspective. I'm Federal. I'm not in the assembly any more.

Mr. WEBB. I can only speak from a State perspective. It's hard for me to put my feet in the Federal Government's shoes either as an elected official or——

Mr. RANGEL. But you would say you have not shared the State perspective with the Federal Government so that they would have a national perspective.

Mr. WEBB. No.

Mr. RANGEL. OK.

Mr. WEBB. No, not a national perspective.

Mr. RANGEL. Mr. Coughlin, I'll be here and I do want to talk with Dr. Primm and Dr. Osborn.

Mr. WEBB. I must say though we are in the middle of a massive expansion program just in the last 2 years——

Mr. RANGEL. I've been in the middle of this program for 20 years. OK? And it's always been massive, it's always been expansive and we always are about to get a handle on it. We're always turning the corner. We always see light at the end of the tunnel and there's always been a massive reduction in demand.

Mr. WEBB. I don't think there's a decrease in demand.

Mr. RANGEL. Well, you're not listening to Mr. Coughlin.

Mr. WEBB. When the President recommends a zero increase in the block grant, Congress doesn't even accept the capacity expansion targeting. We're right in the middle of this expansion program trying to improve effectiveness and access and now the State is faced with this terrible dilemma of absorbing all of that which should have been at least partially paid for at least on a fair share basis.

Mr. RANGEL. Well, you just tell the Governor that he should read the high school senior survey and he would know it's getting better. Then he should get involved in calling up the households, and they would tell him, those who answer the phone, that they're using less drugs and whatever other data that's been collected, which Mr. Coughlin has. You would walk away knowing that there's a lot to be done, but we have a lot to be proud of.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman. I'm pleased to see you are proud of what we're doing.

I have three questions and I would ask you to be brief in your responses because I do want to get on to other Members.

First, for Mr. Nadel. You have recommended the establishment of reporting requirements to the States to provide HHS with information and report to Congress by 1995 on the programs of OTI's—the progress of OTI's State Systems Development Program. Since 1988, the administration has been trying to get the passage of statewide treatment plans. This, in my judgment at least, would provide exactly what you're asking for in the context of those statewide treatment plans. In 1989 and 1990, both the Senate and the House approved versions of the administration's statewide treatment plan legislation.

Have you examined that legislation and do you have an opinion?

Mr. NADEL. I have not——

Mr. COUGHLIN. Is it helpful?

Mr. NADEL. Well, it would certainly be helpful, but we have a legal opinion from HHS. It indicates that HHS by itself could issue regulations to get such a treatment plan. So, we would certainly be supportive of it and we think that it could probably be effectuated

now. But having not studied the legislation, I can't say that everything in it could be required by regulation.

Also, the SSDP covers, in fact, more than just treatment plans. It entails performance evaluations, technical monitoring, technical assistance and we think that information on that would be useful to the Congress. I know there's been some discussion and legislation on the other side to make the equivalent of the whole SSDP mandatory. We think at a minimum that Congress should be provided information on just what's going on.

Mr. COUGHLIN. I'd like to suggest the treatment plan legislation would make that mandatory, as you are suggesting, or allow the HHS to make it mandatory in their development of statewide treatment plans.

For Dr. Osborn, you indicated, among your recommendations, that a larger effort be made by the Federal Government to expand and improve HIV and AIDS-related services. As I pointed out earlier, the President's 1992 budget increases Federal funding by 89 percent for drug treatment, 107 percent for drug prevention, 79 percent for drug research, 105 percent for targeted ADAMHA research on HIV AIDS, and approximately $370 million is available in the President's 1992 budget request for ADAMHA for IV users. This makes the total amount spent on AIDS research by all Federal agencies to be about $1.2 billion, which I'm informed is more than we spend on the combined research on cancer and heart disease.

Is this an appropriate amount that we're spending?

Dr. OSBORN. No, I don't believe we're anywhere near control of the AIDS epidemic, whereas we're enjoying the fruits of several decades worth of work on cancer and heart disease and beginning to see some major inroads in that. I'm not advocating less investment in cancer and heart disease, but I think if we're honest with ourselves, we're dealing with an out-of-control world class epidemic and enough will probably be defined when we begin to get things under control, which is not now.

Mr. COUGHLIN. Do you see any progress being made in the research at all?

Dr. OSBORN. Certainly. I think the research efforts that are going on are excellent. I might point out that you're giving me research expenditures only and we have quite a lot to do as a nation with this epidemic. The research is going to ultimately help us bring it under control, but we have some very urgent problems right now in terms of dealing with both the prevention and the care of people who have been infected and those funds are very inadequate at the moment in order to deal with a problem of this magnitude.

Mr. COUGHLIN. And for Dr. Primm, if I may. The National Commission on AIDS recommends treatment on demand as the most important step that should be taken to alleviate the spread of AIDS by intravenous drugs. The Federal strategy appears to reject that as a goal. Could you explain why that is?

Dr. PRIMM. Dr. Osborn and I spoke about that during the break. In June 1988, the Presidential Commission recommended that we move toward expanding drug treatment in our Nation to meet the crisis of HIV infection and substance abuse, to where it would be treatment on demand. Now, the National Commission has done

likewise. Therefore, we are in total concurrence that this should happen. We are moving toward a better quality of treatment. I think that when we look at the number of treatment slots that are out there presently, we see people taking advantage of them and the more treatment slots we open up the more people are taking advantage of them. But you also at the same time that you open up drug treatment slots, you have to improve the quality of these slots. You have to train counselors, you have to train physicians. We are in the process of trying to do that. We have not yet reached that goal, but I think with the SSDP, with the training of counselors through my office, with the improvement of quality of services, with demonstration grants that we talked about earlier, we certainly will do it. I could give you a report as recommended by the GAO by 1995, which says that we are moving to that goal.

I would like to say something else. I have never sat on a panel that has had as much concurrence as this one has had around these issues. Almost all of us, including the General Accounting Office, have spoken glowingly and optimistically about the SSDP and what it may be able to do.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. Nadel, is legislation going to be needed to implement your recommendations that HHS establish some reporting requirements or can that be done without legislation?

Mr. NADEL. No, sir. That can be done without legislation. The Secretary currently has the authority.

Mr. GILMAN. And are you recommending that he go ahead with it?

Mr. NADEL. Yes, we are.

Mr. GILMAN. And are you in the process of doing that?

Mr. NADEL. Well, in our report we have issued a formal recommendation that the Secretary does require specific reporting standards from the States or requires information from the States.

Mr. GILMAN. Have you asked for comments from the States?

Mr. NADEL. Pardon me?

Mr. GILMAN. Have you asked for comments from the States?

Mr. NADEL. Not on that specific recommendation, no, sir.

Mr. GILMAN. Do you think the States are generally receptive?

Mr. NADEL. I think we will get a mixed message from the States. One of the reasons that we have recommended such reporting requirements is that when they were voluntary we got partial compliance or the Department, rather, got partial cooperation. We think it is important to have a certain amount of uniform, consistent information and that we think that that is consistent with the flexibility inherent in the block grant.

Mr. GILMAN. Did you estimate what such a program would cost?

Mr. NADEL. We did not estimate what it would cost.

Mr. GILMAN. And if there is full compliance and you get the program underway, how long would it take for Congress to get that information?

Mr. NADEL. In terms of the report from HHS, we recommended 1995. In terms of the reporting requirements we're recommending

that HHS impose, we would think—I would be guessing—a couple of years.

Mr. GILMAN. No way of expediting that? Congress wouldn't know until 1995 how effective these programs are?

Mr. NADEL. Well, Congress doesn't know now. I think it will take time to start getting some consistency. We recommended 1995 because the OTI initiative doesn't really kick in full scale until about 1993 and they're not going to be doing all the States, working with all the States at once. We're not saying they should wait until 1995, we're saying that 1995 ought to be the latest that they should report to the Congress.

Mr. GILMAN. Mr. Webb, were you consulted with regard to this proposal?

Mr. WEBB. No, not at this point.

Mr. GILMAN. What are your thoughts about it?

Mr. WEBB. I accept the basic recommendation that there should be a national uniform consistently applied database so that everyone knows what's going on. I don't disagree with that. Someone has to pay for making that happen. That means we have to reformat all the material. We have to go out to all our providers. We change our computer systems and then we have to get agreement from all my colleagues in the Federal Government as to what should be in the data set. This is not an easy task.

Mr. GILMAN. Dr. Primm, how do you feel about it?

Dr. PRIMM. I agree with Mr. Webb that it is not an easy task. We have proposed $20 million per year for the next 3 years in order to implement the SSDP. The majority of these dollars will go to the States to help them collect the data, to prepare their reports, prepare their applications, et cetera. We will also give States technical assistance.

Mr. GILMAN. $20 million just to report all of this?

Dr. PRIMM. Well, it is much more than reporting. I think when Congress demands now that there be some accountability, and there has been no accountability since 1981, you certainly are going to have to pay to get things up to speed to be able to give information that you need. The data has to be collected, there have to be assessments, there has to be technical assistance to teach people how to do this. It is going to cost at least $60 million over the 3-year period.

Mr. GILMAN. $60 million.

Dr. PRIMM. Yes; $20 million per year.

Mr. GILMAN. Dr. Osborn, in 1988, the AIDS Commission advocated drug treatment on demand, increased funding for treatment research, community-based prevention efforts and improved outreach education. What progress have you made in any of those fronts?

Dr. OSBORN. I'm pleased that you're citing the Commission that Dr. Primm served on which was our predecessor commission.

Mr. GILMAN. Yes.

Dr. OSBORN. And from the point at which the National Commission on AIDS began to do its work in August 1989, I believe the first thing we did was to try and reassert that since there had been relatively little progress in the overall recommendations of the Presidential Commission.

In terms of specifics of progress, one of the reasons that I asked Dr. Des Jarlais to come with me is that he's been very helpful to the Commission in providing continuity. I had the pleasure of first working with him on the National Academy of Sciences Institute of Medicine AIDS Study which was in 1986. I think certainly before that because of his professional interest, but certainly since then he may be one of the people who can give us the best sense of continuity.

With your permission, I'd ask Dr. Des Jarlais to comment.

Mr. GILMAN. Yes. Dr. Des Jarlais.

Dr. DES JARLAIS. Yes. It sounds a little like Congressman Rangel's comment of we've been in this business for a long time and there's always a certain amount of optimism, but we certainly haven't solved the problem. Clearly, there is planning for expansion of treatment and perhaps by 1993, 1995, we will see a real expansion. I think most people in the AIDS field feel that what we need is really a doubling of the current treatment capacity if we're going to get to that treatment on demand level.

In terms of the other question about outreach programs, the National Institute of Drug Abuse did set up a nationwide outreach program. All of the information indicates it's been very successful. The question is now will that program be continued. It was set up as a demonstration grant without full thinking through of what would happen when the demonstration part of it ended, whether States would have to pick it up, and most States are not currently in a good financial situation to pick it up, or whether NIDA as a purely research institute would carry it on as services, whether it would go to some other part of ADAMHA, whether it would go to CDC. There's a real chance that this nationwide outreach system, which is probably one of the most effective things the U.S. Government has done with respect to AIDS among drug users, may simply come apart because we haven't done enough planning on how to continue it.

Mr. GILMAN. It was an effective program though?

Dr. DES JARLAIS. It's been a very effective program in terms of getting people into drug abuse treatment, getting people to stop sharing their injection equipment and to a lesser but still important extent——

Mr. GILMAN. What should we be doing to save the program?

Dr. DES JARLAIS. We need to have a Federal commitment to continue the program with Federal dollars and we need to decide where in the Federal Government this should be housed. One of the Commission's recommendations was that we need a single agency in the Federal Government taking on the twin epidemics of AIDS and drug abuse. Whatever agency is designated to have that leadership responsibility should be in charge of this part.

Mr. GILMAN. Dr. Primm, doesn't your office have somewhat of that jurisdiction?

Dr. PRIMM. No, Mr. Chairman. The Alcohol, Drug Abuse and Mental Health Administration and the Public Health Service have begun to work very closely with the Centers for Disease Control. All the public health service agencies are now coordinating their efforts to do something about this. But there is not one place in the Public Health Service. The National AIDS Program office may be

similar to what Don may be talking about, but we don't have a place as he described it.

Mr. GILMAN. What do we have to do? Do we need legislation to create that? Can't we do that without legislation?

Dr. PRIMM. Well, I did not say, Mr. Chairman, that I was in accord with what Don suggested. It may not need to be a new agency established to do this.

Dr. DES JARLAIS. I wasn't suggesting we have a new agency, but we should have a designated lead agency that would make sure programs like a successful demonstration program do get continued.

Mr. GILMAN. Can't we pick up a phone and say, "You're it," and follow up instead of letting this thing go to pot?

Dr. PRIMM. Well, my office has not even been authorized yet by Congress. I do not know whether we could do that. I certainly would undertake it if that were the case.

Mr. GILMAN. I hope you'd look into that, Dr. Primm. You're in the policy saddle there and I hope that the President is hoisting them to you and maybe you can get that organized without having to go through a lot of legislation. It sounds like you've got an effective program. We're just letting it go down the drain.

Dr. PRIMM. Yes, sir.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Towns.

Mr. TOWNS. I would just like to pick up on the point that the gentleman from New York just raised. Dr. Primm and I also go back a long way. But it seems to me that authority is not the problem. They have broad authority already. I don't think that's an issue. I think what we need to do is just make some decisions as to really which way we want to go.

Let me raise a couple of questions which really, really bother me. How do you determine who gets funds? You don't seem to know what they're doing. How do you make a decision? Do you fund me every year and I come back and you fund me again? Is it the fact that I come and I use some strong language or bring some folks that advocate for me or I have somebody come and say,"Well, if you don't fund me, then I might knock down the door." How do the people get money because you really don't have any record, any indication in terms of what they do with it after they get it.

Can anybody answer that for me? I would like for you, Mr. Webb, to respond and then anybody who wants to take a crack at it because you keep using the word "comprehensive." I need a new definition of that too because you use it a little loosely and I have some problems understanding what you mean by the term "comprehensive."

Mr. WEBB. One should not be left with the impression while the Federal Government may not have the kind of specific standards or database, that doesn't mean the States have been left in a kind of a laissez-faire, do what you want to do. We have an extremely difficult—and Dr. Primm can attest to this, licensing, quality assurance process that we do on an ongoing basis. Every program is at least reviewed and assessed on an annual basis. We have updated reporting requirements. We have 500,000 people in our database and we're constantly measuring programs in terms of their effective-

ness and in terms of cost. Probably one of the most frustrating things for all of our providers is the ongoing ability to pay for the expanded services.

So, we do know who are our better providers, what's going on, who should get the new dollars and in cases—I mean to have not just have a notch on my handle, but on cases where we don't have compliant programs either in terms of cost, quality or access, they're out of business. So, I don't want to leave you with this impression, especially from a Congressman from New York State, that these funds are just kind of handed out on a kind of a favorite kind of basis. That's just not the way it's done at all in New York. We've had a long-term history of a quality assurance program.

Comprehensiveness. This is where we need to grow. You cannot treat someone without thinking about their family, their employment opportunities, their related health care needs. You just cannot treat anybody that way. Someone coming out of prison, 21,000 individuals in our State come out of prison every year. 21,000. More than half need ongoing substance abuse and alcohol treatment. We're not even close to that number. That individual coming out of prison gets first 30 days, $50 check and that's it, they're out on the street again. That's not the way we should be doing it.

So, what we're trying to do, when I say comprehensive, that person should leave with a program in hand, a case manager if you want to use the modern terminology, a social worker, employment opportunity, a place to live. That's what I'm talking about, some very basics. I'm not talking about some high fallutin' kind of thing coming out of the social work schools or one of those kinds of things. These are basics, now, in all due respect to my social workers.

But when you have 30 percent of our individuals in the homeless shelters who have had a previous criminal justice history, why has that happened? They don't have a place to live. We need a Federal housing policy. We need to start talking about some of those kinds of basic needs and where it happens. So, when I say talk comprehensive, I'm not talking about some pie-in-the-sky kind of stuff.

Mr. TOWNS. I was hoping that was what you were talking about, when you say "comprehensive." I was also hoping that you would include the fact that the person would have an opportunity to be involved in more than one type of treatment. For instance, if that person does not work out in this particular program, that you would have the opportunity to move him or her to another one. I was hoping that you would in some way or another include that, because I think so often we are caught up in a situation where we force a person into a certain type of treatment and it just might not be the right type of program for that individual.

Mr. WEBB. And this is where we need a lot of work. Someone shows up at the door of a therapeutic community or methadone maintenance or what-have-you, one shoe doesn't fit all.

Mr. TOWNS. Right.

Mr. WEBB. We need assessment. In fact, Dr. Primm has promoted this "target cities," which we are one of the recipients, one out of eight cities in the whole country to actually demonstrate our ability to assess, diagnose and properly place. I'm not saying we have a

perfect system. We have a long way to go to match the right service in terms of the needs of the individual.

Mr. GILMAN. Would the gentleman yield?

Mr. TOWNS. I'd be delighted to yield to the gentleman from New York.

Mr. GILMAN. Mr. Webb, how much does the State allocate to your division?

Mr. WEBB. We spend approximately $400 million public dollars, only 18 percent of which are Federal dollars. All the rest are State and local dollars, Mr. Gilman.

Mr. GILMAN. $400 million for your office?

Mr. WEBB. Yes.

Mr. GILMAN. And how much of that is Federal?

Mr. WEBB. Eighteen percent.

Mr. GILMAN. Thank you.

Mr. TOWNS. Yes, Dr. Primm.

Dr. PRIMM. Could I say something to that, Mr. Towns?

First of all, Mr. Webb is correct in saying that some States, and New York is an example, monitor very, very closely drug treatment programs. Drug treatment programs in New York are monitored more than any other programs dealing with health in this country. I can attest to that.

You talked about knowing what happens to the money that we are spending, the block grant dollars, that go into the States. The discretionary dollars, the demonstration grants that come out of my office, or the Federal Government, for drug treatment and prevention are awarded on a competitive basis.

We put out an initiative or request for applications or proposals on a specific area of concern that has been proven to be efficacious by research and previous study. That initiative is responded to by providers through the States.

A Federal review panel, composed of experts in the areas of treatment and prevention, looks at these applications and makes a determination on which serve our purposes the best according to the guidelines specified in the initial requests for applications. Those applications are given a priority score and grant dollars are awarded according to those scores. It is highly competitive. Then we go out and evaluate those programs and follow them up to see if they are doing what they said that they were going to do in their initial application.

Mr. TOWNS. Mr. Chairman, I know my time has expired, but can I ask half a question?

Mr. RANGEL. OK.

Mr. TOWNS. What are we doing in the area of research?

Dr. PRIMM. A lot. Are you asking me in terms of——

Mr. TOWNS. I am asking anyone to respond.

Dr. PRIMM. Well, I think there is a considerable amount of research going on in ADAMHA. The research arms of ADAMHA: The National Institute of Mental Health, the National Institute of Alcoholism and Alcohol Abuse and the National Institute of Drug Abuse are all doing research relative to this issue and comorbidity, the co-occurrence of these three disorders, and what to do about them. We have an ongoing medication development division within the National Institute of Drug Abuse that is looking at substitution

therapy for cocaine use and for other drug use, combinations of different modalities of treatment. All are being participated in by those three agencies.

So, research is alive and well. I certainly would like to see a little bit more concentration on service delivery at this juncture.

Mr. RANGEL. Dr. Primm, of all the research in the last 25 years with the billions of dollars that have gone into research, the only thing that I know that has really come out that's been accepted has been methadone.

Dr. PRIMM. Well, that is only partially true, Mr. Chairman. There is buprenorphine.

Mr. RANGEL. But is it used in New York State?

Dr. PRIMM. Well, they are still under investigation.

Mr. RANGEL. Oh, I know they still research them, but I meant—and I know it takes time to find——

Dr. PRIMM. There's substitution therapy now being looked at for cocaine use and——

Mr. RANGEL. Listen, I'm optimistic. I just know that all we've been able to come up with is methadone because I've been looking for some other solution.

Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman. I just have two quick questions.

One, it was indicated or I was aware that in the latter part of the summer two institutions, two hospitals were selected for treatment, one in New Jersey and one I think somewhere out on the west coast. I'm just curious to know how that New Jersey institution was selected. We're glad that it is in the State, but how does the Department intend to see that there is a mix and that there are all kinds of persons made available to participate in the treatment center up there in Harmon Cole somewhere because if you're looking for——

Dr. PRIMM. Secaucus, Mr. Payne.

Mr. PAYNE. Yes. If you're really looking for the most isolated place in New Jersey, I guess second from the Stokes State Forest, Secaucus is really not that accessible. It's out of the urban settings. If you're looking for community participation, it's almost absent of the type of community where this problem is so prevalent.

What kind of a model and how—I'm sure you thought about it. How do you intend to involve people from the urban centers like a Newark or Camden, New Brunswick, unless it's to be done only in a research sort of atmosphere without community suggestion or participation?

Dr. PRIMM. Let me begin by answering your first question. One of the most highly competitive grants that we have made is a cooperative agreement. This is an agreement between the State and the Federal Government and, of course, the providers who are providing those services at Secaucus. There were five applicants for these dollars to create drug treatment campuses. The idea originated in New York State by Lieutenant Governor Lundine and Mitch Rosenthal who is the director of Phoenix House. Of course, New York was one of the applicants for those dollars.

New Jersey and Texas were the recipients of the award. We looked at it from a geographical point of view, and we looked at it

from the merit of the application that came from the State. Secaucus is an area probably where we got the least resistance and opposition to the location of a treatment campus of 500 people or more who may come from the surrounding areas, sent there to participate in therapeutic communities. One would maybe have a 6-month stay, one would have a 9-month stay, one may even have a 3-month stay with a central intake unit, central services, medical services, and so forth. Sort of a drug-free campus to look at different modalities and compare the outcomes of different modalities because we have long since known that in drug treatment there are different strokes for different folks.

Mr. TOWNS. What about social workers?

Dr. PRIMM. Very little treatment for social workers. But the point I am trying to make here is that we need a handle on what is good for a specific individual, and these treatment campuses will do that. I was very happy with the application that came from New Jersey and you should be proud that we feel that it will be a highly successful research project that will give us guidance of what to do in other places around the United States. The other one, of course, is in Houston, Texas.

I think that answers your question.

Mr. PAYNE. I'm glad to hear that and we were proud that it was in New Jersey. My only concern was that it's accessible and now you've addressed that and explained that people from throughout the State will benefit, and that it will be done by the State, that the State would know where potential clients are located currently and even in the general northeast region. I just didn't want it to be restricted.

As we've seen in, for example, clinical tests in New Jersey, in the CDC or NIH programs, there haven't been any real clinical studies done in the city. They've been out in Robert Wood Johnson, down in suburban Somerset County and the people that would normally benefit from a program of that nature are people that you have to really concentrate on getting to the site where they should have their treatment. There are a lot of people who lack a lot of the basic initiatives. So, to be down in some suburban area to have clinical tests that are non-residential, it leaves a total population finding these services inaccessible. So, that was my only concern about accessibility to a broad spectrum of potential clients.

Dr. PRIMM. These are long-stay facilities and the people will be drawn from Northern New Jersey towns, including your town, Newark and of course Jersey City, Paterson, et cetera. So, the draw will be from those places.

I wanted to comment on something else, Mr. Chairman, if you will allow me. You all have often heard me talk about a supermarket of services. Congressman Towns had asked about what happens when a patient might come to one program using a drug or a combination of drugs that cannot be helped in that particular program. Well, I think drug treatment programs, where feasible, should offer a comprehensive array of services. So, from the shelf of that supermarket, one could take what one needed to do something about the problem.

Now, in many instances, that is very difficult to do because we are talking about an expenditure that is too great to create techni-

cians for all of these different things. However, what we are encouraging, and Mr. Webb mentioned this, is the networking, is the using those services, case management, those services that exist in the community already to serve some of those needs. That has not been done in our country. People who are in alcoholism treatment programs don't want to treat somebody who may be a heroin user who is being treated therapeutically with substitution therapy because they just don't want that person there.

There also must be after-care services. This is a chronic disease. The Chairman asked, how many people do you know after 2 years are free of drugs and that's a very difficult question. They might be free of drugs after 2 years, but maybe in the third or the fourth or the fifth year that person may relapse. This is a chronic problem that must have our attention throughout the continuum of this disease. After one comes out of formal drug treatment, they still should remain in Narcotics Anonymous, Alcoholics Anonymous, Cocaine Anonymous, whatever alphabet soup that is out there that allows that individual to stay a productive, functional citizen and free of drugs. So, I think that is how we have to see this problem, no other way.

Mr. PAYNE. Just my last short question and you kind of touched on it. We saw also the weed and seed program start and Trenton, New Jersey was one of the cities selected. Now, we've seen the weed part start. They've locked up some people and so forth and there are more prosecutors and law enforcement people added in Trenton. I'm concerned about the seed part though. That's the difficult part. Do you know whether there will be as much interest in the seed part, the putting in the community the things that are missing, the rehabilitation, the whole fact of the environment and all that? Can anyone comment on the seed part of the weed and seed program?

Mr. WEBB. In one program that I'm aware of what we're trying to do in New York City, that hasn't happened yet, the seed part.

Mr. PAYNE. And that's my concern too. It hasn't happened in Trenton either. We're into the weeding part and that's good. We need to weed it out. But I hope that they don't forget the seed part because you can just keep on weeding and if you don't put in the community what's needed to try to prevent drug abuse and promote opportunity; job opportunities and all the other things, then you just might as well call it weed and weed.

Mr. WEBB. Well, we're taking the weed piece in terms of our tactical strike teams in the city of New York, which has done an enormously good job. The seed piece is what we're doing with the city police department called C-POPS, our community policing officers. So, specifically starting with drug free school zones, we are working and training the police force in the city of New York to specifically deal with what they would observe other children engage in other kinds of things and hooking those C-POPS, we call them C-POPS, community policing, into drug programs. We have a number of those demo sites. So, we're at the beginning pieces of the seeding, not yet to see the flourishing yet.

Dr. PRIMM. The Robert Wood Johnson Foundation and the Office of Substance Abuse Prevention have funded a project. It may not be the specific weed and seed program that you are talking about,

and it just slips my mind now what that particular effort, initiative is——

Mr. PAYNE. It's the fighting-back initiative. We have one of the grants. As a matter of fact, tomorrow we are going to have the final site visit where we're hoping Newark will be the recipient of a $3 million grant from Robert Wood Johnson Foundation on the fighting-back initiative which is the one you're talking about.

Dr. PRIMM. The Century Fund, headed by Mr. Grinker in New York, a former HRA Commissioner, along with the Department of Justice of the Federal Government, also have a program. Now we're seeing efforts from foundations and private funding sources, along with public funding sources to do the job that's necessary.

Mr. PAYNE. We'd really like to get the Federal Government involved if we do get the fighting-back initiative additional grant from Robert Wood Johnson, then to tie that into some weed and seed and sort of complement and really have a real demonstration project going. So, if Newark gets that award tomorrow, we'd certainly be back in touch with your office.

Mr. RANGEL. Well, the Committee wants to monitor that because we want to make certain that we can get as close to comprehensive as we can because that's what works.

Just a little housekeeping before we adjourn. The Commission on AIDS advocated needle exchange and, of course, Dr. Sullivan is a member of that Commission. I assume he did not concur with that recommendation.

Dr. OSBORN. The National Commission on AIDS has 12 voting members or had 12. We lost one of our members whom we mourn, Belinda Mason. And then we have three members who are ex-officio by virtue of their Cabinet appointments, Dr. Sullivan, Secretary Cheney and Secretary Derwinski. We have since the beginning honored the sense of that arrangement which gives us the very valuable input of those three Cabinet departments.

Mr. RANGEL. I agree with you, but I'm just saying that there's no evidence that he's changed his position as being in opposition.

Dr. OSBORN. I'm not aware of any. I think that you certainly wouldn't want to infer it just directly from the report.

Mr. RANGEL. Right. And, Dr. Primm, you would not know whether or not the Secretary has changed his position?

Dr. PRIMM. I do not think we should speak of opposition to it. I think there is nonconcurrence; that it is as efficacious as has been reported.

Mr. RANGEL. That is your position and that's unequivocal. That's for the record. That's good enough. I assumed that was his position all along, whatever that is.

Let me say this. I want to talk about comprehensive and I want to talk briefly about monitoring. When you, Mr. Webb, were talking about comprehensive, it was very moving as to what a person needs who comes in to treatment with no skills, has spent time in jail, has no job and is addicted to drugs. So you make him drug free and he's probably in the category of people who don't stay the 30 days. You know, a meal, someone to talk with, a shower, and he's back on drugs.

What rough percentage of people who enter New York State's programs, and I know the high level of monitoring that we have,

but what percentage of our clients fall into that category that they can't receive comprehensive treatment and some don't want it?

Mr. WEBB. And some don't want it. I mean, that's part of the reality. About 50 percent of all our clients——

Mr. RANGEL. Well, what we basically are saying——

Mr. WEBB. Let me finish the statement. Fifty percent of all our clients who show up at the front door in residential settings leave in the first 30 days. In methadone maintenance where we have anywhere from 30 to 35 percent turnover, those are our two main treatment modalities.

Mr. RANGEL. Dr. Primm was shaking his head to affirm everything you were saying. And so really what we're faced with, you know, is not the degree of monitoring that you have. You don't monitor, Mr. Towns, these people who just come in to get straight for a while and then leave. I mean, there's nothing more. That's how Mr. Coughlin, can tell you who came in, how long they stayed and the fact that they left.

And so, the only time you can really check is when you've found somebody who wants to be treated and you have the resources to give the type of treatment that he or she needs. And unfortunately, we have not really reached that goal on the local, State, or Federal level and I submit that we're just wasting a lot of money.

Now, do I say spend more money? Yes. Why? Because it's better than nothing. At least they're walking in off the street. At least they're trying to reach out. But until we can find out not what we have researched as to what other chemicals we can come up with, because the General Accounting Office said that all these billions of dollars spent on what chemicals we need—I'm not a very religious person, but we don't need any more than what comes out of Matthew, staying out of jail, getting something to eat, the ability to get a job and to be cared for by your family and friends and to have some status in the community.

And I don't see how we're going to reach that when we have an administration that will not support the type of initiatives, except for the thousand points of light, that are going to allow a person to say, "I want treatment." And after the 30 days when they say, "Well, Mr. Webb, I am now off drugs. Now what? You tell me that you can't educate, you can't train me. You can't do anything. Where do I go?" And so I think that's where we're going to have to get some research, Dr. Primm.

And I'm not that concerned about the 50 percent that you cannot take care of, because that's not going to happen as long as we have the same type of political understanding as to where the resources are going to come from, but at least we can concentrate what limited resources we have with research to see what is working and what is needed.

And it may turn out, as we found out in Bolivia, that crop substitution really wasn't just substituting a crop. It was improving the economy. And it could be that we just have to provide job opportunity, homes, and some hope, and that could be the best modality after you've made them drug free.

Dr. Primm.

Dr. PRIMM. Let me comment on that, Mr. Chairman. We are now working with the Housing and Urban Development Department

and the Department of Labor. We have ongoing joint programs. We are involved in initiatives to do something about the problem just as you laid it out, with housing, education, vocational involvement, et cetera, and I think you are going to see quite a change.

Mr. RANGEL. Dr. Primm, it hurts me to hear you talking like that, because we are doing so little in housing on the Federal level that my mayor's biggest problem is to fight between the rehabilitated drug addicts, the homeless, and the working poor, and it is really sad to see the people on the lowest rung of the economic ladder trying to get into these limited houses that we have.

The Federal Government is not involved in providing shelter. I mean, they've been out of this since Sam Pierce. They've been out of it for a long time. So, I don't know what it's going to take to be able to—if you had the best program in the world, you put the person out and you don't even give him the $50.00 a convict gets coming out of prison. It's sad and I don't know what kind of research—I expect doctors and scientists to come up with research to say, "You can get Rangel all the chemicals you want, but if an addict is just as dumb when he is finished becoming detoxified as he was before he went on drugs, what now are you going to do for him?" And you've got to send him back to the churches and temples.

What percentage of the programs are run by churches?

Mr. WEBB. I don't know what the percentage is. We use the churches and community associations extensively.

Mr. RANGEL. I know, but the church isn't involved. I mean, the thousand points of light and drug rehab ain't there.

Mr. WEBB. But to pick up on——

Mr. RANGEL. Unless there's some public dollars.

Mr. WEBB. I understand, but I want to pick up on Dr. Osborn in terms of the twin epidemics. We have to use every mechanism we can to get people into treatment. We should seriously keep an open mind about needle exchange. We should do everything we can about street outreach and not let these programs die. We have to be non-traditional about our ability to get people into treatment and also work on the assumption that these people do want to get better as opposed to, "They're never going to get better, so don't do anything." We can fall into that trap very easily.

Mr. RANGEL. Well, I'm not because I support what we've got. But I want those who are researching to come up with at least what we should be working toward.

Let me thank you. We have to run and vote. There has been some exciting news. I feel a lot better in knowing what's occurring.

Dr. PRIMM. I want to thank you, Mr. Chairman, on the part of the Secretary of the Alcohol, Drug Abuse and Mental Health Administration.

Mr. COUGHLIN. A very good hearing. Thank you very much.

Mr. RANGEL. Thank you.

Dr. PRIMM. Thank you.

[Whereupon, at 3:47 p.m., the committee was adjourned.]

APPENDIX

National Association of State Alcohol and Drug Abuse Directors, Inc.

November 8, 1991

President
John S. Gustafson
New York

First Vice President
Geraldine Sylvester
New Hampshire

Vice President for Alcohol Abuse Issues
Janet Zwick
Iowa

Vice President for Drug Abuse Issues
Patricia A. Redmond
Georgia

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Texas
Sue Giles
Missouri
John Allen
North Dakota
Andrew M. Mecca, Dr. P.H.
California
Ken Stark
Washington

Executive Director
William Butynski

Honorable Charles B. Rangel
Chairman
Select Committee on Narcotics
Abuse And Control
234 Ford House Office Building
Washington, D.C. 20515-6425

Dear Chairman Rangel:

On behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) I would like to thank you for the opportunity to submit our written statement into the record which addresses the recent GAO study of the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant.

The States are in agreement with GAO that data collection and analysis are important undertakings to assist the Congress, the Executive Branch and the States to understand how ADMS Block Grant funds are utilized. However, before new data collection systems are implemented, the State Alcohol and Drug Abuse Agencies encourage the Congress, GAO and HHS to assess the role of the many existing federal data instruments and systems now utilized by such agencies as the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), the Office for Treatment Improvement (OTI) and their parent agency the Alcohol, Drug Abuse and Mental Health Administration. We are aware of at least ten (10) national data collection efforts currently underway that should be reviewed to determine what information is already being collected, where gaps exist and what new information, if any, is needed.

The Office of National Drug Control Policy (ONDCP) and the Congress are currently discussing implementation of a State prevention and treatment plan that would require States to provide needs assessment and related information and to report on the use of ADMS Block Grant funds. We are hopeful that when implemented this new system will provide the answers to many of the questions asked by the Select Committee on Narcotics Abuse and Control, other Members of Congress and the Administration.

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As Congress and the Administration consider additional data collection mechanisms, the State Alcohol and Drug Abuse Agencies encourage the continued inclusion of alcohol-related information. We are concerned that since OTI and the ONDCP focus primarily on drugs other than alcohol that data reporting systems may not be designed to reflect the total drug abuse needs, as well as State and Block Grant supported prevention and treatment services. The States and local communities are well aware that our Nation's drug problem is not solely an illegal drug abuse problem. Also, the Congress should ensure that any new data systems are developed in meaningful collaboration with the State Agencies who must provide the information.

I. HISTORICAL PERSPECTIVE

Prior to the advent of the ADMS Block Grant, States were required to provide a variety of comparable data to the federal government. Since the ADMS Block Grant, States have been concerned about the federal government's initial lack of interest in collecting comparable national data and have been working voluntarily with several federal agencies to ensure that information about funding and services is collected, analyzed and made available to all interested parties, including the U.S. Congress.

NASADAD and the States recognize that over the course of the last 10 years, we have lost the ability to collect and analyze some comparable national data and that this has hampered recent efforts to determine the nature of our alcohol and other drug abuse problem and to fashion a national strategy and course of action.

II. PRESENT SITUATION

Since 1981 the States have continuously provided nearly fifty percent (50%) of the total expenditures for treatment and prevention programs throughout the country. For Fiscal Year 1990, the alcohol and drug expenditures were $2.911 billion in which the federal government provided approximately twenty-nine percent (29%), while the States provided nearly forty-eight percent (48%), county and local government seven point five percent (7.5%) and the other roughly fifteen percent (15%) was from other sources such as client fees, court fines and reimbursements from private health insurance.

The State Alcohol and Drug Agencies wish to continue and expand cooperative and collaborative State/Federal data collection and analysis efforts while minimizing duplication of data collected from the programs (10 or more data collection systems are already utilized by the federal government).

It would be difficult for States to revise and expand their current data collection systems without resources. Therefore, it would be helpful for the federal government to allocate specific funds to the States for the purpose of collecting the data deemed necessary by the federal

government, State Agencies and the relevant national State associations (i.e., NASADAD and NASMHPD).

Even though the original Block Grant legislation prohibited the federal government from requiring States to submit certain information, the State Alcohol and Drug Agencies took the initiative to work with NIDA and NIAAA to design relevant and systematic data that would be voluntarily collected and provided by the States and the federal government, i.e., the State Alcohol and Drug Abuse Profile (SADAP).

We are concerned that the GAO report does not mention ongoing efforts undertaken by NIDA and NIAAA to work with State Alcohol and Drug Abuse Agencies and NASADAD to design and collect important data. For example, since 1983, NASADAD has conducted the State Alcohol and Drug Abuse Profile (SADAP) and has collected fiscal and services related information from the States, as well as narrative responses to need, policy and other questions.

States coordinate and encourage local provider participation in the National Drug and Alcohol Treatment Unit Survey (NDATUS) which collects valuable data from private and public treatment programs. State Alcohol and Drug Agencies are also working cooperatively with NIDA and NIAAA to implement the Client Data System (CDS) to collect a basic core of information on all clients entering State supported treatment programs. All States are expected to have this system up and running by mid-1992. Systematic discussions are already underway to determine how this new client data system will be expanded to collect discharge data.

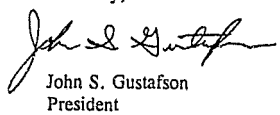
III. DIFFICULTIES

In order to have all the States become involved in this process, the federal government along with the State Alcohol and Drug Agency Director's need to work in a cooperative venture that will be beneficial to all parties. There are fundamental questions that need to be addressed and an open dialogue must be maintained. Some of the questions that have been raised are; the issue of structuring the reporting requirements, what information needs to be collected, who will be analyzing the data, and most important, who will provide the necessary funding to complete the process.

States have also been working with OTI to design and implement a state planning and reporting system that will enable uniform comparable data to be collected by the States on the use of ADMS Block Grant dollars. As an example of this cooperative effort, State Agencies were asked by OTI to review and comment on the revised ADMS Block Grant application. Unfortunately, States were initially given only five days to review and comment on the 116 page document. Subsequently, OTI has recognized that the federal government must establish more realistic timetables and procedures for eliciting State Agency input and for implementing new data collection mechanisms. More recently, cooperation has improved.

State Agencies and their relevant national associations look forward to the opportunity to participate in ongoing dialogue to develop a collaborative process for the collection of additional data that will be of value to all parties concerned. The States welcome the occasion to provide input and to work collaboratively to meet growing State and federal needs.

Sincerely,



John S. Gustafson
President

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