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HHS DRUG TREATMENT SUPPORT: IS SAMHSA OPTIMIZING RESOURCES?

HEARINGS

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

FEBRUARY 17 AND MARCH 14, 2000

Serial No. 106–153

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

67–551 DTP WASHINGTON : 2001

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HHS DRUG TREATMENT SUPPORT: IS SAMHSA OPTIMIZING RESOURCES?

THURSDAY, FEBRUARY 17, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:13 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Souder, Mink, Cummings, and Kucinich.

Staff present: Sharon Pinkerton, staff director and chief counsel; Don Deering, congressional fellow; Mason Alinger and Frank Edrington, professional staff members; Lisa Wandler, clerk; Cherri Branson, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. MICA. Good morning. I would like to call this hearing of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources to order.

I apologize for the delay. Several other Members are involved in other committee business.

This morning we are conducting a hearing entitled, "HHS Drug Treatment Support: Is SAMHSA Optimizing Resources?"

I will open first with my opening statement and recognize other Members, and then we will hear from our witnesses. I think we have three panels today.

Our subcommittee is conducting this oversight hearing today as a part of a series of hearings to examine programs and agency operations within the Department of Health and Human Services. This subcommittee is particularly interested in agencies with critical responsibilities in implementing our national drug control strategy.

The Substance Abuse and Mental Health Services [SAMHSA], as we refer to the agency, is the Federal agency before us today, and its support for drug treatment is the focus of our hearing.

National estimates of Americans in need of drug treatment range from 4.4 to 8.9 million, yet less than 2 million people reportedly receive treatment. This gap of course must be addressed since drug treatment needs today, unfortunately, are predicted to grow, not diminish.

SAMHSA's block grant program is a key element to reducing the gap as States and communities provide direct services and each

block grant dollar spent on treatment generates $1.50 in additional State or local treatment spending.

SAMHSA claims to be contributing to the first three goals of our national strategy, which I will paraphrase. The first goal is educating and enabling youth to reject illegal drugs and tobacco. The second goal is reducing drug-related crime and violence. And the third goal is reducing the cost of drug abuse.

To achieve these goals, SAMHSA must optimize its resources. It must also provide the most efficient and effective support possible for State and community drug treatment efforts. Today, we will investigate whether this is happening and what should be done if, in fact, it is not.

As we will hear, States and communities are making progress in their drug treatment efforts but continue to have pressing needs. Every drug treatment dollar received by those on the front line is extremely vital.

We will learn that the Federal Government should allocate resources to support more successful treatment programs that will serve more clients, and that is one of my major concerns is that we reach out and serve more people, but with more successful programs. We will also learn that SAMHSA has an inordinate administrative cost in overhead, and somehow we must reduce the red tape and bureaucratic obstacles that hinder service to the States and also these local communities programs that are so effective. In doing so, SAMHSA can better achieve the goals of our national drug control strategy.

Our first panel today represents local treatment efforts on the front line of the drug epidemic. We will hear testimony from local treatment providers both public and private indicating that every treatment dollar makes a difference.

One witness is concerned that Federal funds are not available to help establish a needed local treatment facility. As a result, clients must travel significant distances outside their community.

We will also hear from a client how effective drug treatment enabled her to overcome addiction and to reclaim her life. Another treatment provider represented here today is faith-based. Some of our most successful programs, in fact, are faith-based. This provider's counseling and work elements apparently did not match traditional public treatment facility licensing criteria, thus preventing the program from qualifying for Federal support.

Worse yet, Federal food stamp assistance for its clients has been cutoff, even though clients would continue to receive food stamps had they remained on the street abusing drugs. There is something dramatically wrong with this picture.

Should Federal assistance not reach deserving clients and programs that work even though the program uses religious or faith-based counseling and work as treatment elements?

Our second panel will address the State perspective, where most drug treatment is actually funded and administered. We will hear from the General Accounting Office. GAO has provided descriptive data on what SAMHSA is doing with its resources. This data provides a basis for further questions regarding how agency efficiencies and effectiveness can be improved, a topic we will explore in this hearing.

GAO data indicates that about 80 percent of SAMHSA's substance abuse grant funds flow to the States through block grants managed by about 11 percent of the agency's staff. The remaining 89 percent of SAMHSA's staff is engaged in Washington-based discretionary grants or other agency activities. To me, this represents some sort of a misallocation of personell and resources based upon the mistaken belief that Washington knows best. I think our experience has shown us just the opposite.

We have witnesses from several State programs that are successful in breaking the train and chain of drug addiction, restoring families, and creating productive citizens and saving lives really needs to be the goal of all of these programs and some of them are successful, some of them are not.

The States that have some successful programs are New York, and we visited one of those programs. I do not think the members that are here today got to go with us but the DTAP program was extremely successful in Texas and Washington. GAO has commended these States for their successes in a number of drug treatment areas.

We look forward to learning more about what works in these and other States and hearing about their successes and how we can pattern them.

We also have a witness who will address the topic of evaluation. We need to understand how drug treatment works and what, in fact, works best. Still, we do not need to reinvent the wheel or spend hundreds of millions, sometimes billions of dollars, on interesting but unnecessary Washington based research at the expense of precious treatment dollars.

Last week, the SAMHSA administrator, Dr. Chavez, testified on the effectiveness of current drug treatment programs. She stated,

> An evaluation of treatment programs funded by the Center for Substance Abuse found a 50 percent reduction in drug abuse among their clients in 1 year after treatment. Our services research outcome study produced similar findings 5 years following treatment. We have achieved success that can parallel or exceed the results of patients receiving treatment for other chronic illnesses like diabetes, hypertension, and asthma.

Citing a 48 community study that found significant reductions in drug and alcohol abuse among males, Dr. Chavez concluded, "We know what works in prevention and treatment." That is important for us to also know as a subcommittee in Congress that funds these programs.

While I agree that we must continue to evaluate drug treatment programs, I do not agree that the States like New York, Texas, or Washington must rely on advice and mandates from all from Washington, DC.

These States have fine universities that are quite capable of conducting rigorous research and evaluation. States can easily find talent in Washington, DC, or other locales when needed, but States remain the true laboratories of democracy where most innovation does, in fact, occur.

Furthermore, States are quite willing to share data and results with others and the Internet also is a new mechanism to provide an efficient way to carry that out.

Our final panel today will include an official from SAMHSA's Center for Substance Abuse Treatment. It is my hope that she and other SAMHSA officials will provide this subcommittee with the answers to questions that we have relating to agency activities and operations.

Among the questions which we need to obtain the answers for some of the following: Why our States forced to undergo so much bureaucratic red tape to receive their block grants? I understand that some States invest more than 400 man-hours just completing the applications. If the IRS can accept an electronic tax return and immediately send a refund, other Federal agencies should be just as efficient.

Why does SAMHSA choose to award such a large percentage of its moneys through discretionary grants called knowledge development and application [KDA], and targeted capacity expansion [TCE], grants? Why are these grants not coordinated with the States, which may be forced to pick up their funding later?

Does SAMHSA really have superior knowledge and are States clamoring for more Federal guidance? I think not.

The National Governors Association and the National Association of State and Alcohol and Drug Abuse Directors favor more consolidated block grants, more State flexibility, and less red tape. I remain very concerned with the allocation of SAMHSA's staff and resources.

While 59 staff are dedicated to all State block grant activities, including mental health, prevention and treatment combined, the Office of SAMHSA Director alone has 73 staff, furthermore, 139 staff in the agency's three centers are assigned just to KDA discretionary grants.

I am concerned that SAMHSA's enormous administrative costs in the GAO reports in 1999 fiscal year, SAMHSA's administrative costs were more than $150 million. Now, if we could just divide that by 50 States and add $3 million to each State rather than support this huge Washington bureaucracy, how many people could be treated for that amount?

It is also unclear to me why SAMHSA is spending tens of millions each year for research when the National Institute on Drug Abuse was established as the primary research agency. Is NIDA not conducting practical research applicable to treatment evaluation and delivery? If not, why not?

Finally, SAMHSA has a problem for which a statutory cure may be needed in order to protect State treatment funds. The problem is that SAMHSA's enforcement of the Synar provision within the Substance Abuse Prevention and Treatment block grant. The provision, established in 1992, requires States to reduce smoking. It provides a 40-percent reduction in block grants for State inaction.

In recent years, SAMHSA has moved to impose unreasonable requirements on States, including State-specific annual target rates. As a consequence, in fiscal year 2000, seven States and the District of Columbia stood to lose millions of drug prevention and treatment dollars, but Congress provided them a 1-year conditional reprieve.

I understand that SAMHSA has rescinded its guidance to these States and still has not issued new guidance. Why the delay? Other States, in fact, are at risk of losing funds, much needed funds, in

the future. Does it make sense to deny desperately needed State treatment funds because progress regarding youth smoking does not satisfy SAMHSA? That is a question I think we are also going to have to ask today. The Nation's drug czar, the States, and others think not. This needs to be fixed, and SAMHSA should act now.

[The prepared statement of Hon. John L. Mica follows:]

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INDEPENDENT

OPENING STATEMENT
Chairman John L. Mica

Subcommittee on Criminal Justice, Drug Policy and Human Resources

February 17th, 2000 Hearing:

"Drug Treatment : Is the Federal Government Optimizing Resources?"

Our Subcommittee is conducting this oversight hearing today as the part of a series of hearings to examine programs and agency operations within the Department of Health and Human Services (HHS). This Subcommittee is particularly interested in agencies with critical responsibilities in implementing our National Drug Control Strategy. The Substance Abuse and Mental Health Services Administration (or "SAMHSA" as we refer to the agency) is the federal agency before us today, and its support for drug treatment is the focus of this hearing.

National estimates of Americans in need of drug treatment range from **4.4 to 8.9 million**, yet less than **two million** people reportedly receive treatment. This "gap" must be addressed, as drug treatment needs are predicted to grow, not diminish. SAMHSA's block grant program is a key element in reducing the gap, as states and communities provide direct services and each block-grant dollar spent on treatment generates 1.5 dollars in additional state or local treatment spending.

SAMHSA claims to be contributing to the first three goals of our national strategy (which I will paraphrase): **Goal 1**: Educating and enabling youth to reject illegal drugs and tobacco; **Goal 2**: Reducing drug-related crime and violence; and **Goal 3**: Reducing the costs of drug abuse. To achieve these goals, SAMHSA must optimize its resources, and provide the most efficient and effective support possible for state and community drug treatment efforts. Today we will investigate whether this is happening, and what should be done if it isn't.

As we will hear, states and communities are making progress in their drug treatment efforts, but continue to have pressing needs. Every drug treatment dollar received by those on the front-line is vital. We will learn that the federal government should allocate resources to support

more successful drug treatment programs that will serve **more** clients. We also will learn that SAMHSA has inordinate administrative costs, and must reduce red tape and bureaucratic obstacles that hinder service to the states. In doing so, SAMHSA can better achieve the goals of our National Drug Control Strategy.

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To me, this represents a misallocation of personnel and resources, based upon the mistaken belief that Washington knows what is best. Experience has shown us the opposite.

We have witnesses from several states programs that are successful in breaking the chains of drug addiction, restoring families and productive citizens, and saving lives. The states are New York, Texas and Washington. GAO has commended these states for their successes in a number of drug treatment areas. We look forward to learning more about what works in these and other states.

We also have a witness who will address the topic of evaluation. We need to understand how drug treatment works and what works best. Still, we do not need to reinvent the wheel or spend hundreds of millions of dollars on interesting but unnecessary Washington, DC-based research at the expense of precious treatment dollars. Last week, SAMHSHA Administrator Dr. Chavez testified on the effectiveness of current drug treatment programs. She stated:

> **An evaluation of treatment programs funded by the Center for Substance Abuse (CSAT) found a 50% reduction in drug abuse among their clients one year after treatment. ... Our Services Research Outcomes Study produced similar findings five years following treatment. We have achieved success that can parallel or exceed the results of patients receiving treatment for other chronic illnesses like**

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Why are states forced to undergo so much bureaucratic red tape to receive their block grant funds? I understand that some states invest more than 400 man-hours just completing the applications. If the IRS can accept electronic tax returns and immediately send a refund, other federal agencies should be just as efficient.

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percent reduction in block grants for state inaction.

In recent years, SAMHSA has moved to impose unreasonable requirements on states, including state-specific annual target rates. As a consequence, in FY 2000, seven states and the District of Columbia stood to lose millions of drug prevention and treatment dollars, but Congress provided them a one-year conditional reprieve.

I understand that SAMHSA has rescinded its guidance to these states, and still has not issued new guidance. Why the delay? Other states are at risk of losing funds in the future. Does it make sense to deny desperately needed state treatment funds because progress regarding youth smoking does not satisfy SAMHSA? The nation's drug czar, the states and many others think not.

This needs to be fixed, and SAMHSA should act now!

I wish to thank all witnesses for appearing before us today. I look forward to hearing your testimony on this topic of local, state and national importance to our continued drug control efforts.

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MEMORANDUM

TO: **Members, Subcommittee on Criminal Justice, Drug Policy and Human Resources**
FROM: **John L. Mica, Chairman**
DATE: **February 14, 2000**
RE: **HHS Drug Treatment Support: Is SAMHSA Optimizing Resources?**

On Thursday, February 17, at 10:00 a.m., in room 2154 Rayburn, the Subcommittee on Criminal Justice, Drug Policy and Human Resources will hold an oversight hearing on the Substance Abuse and Mental Health Services Administration (SAMHSA). The hearing will focus on SAMHSA support for drug treatment services, including: 1) how effectively and efficiently federal resources are utilized; and 2) what improvements are needed.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

The Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services (DHHS), is responsible for supporting mental health and substance abuse prevention and treatment services throughout the country by providing technical assistance, categorical grants, and block grants to the states. Created in 1992 (P.L. 102-321), SAMHSA administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant, which provides funds to states for alcohol and drug abuse prevention, treatment, and rehabilitation programs and activities. SAMHSA also administers the Block Grant for Community Mental Health Services, which provides funds to states for mental health services and support through community mental health centers. In addition to administering the two block grants and providing technical assistance to states, SAMHSA funds children's mental health programs, services to mentally ill homeless persons, programs designed to improve the delivery of substance abuse and mental illness prevention and treatment services. SAMHSA's FY2000 appropriation is $2.65 billion: $1.96 billion for substance abuse related activities; $632 million for mental health related activities; and $59 million for program management (P.L. 106-113).

HISTORY OF FEDERAL SUBSTANCE ABUSE INITIATIVES

Over the last 30 years, Congress has created a variety of federal programs supporting the prevention and treatment of, and research relating to, substance abuse and mental illness. From 1974 through 1992 these activities were administered in DHHS by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). ADAMHA consisted of three research institutes:

National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institute on Drug Abuse (NIDA); and, National Institute of Mental Health(NIMH) and two service offices: Office for Substance Abuse Prevention (OSAP) and Office for Treatment Improvement (OTI). ADAMHA was responsible for administering the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant, the major federal program focused on these issues.

The ADAMHA Reorganization Act of 1992 (P.L. 102-321) replaced ADAMHA with SAMHSA, a services-oriented agency, transferred ADAMHA's three research institutes to the National Institutes of Health (NIH), and replaced the ADMS block grant with two separate block grants: 1) the Block Grant for Prevention and Treatment of Substance Abuse, which provides funds to states for alcohol and drug abuse prevention and treatment programs and activities, and the Block Grant for Community Mental Health Services, which provides funds to states for mental health services and support through community mental health centers. SAMHSA's support of drug treatment, through its Block Grants for Prevention and Treatment of Substance Abuse, will be a key topic of this hearing

SAMHSA PROGRAMS

SAMHSA is comprised of three centers that carry out the agency's mission of providing substance abuse and mental health services: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). The activities of CSAT will be a key topic of this hearing. In addition, six special offices focus and coordinate the agency's work in certain areas. These include the Office of Applied Studies; the Office of Managed Care; the Office on Acquired Immune Deficiency Syndrome (AIDS); the Office for Women's Services; the Associate Administrator for Alcohol Prevention and Treatment Policy; the Associate Administrator for Alcohol Prevention and Treatment Policy; and the Associate Administrator for Minority Concerns. SAMHSA's three centers administer the block grants, which account for about 75% of SAMHSA's budget. In FY1999, these grants totaled $1.874 billion, $1.585 billion for substance abuse prevention and treatment, and $289 million for mental health services. SAMHSA's remaining FY1999 budget was used to fund other SAMHSA grants and programs, including $53 million to program management.

THE SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

The substance abuse block grant, administered by the CSAT, is the primary tool the federal government uses to support state substance abuse prevention and treatment programs. The FY2000 appropriation for the block grant is $1.6 billion. Funds go directly to states, which have broad discretion to decide how to use them, within federal guidelines. Funds are allocated to states under a formula reflecting several factors: state personal income data; state financial resources; state population estimates, and the cost of providing services in each particular state. States participating in the substance abuse block grant are required to spend 35% of their grant for alcohol prevention and treatment related activities, 35% for drug prevention and treatment related activities, and 20% to provide primary prevention and education services to at-risk populations.

To receive their full block grant allocation, states must have a law providing that it is unlawful for any manufacturer, retailer, or distributer to sell tobacco products to individuals under 18. States must also have a mechanism for measuring compliance with the law, and for reducing non-compliance to specified levels. State block grants are conditioned upon providing specified levels of spending for women and children with special needs, and some states are required to set aside at least 2% of their grant for outpatient HIV services.

States may not use grant funds to provide inpatient services, except when medically necessary for substance abuse treatment., and when such services cannot be provided in the community. In addition, SAPT block grant funds may not be used to provide financial assistance to any entity other than a public or nonprofit private entity. Not more than 5% of grant funds may be used for administration.

This block grant includes a 5% set-aside which supports data collection, technical assistance, the National Data Center, and program evaluation. The set-aside has been used to fund National Household Survey on Drug Abuse, the Drug Abuse Warning Network (DAWN), the Drug and Alcohol Services Information System (DASIS), and the Alcohol and Drug Services Survey (ADSS).

Additional SAMHSA grants and programs include: the Community Health Services Block Grant, Knowledge Development and Application (KDA) Grants, Children's Mental Health Services Program, Protection and Advocacy grants, and Projects for Assistance in Transition from Homelessness.

Knowledge Development and Application (KDA) Grants

The primary source of SAMHSA's discretionary grant funding is the KDA program. The goal of this program is to develop new knowledge about ways to improve prevention and treatment services for substance abuse and mental illness, and to work with state and local governments as well as providers, families, and consumers to apply that knowledge effectively. KDA grants will not provide operating funds for service programs, except as required by the knowledge development activity.

SAMHSA claims that the new KDA approach is designed to identify policy and service delivery questions and problems of national concern, provide relevant findings, and ensure that information learned is used to improve state-of-the-art practice at the state and community levels. The KDA programs differ from research in that they are undertaken in actual service settings rather than in specially created and controlled environments. The KDA program includes funds for the Targeted Capacity Expansion (TCE) program designed to address gaps in treatment capacity by supporting strategic responses to demand for substance abuse (including alcohol and drug) treatment services at the state and local level. For FY2001, the President has proposed an additional $54 million for TCE grants, approximately $10 million of which will be used for services to ex-offenders.

General Accounting Office Report on Drug Abuse Treatment - ***Release Date: 2/17/00***

GAO surveyed 16 states to learn more about 1) the activities supported by the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment block grant and Knowledge Development and Application grant funds for drug abuse treatment, 2) the mechanisms SAMHSA and states have in place to monitor fund use, and 3) SAMHSA and states' efforts to determine the effectiveness of drug abuse treatment supported with SAPT block grant funds. The report will be released the day of the hearing.

For additional information about these grants and programs, see CRS report #97-844 EPW, dated March 19, 1999, titled "The Substance Abuse and Mental Health Services Administration."

WITNESSES

The following witnesses will testify or have been invited to testify before the Subcommittee.

Mr. Jerry Nance, Executive Director, Teen Challenge International, Florida
Dr. Charlotte Giuliani, Director of Substance Abuse Treatment,
Seminole Community Mental Health Center
Ms. JoAnne Murwin, Seminole Community Resident

Ms. Janet Heinrich, Associate Director, Health Finance and Public Health Issues,
U.S. General Accounting Office
Mr. Paul Puccio, Executive Deputy Commissioner, Alcoholism and Substance Abuse Services
Albany, New York
Dr. John Keppler, Clinical Director, Commission on Alcohol and Drug Abuse
Austin, Texas
Mr. Kenneth Stark, Director, Division of Alcohol and Substance Abuse
Olympia, Washington
Dr. Martin Iguchi, Co-Director, Drug Policy Research Center

Dr. H. Westley Clark, Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

STAFF CONTACT

If you have any questions, please contact Steve Dillingham, Special Counsel, at (202) 225-2577.

Mr. MICA. I wish to thank all of the witnesses who are appearing before us today. I also wish to thank the ranking member of the subcommittee whose primary interest has been to ensure that we have good, adequate, accessible, and effective treatment. I am pleased to recognize her for an opening statement at this time.

Mrs. Mink.

Mrs. MINK. Thank you very much, Mr. Chairman. I would ask that my prepared statement be included in the record at this time.

[The prepared statement of Hon. Patsy T. Mink follows:]

PATSY T. MINK
SECOND DISTRICT, HAWAII

WASHINGTON OFFICE:
2135 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–1102
(202) 225–4906
FAX: (202) 225-4987
http://www.house.gov/writerep/

DISTRICT OFFICE:
5104 PRINCE KUHIO FEDERAL BUILDING
P.O. BOX 50124
HONOLULU, HI 96850-4977
(808) 541–1986
FAX: (808) 538–0233

BIG ISLAND: (808) 935–3756
MAUI: (808) 242–1818
KAUAI: (808) 245–1951

Congress of the United States
House of Representatives
Washington, DC 20515–1102

COMMITTEE ON EDUCATION AND THE WORKFORCE
EARLY CHILDHOOD, YOUTH AND FAMILIES SUBCOMMITTEE
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DEMOCRATIC CAUCUS EDUCATION AGENDA TASK FORCE, CO-CHAIR

Opening Statement
Congresswoman Patsy T. Mink

Subcommittee on
Criminal Justice, Drug Policy and Human Resources
Hearing on
"HHS Drug Treatment Support:
Is SAMSHA Optimizing Resources?"

Thursday, February 17, 2000
10:00 a.m.
2254 Rayburn House Office Building

Mr. Chairman, thank you for holding today's hearing.

In 1998, 13.6 million Americans reported using an illicit drug. SAMSHA has estimated that there are 8.9 million people who need drug and alcohol treatment in this country. The cost of drug abuse to society, including costs for health care, costs associated with the criminal justice system and lost resources due to decreased worker productivity are estimated at $67 billion annually. Today, the federal commitment to treatment is $3.2 billion or about 20% of the current federal drug control budget. According to the Office of National Drug Control Policy, 50% of adults and 80% of teens and children who need treatment are turned away. Some would say that the federal commitment to drug treatment can only be described as inadequate.

Studies have demonstrated that drug treatment is a cost-effective means of controlling drug abuse and crime. A 1994 study by the California Department of Alcohol and Drug Programs found that treatment can generate a seven-to-one return on investment. The study found that the greater the time spent in treatment, the greater the reduction in individual criminal activity.

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According to testimony that Dr. Alan Leshner of the National Institute on Drug Abuse, gave before this subcommittee, most scientists agree that addiction is the result of chemical and physical changes in the brain caused by drug use. Scientists recognize that addiction extends beyond physiological components to include significant behavioral and psychological aspects. Further, people who receive treatment for drug abuse are not always cured the first time. All of these factors combine to make drug treatment an expensive and time consuming process. Yet at $67 billion in costs to society each year, drug addiction and abuse are even more expensive.

Mr. Chairman, we have had many hearings that have reiterated the following points: treatment works; there are unmet treatment needs and providing treatment is beneficial to society.

Today, GAO adds to this list by telling us that the federal treatment effort has been devolved to the states. Through block grants SAMSHA has distributed 95% of its block grant funds to the states and monitors state compliance with statutory requirements.

However, Mr. Chairman, in the report that it will testify about today, GAO found that many states do not measure the performance of drug treatment programs because there is no federal statutory requirement for the states to collect and report data on post-treatment outcomes. Our federal response should include sufficient funding for treatment, responsible use of the funding and accountability by states and program participants. We have done none of these things.

Mr. Chairman, I look forward to hearing the testimony of our witnesses today.

Mr. MICA. Without objection, so ordered.

Mrs. MINK. I would just like to make a few responses at this point to the chairman's observations.

I think that we all are very much concerned about how Federal funds are spent. We are constantly reminding our Federal officials that they must march to the heavy drumbeat of accountability to make sure that the statutory guidelines and requirements that have been laid out by Congress are fully adhered to and that, as Federal officials, they will be held accountable for this performance.

So given those requirements by statute and by appropriation riders and so forth, the Federal agencies are compelled to adhere to these requirements and restrictions. So I think we ought not to criticize the agencies for those actions and steps that they have taken because of congressional mandates.

I believe very strongly, as the chairman has indicated, that the primary responsibility for drug prevention and treatment lies in the local and State communities. I serve on the education committee and we are constantly reminded of those who come to the Congress that the primary responsibility in education is local and supplemented by State funding, and that the Federal responsibility is very minute. In the case of education, it borders around 7 or 8 percent only of the funding for the total educational requirements from K–12.

So, similarly, it seems to me that Congress has to abide by the idea that drug prevention and treatment programs are basically responsibilities of the local and State governments. It is an enormous responsibility admitted by the fact that Congress has taken steps to include vast sums of money to supplement the State and local efforts.

In doing so, I believe it is very critical that the Congress set forth guidelines on how these funds are to be spent. We cannot simply be saying that there is a formula based upon population or based upon some other criteria of need that funds are going to be allocated without some fairly stringent requirements. And yet these are the requirements that have come under fire.

I think it is important to look at the overhead criticisms that the chairman has made with regard to the Federal agencies and to make sure that they are not excessive, and that the bulk of the moneys are being distributed to the local and State agencies. But I cannot quarrel with the requirement that the agency places upon the allocation of these funds by making sure that they are going for the specific purposes and needs as indicated by the State and local agencies's applications.

So I would strongly urge that we not remove the agency's responsibilities to make sure that the allocations conform to the basic outlines of needs as established by the Congress and established by themselves. If they set up criteria as the basis for their application for block grants or other kinds of grants, then they ought to demonstrate that those needs are being met by the Federal funds that are being allocated.

Treatment is an enormously expensive program but I continue to feel that that is probably one of our greatest needs and deficits currently in our drug policy program, when we are told that only 50 percent of those that come for treatment are actually able to be

serviced, we know that we have not really begun to meet that requirement. Think of the others that are not even coming for treatment requirements and are out there and have not been reached; 80 percent of the addicts have no treatment program. And so rather than diminish the responsibility of the Federal Government in this area of treatment, I think that Congress has a responsibility to look at it more critically.

We need to find out what programs are working. That, I think, is a responsibility of the SAMHSA agency. We have the research capability at NIH and they need to find research areas that are better than what are being performed out there in the field today, but SAMHSA's responsibility is to tell us what works and what ways that the Federal Government can intercede to make those programs that do work more extensively utilized by other State and local agencies.

Prevention is a whole other part of this enormous triangle. If we could prevent addiction, then we do not need to be as concerned about treatment. But if we cannot prevent through all the intervention requirements that we have in our educational system, then we need to pay attention to treatment.

And so, as a member of the subcommittee, as the chairman has indicated, I have been very concerned about this treatment deficit and have tried to do what I could to put my inquiries in this area because I feel that this Nation deserves better. We cannot relegate these addicts to a life of despair, hopelessness and total support by the taxpayers because of their addiction. We need to find ways to treat them so that they can be restored to active participants in our society rather than deficits.

The reports that have been issued by GAO indicate that the drain upon our economy and our society is somewhere around $67 billion. I have however seen reports where that figure has been quadrupled to $200 billion as a drain and cost of productivity and because of the provision of extra services and other things.

So the cost to this Nation is enormous and the intervention by the Congress and the Federal Government is essential. We may be able to perfect it, direct it better, but its intervention is critical, notwithstanding the fact that I personally believe that this is essentially a State and local responsibility.

Thank you, Mr. Chairman.

Mr. MICA. I thank the gentlewoman.

I recognize the gentleman from Indiana, Mr. Souder. No opening statement.

I am pleased to recognize the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

I want to thank you and our ranking member for requesting the GAO report and calling for this hearing.

I want to associate myself with the words of our ranking member, Mrs. Mink. I want to add to that that one of my concerns, in a city that has the problems that Baltimore has with regard to drug addiction, is quality of treatment.

One of the things that we have recently talked about with our new mayor and with a group of former addicts, recovering addicts now, is that a lot of time, I mean, these people really believe that

some of the treatment programs are not doing what they claim they are supposed to be doing. And I hope that some of your comments will go to it. It is one thing to have the treatment slots, it is another thing to have—for those organizations that provide treatment to be effective.

I think that if they are not effective or there are no standards, then I think we are just playing a game on ourselves. Drug addiction, as Mrs. Mink has stated so well, has an effect on so many parts of our society.

Just the other day, I took my daughter to the emergency room at one of our local hospitals and I was sitting there for about an hour and I watched the ambulances come and go and I asked one of the attendants, I said, you guys are kind of busy. And he just shared with me that 85 percent of all their ambulance runs in Baltimore city are drug-related. That is astounding. And so, you could imagine we could probably save a lot of money in Baltimore if we did not have the kind of problems we have.

But my point is that, you know, I just want to make sure that whatever money is being spent, that it is being spent effectively and efficiently, effectively and efficiently.

I note from some documents that we have up here that during 1999 your administrative costs were 6 percent. I mean, I do not think that is bad at all. But it would be interesting for us to know what kind of followup there is and, with regard to these dollars being spent, are we really getting people off of drugs, and if we are not, then what could we do from this level.

While it is, as Mrs. Mink said, a local kind of situation, if Federal dollars are being spent and there are taxpayers' dollars, we want to make sure that they are spent in a way that achieves the goals that we have set out.

So I look forward to the hearing today and I want to thank all of our witnesses for being with us.

Mr. MICA. I thank the members of the panel for their opening statements.

We will now turn to our first panel of witnesses. We have today, as a little of the chairman's prerogative, witnesses who are all from central Florida. I want to say that, in fairness now, on the 27th I will be in Baltimore with Mr. Cummings, and we are going to do a hearing in Baltimore, so I will travel there, which is not a big deal. It is not that far but it is an important hearing.

Mr. Cummings, I hope we can have the mayor and the police chief there. I was thinking about this this morning. In fact, I want the mayor and the police chief there, and I want to hear what their plans are. You have a new mayor, I think, and a new police chief. I am going to invite them. If they do not respond, I may consider requiring their attendance. I think it is so important.

Mr. Cummings represents an area that he has, he estimates, some 60,000 drug addicts. Crime is still high and it is our responsibility to see that the programs work and that the situation in Baltimore comes under some control. That is surely our responsibility. But I will be there the 27th. I invite Members to be there.

Then I will travel to Honolulu, which I prefer more than Baltimore, on the 20th with Mrs. Mink, and invite the other members of the panel. I am sorry I have to go and just fly back, because I

would love to stay. But we will hear from her constituents her problems relating to Southeast Asia drug trafficking and treatment and other things in that community.

Then on March 6th, for the information of this subcommittee, we will be in Sacramento. Mr. Ose may be joining us. He was with me earlier in Sacramento. He has requested a field hearing in his community about the problem.

Finally, on the 7th, in San Diego we will deal with the southwest border and our oversight responsibility, at the request of Member Mr. Bilbray.

So while the chairman takes a little liberty in inviting these folks from sunny Florida into the cold cockles of Washington, I am pleased to welcome them, and we will accommodate the other members accordingly.

On our panel, we have Mr. Jerry Nance, who is the executive director of Teen Challenge International, which is located in central Florida; we have Dr. Charlotte Giuliani, director of substance abuse treatment, Seminole Community Mental Health Center; and Ms. JoAnne Murwin, who is a Seminole County resident from central Florida who is recovering and who has had difficulty, she will describe, with drug addiction.

I am pleased to welcome all three of you. I appreciate your being with us this morning.

We are an investigations and oversight subcommittee of Congress. In that regard, we do swear in our witnesses. If you would please stand.

[Witnesses sworn.]

Mr. MICA. The witnesses answered in the affirmative.

I am pleased to have you join us again today. What we also do is, if you go over 5 minutes today, she is going to put a little red light on, and I will ask you to conclude. You can submit lengthy statements for the record just upon request and I will do that. Then we will have an opportunity for a few questions from members of the subcommittee.

So, with that, let me introduce and welcome Jerry Nance, executive director of Teen Challenge.

STATEMENTS OF JERRY NANCE, EXECUTIVE DIRECTOR, TEEN CHALLENGE INTERNATIONAL, FLORIDA; DR. CHARLOTTE GIULIANI, DIRECTOR OF SUBSTANCE ABUSE TREATMENT, SEMINOLE COMMUNITY MENTAL HEALTH CENTER; AND JOANNE MURWIN, SEMINOLE COUNTY RESIDENT

Mr. NANCE. I am Jerry Nance. I want to introduce to you one of the best kept secrets, I believe, in the world; and I believe that is Teen Challenge.

Teen Challenge was founded by David Wilkerson in Brooklyn, NY, in 1958. And this year we celebrate 41 years of service, with 140 Teen Challenge centers in the United States and an additional 250-plus centers in more than 67 countries of the world. The majority of these centers operate 1-year faith-based residential programs.

Independent studies have shown that Teen Challenge programs have consistently documented 87 percent success rates. Let me just highlight some of the results of a June 1999 research that was done by Northwestern University study, just a couple of remarks.

Their research said that one of the most powerful features of Teen Challenge is the work, training, and the strict discipline. The research compared Teen Challenge to other drug programs and of the other group only 41 percent were employed 1 to 2 years after they completed the program while 90 percent of the Teen Challenge graduates were employed 1 to 2 years later.

The Teen Challenge program costs an average of $1,000 a month, in comparison to other programs which cost between $10,000 and $30,000 a month.

They found that students in the program have an attitude of, "it's a privilege to be here" and they were very thankful that they had a chance to participate in the Teen Challenge program.

My responsibilities are that I oversee the Teen Challenge centers in Florida and now in Georgia. Currently, we operate nine centers in the State of Florida, three in Georgia, with 350 beds for boys, girls, men, and women.

Our budget last year was $3.6 million, and of that we only received $15,000 from a block grant in Volusia County to do prevention work. According to the National Teen Challenge headquarters office in Springfield, MO, of the 140 Teen Challenge centers in America, less than 10 percent were State licensed. This is because of the difficulties many times in negotiating contracts and/or relationships between the faith-based program that exists in Teen Challenge.

Some key issues today that I would like to bring to this hearing's attention is, and I am not here today to ask you to fund all faith-based programs, on the contrary, I am here to say that we are happy to fund what we did as far as our program, but I have three distinct issues that I believe need to be addressed and need the attention of this committee.

No. 1 is food stamps. At our Sanford, FL, men's facility, we house 140 men, ages 18 years old and older. Last year our students lost the ability to file for food stamps. The Food and Drug Administration made a decision to not allow students in programs that were not State licensed to receive food stamps. This decision cost Teen Challenge in excess of a $100,000.

This decision not only affected Teen Challenge students, but also students and other humanitarian organizations, like Salvation Armies and inner-city missions. My question is does this make any sense? An individual can live in the streets, he can use drugs, he can rob people and steal and get their food stamps, but if they come to a faith-based, non-State licensed facility like Teen Challenge, they lose their food stamps. It does not make sense to me.

The second area of concern I believe that needs attention is the issue of faith-based programs and State licensure. In 1998, Teen Challenge of Florida attempted to secure State licensure with children and family services at the time that we had lost our food stamps. But due to the conflict with program requirements, we withdrew our efforts.

In addition, we reviewed the Department of Juvenile Justice service provider contracts and the Department of Corrections requirements, and in each case we found key conflicts with the program requirements in relationship to the faith-based issues that we feel are important to our program.

Examples: All Teen Challenge's programs require mandatory chapel attendance, and that is almost without regard to the main problem that we have in licensure. Adults in Florida State license programs were required to have 20 hours of group counseling each week. The Teen Challenge's curriculum, although proven successful, was reviewed and found not to be acceptable to the State of Florida standards. Therefore, to adhere to State licensure, Teen Challenge would have to restructure the entire program and rewrite or restructure the entire curriculum, and we are not willing to do that to alter our curriculum or risk jeopardizing the 86 percent success rate for money.

The problem is faith-based programs cannot realistically fit into the current guidelines used to certify programs. These guidelines are based on the medical model, which it works for some and others maybe they need the faith-based programs. And the truly faith-based programs like Teen Challenge are based on faith in God as well as Biblical principles and, thus, we have a model that we believe works.

The current guidelines make no allowances for the differences between the two systems of helping. Though we do have National accreditation standards for Teen Challenge, they differ greatly from State standards in regards to program. I have a few copies available if anyone is interested in looking at those.

To the best of my knowledge, I do not know of one effort being made to bring the faith-based residential programs and the State guidelines together. I would like to suggest a study of how a successful faith-based program can work in cooperation with State guidelines without violating the separation of church and State. And I now find that often is the issue.

The third issue I believe needs attention is the medical care for students in faith-based programs. Individuals who come to Teen Challenge with addiction problems are usually desperate and destitute. They often do not have family or any other means of support, financial or otherwise, often emergency medical expenses must be absorbed by Teen Challenge.

The services of Teen Challenge are offered free of charge to adults who can pay the intake fees. Less than 5 percent of our income comes from adult students with financial contributions.

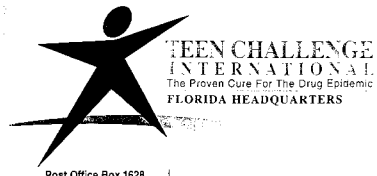
Currently, 20 percent of our student population are court-ordered. We work closely with the judges and public defenders, States attorneys, and they refer many, many people to Teen Challenge.

Let me just underscore, in closing, I am not asking for you to support the program cost of Teen Challenge. But we do need to evaluate the food stamp issue, the guidelines for licensing of faith-based programs, and the reviewing of medical coverage for residents of Teen Challenge and other faith-based programs.

I would offer my services, as well as the services of the National Teen Challenge director, to participate on a committee to address those issues.

Mr. MICA. Thank you for your testimony. We will suspend questions until we have heard from all the witnesses.

[The prepared statement of Mr. Nance follows:]



Post Office Box 1628
Sanford, FL 32772
Phone 407/330-9600
Fax 407/330-0407

BAY AREA
1410 East Lake Road
Tarpon Springs, FL 34689
Phone 727/937-1033
Fax 727/934-6135

CENTRAL
3706 S. Sanford Avenue
Sanford, FL 32773
Phone 407/330-9600
Fax 407/330-1345

EAST
217 N. Stone Street
DeLand, FL 32720
Phone 904/738-3881
Fax 904/738-5661

EAST COAST
Post Office Box 265399
Daytona Beach, FL 32126
Phone 904/253-3918
Fax 904/253-4202

GULF COAST
9510 Chandler Street
Pensacola, FL 32534
Phone 850/478-6180
Fax 850/477-7012

SOUTH
13601 S.W. 26th Street
Davie, FL 33325
Phone 954/476-0809
Fax 954/476-1455

SOUTHWEST
5646 Seventh Avenue
Ft. Myers, FL 33907
Phone 941/275-1974
Fax 941/275-1975

WEST
Route 4, Box 380-B
Bonifay, FL 32425
Phone 850/547-9011
Fax 850/547-2566

TCIMI: MINISTRY INSTITUTE
Post Office Box 5280
Jacksonville, FL 32247
Phone 904/398-0013
Fax 904/398-0704

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Senate Subcommittee on Criminal Justice,
Drug Policy, and Human Resources
February 17, 2000

Speaker

Jerry Nance, Executive Director/CEO of Teen Challenge of Florida Inc.

Current position held for 9 years; ordained minister with the Assemblies of God; M.S. in Community Counseling, Barry University; twenty years of experience with youth and addiction services; member of the Teen Challenge International Board of Directors; developed 13 new Teen Challenge programs in the last seven years in Florida and Georgia and two additional centers in Jamaica and Barbados.

I. Introduction

I want to share with you one of the best-kept secrets in the world today – Teen Challenge.

Teen Challenge was founded by David Wilkerson in Brooklyn, NY in 1958. Celebrating 41 years of service, there are now 140 Teen Challenge centers in the United States. There is a bed capacity of approximately 3,000 in the US centers. The majority of these centers operate one-year faith-based residential programs.

Over the years, Teen Challenge has emerged into an international program with 250 centers in more than 67 countries of the world.

Independent studies have shown the Teen Challenge program to consistently have an 86% success rate. In 1975, NIDA conducted a research project and found that 86% of those who completed the Teen Challenge program remained drug free. In 1994, the University of Tennessee conducted another study and found that Teen Challenge had phenomenal success. Research completed in June of 1999, done by Northwest University Illinois, found that 86% of those who complete the Teen Challenge program have remained drug free.

Let me highlight some of the results of the Northwestern University study:

- The study took 3 years. They interviewed Teen Challenge graduates from the east coast to the west coast.
- They found that Teen Challenge graduates were more likely to be living normal lives, holding down jobs and not needing further treatment.
- They found that nearly all have escaped the "revolving door phenomenon" of substance abuse treatment.
- The researchers said that one of the most powerful features of Teen Challenge is the work training and strict discipline.
- The research compared Teen Challenge to other drug programs, and of the other group only 41% were employed one and two years later, while 90% of the Teen Challenge graduates were employed one and two years later.
- They found that the students in the program have an attitude of "It's a privilege to be here" and were very thankful for the chance they had to participate in the Teen Challenge program.

II. Teen Challenge International - Florida / Georgia

Currently, we operate nine centers in Florida and three centers in Georgia with beds for 350 boys, girls, men and women. We have been asked why we call ourselves *Teen* Challenge when we offer our successful residential curriculum to adults as well. Years ago, most states began to require juveniles and adults to be housed separately. This created a need for us to develop adult facilities for the students 18 years and above who were in our care.

With a budget of $3.6 million last year, we only received $15,000 from a block grant in Volusia County for prevention. We did not receive any other government funding for any of our residential centers.

According to the National Teen Challenge headquarters, of the 140 centers, less than 10% are state licensed. The 10% who are licensed have been able to negotiate the standards of their individual state without compromising the Teen Challenge philosophy. Otherwise, there would be no government support due to the fact that Teen Challenge is a faith-based drug and alcohol rehabilitation organization.

III. Key Issues of Concern

I am not here today to ask you to fund *all* faith-based programs. On the contrary, I am here to point out three distinct issues that need to be addressed.

1. Food Stamps

At our Sanford, Florida men's facility, we house 140 men ages 18 and older. Last year, our students lost the ability to file for food stamps. These stamps were used by Teen Challenge to feed the students. The Food and Drug Administration made a decision to not allow programs that were not state licensed to receive food stamps. Because we were not state licensed, our students were denied their stamps. This decision cost Teen Challenge in excess of $100,000.

This decision not only affected Teen Challenge students, but other humanitarian organizations like the Salvation Army and other faith-based organizations and inner-city missions.

Does this make sense to you? An individual can live in the streets, use drugs, rob people and still get their food stamps, but if they decide to get help and come into a faith-based program, they lose their stamps.

2. Faith-based programs and state license

In 1998, Teen Challenge attempted to secure state licensure with Children and Family Services at the time we lost our food stamps, but due to the conflict with program requirements, we withdrew our efforts. The issue is not that we don't want to meet safety, health, staffing or other requirements. With every attempt we have made, there have been some vital issues that conflict with our faith-based philosophy and success. We reviewed the Department of Juvenile Justice service provider contracts, and The Department of Corrections requirements, and in each case we found key conflicts:

a. All Teen Challenges require mandatory chapel time, as do most faith-based programs.
b. Adults in Florida state licensed programs were required to have 20 hours of group counseling each week. Teen Challenge's curriculum, although proven successful, was reviewed and found not to be acceptable to the state standards of Florida. Therefore, to adhere to state licensure, Teen Challenge would have to restructure the entire curriculum. We are not willing to alter our curriculum and risk jeopardizing our 86% success rate.

The problem is that faith-based programs cannot realistically fit into the guidelines currently used to certify programs. These guidelines are based on the medical model, and true faith-based programs are based on faith in God and biblical principals. The current guidelines make no allowance for these differences.

To the best of my knowledge, I do not know of one effort made to bring the faith-based residential programs and state guidelines together.

I would like to suggest a study of how a successful faith-based program can work in cooperation with state guidelines, without violating separation of church and state.

3. Medical care for students in faith-based programs

Individuals who come to Teen Challenge with addiction problems are usually desperate and destitute. They often do not have family or any other means of support, financial or otherwise, so often emergency medical expenses must be absorbed by Teen Challenge. The services of Teen Challenge are offered free of charge to adult students who are not able to pay. Less than 5% of our income comes from student's financial contributions.

Currently, 20% of our students are court ordered. We work closely with local judges, public defenders and states attorneys, who direct certain cases to Teen Challenge. At this time, we receive no compensation for these services.

Let me underscore this point. I am not asking you to fund our program cost, but I am asking you to:

- evaluate the food stamp issue
- re-examine the guidelines for the licensing of faith-based organizations
- review medical coverage for residents in Teen Challenge and other faith-based organizations.

I would like to offer my services and services of the National Teen Challenge Director, John Castellani to serve on a committee to address these issues.

Attachments:

Government Study Validates Results – Research Summation

Teen Challenge of Chattanooga, Inc., - Alumni Survey

A Comparative Evaluation – Northwestern University

GOVERNMENT STUDY VALIDATES RESULTS
RESEARCH SUMMATION

Health, Education, and Welfare Department's study on Teen Challenge Training Center, conducted by Catherine B. Hess, M.D., M.P.H.

MAJOR STUDY OBJECTIVE: What proportion of the program Participants are drug free 6 to 7 years After entering program.

STUDY GROUPS:

1. Participants dropped out in initial phase.	(70)
2. Participants dropped out in phase II.	(52)
3. Participants graduated from program.	(64)
Total participants in study	(186)

STUDY RESULTS:

	GROUP 1	GROUP 2	GROUP 3
Not using Narcotics	54%	76%	86%

Eighty-six percent (86%) of participants were still drug free 6-7 years after graduating from Teen Challenge. **IN ADDITION:** 72% furthered their education with 29 graduating from Bible College.

Dr. Hess summarizes: The instilling of faith by a forgiving God can offer the addict a firm spiritual support which the socially and physically insecure person urgently needs to shore up his self-image and insecurity ... His belief system becomes self-validating, and his basic needs of security, recognition, response, and new horizons seem to be met in this specific approach which is totally absent in all other therapeutic community programs ... Faith makes the difference.

ENDORSEMENTS

" I sincerely appreciate your efforts to reach and rehabilitate the many young people who have at present no hope in life. The ministry and dedication of Teen Challenge deserves the commendation of every citizen."

President Ronald Reagan

" The Teen Challenge Center... stands out among all the programs we saw as being one that offered the highest level of rehabilitative input to its clients."

Fredrick B. Glaser, MD
Secretary on Drug and Alcohol Abuse
Medical College of Pennsylvania

" Of all the programs to help drug addicts reported to the commission, the most successful is a religiously based program conducted by Teen Challenge."

Dr. John A. Howard
National Commission on Drug Abuse

Teen Challenge of Chattanooga, Inc.
Alumni Survey
December 14, 1994

Teen Challenge of Chattanooga, Inc., has conducted an alumni survey which indicates a 75% success rate. Teen Challenge receives no funding from the government, which means no tax dollars are being spent to sequester the drug and alcohol problem.

Teen Challenge, a non-profit Christian residential organization, helps men ages 16 and up who struggle with alcohol and drug problems not only on a local level, but also on a national level with over 150 centers.

The survey, conducted by Dr. Roger Thompson, Head of the Criminal Justice Department at the University of Tennessee at Chattanooga, represents men whose lives have been influenced by Teen Challenge. Once the person has completed the program, a dramatic lifestyle is apparent and long lasting.

Interest was expressed by the Teen Challenge of Chattanooga, Inc. leadership and Board of Directors to conduct a survey of alumni so as to determine their success in recovering from alcohol and drugs. The survey was conducted beginning in the summer of '92 and concluding in the fall of '94. Among the many issues examined in the survey, the major ones included the individual's status in the following areas: drug-free lifestyle, employment, legal, educational and church attendance.

Research herein focused on those successfully completing the induction program of Teen Challenge of Chattanooga, Inc. These men spend four to six months in the Chattanooga program, and then transfer to a Teen Challenge training center in Cape Girardeau, MO, or Rehrersburg, PA, for an additional 8-10 months of training. Alumni from a 15-year time period (1979-1991) were included, totaling 213 individuals. A random sample of 50 alumni was selected for this research project with a 50% response. The adequate response allowed us to analyze the success of the Teen Challenge program in the following areas:

- It is noteworthy that 72% of the respondents had drug treatment prior to entering Teen Challenge of Chattanooga, Inc. Survey indicated that there have been no additional drug treatment program(s) in the lives of 88% of the respondents since Teen Challenge. In terms of program recommendation, Teen Challenge was named by 88% of the respondents as the treatment program most beneficial.

- 60% of the respondents continued their education upon completion of Teen Challenge. The areas include getting their G.E.D or pursuing college level education.

- 72% of the respondents indicated their current status as employed. Further analysis of the 28% not employed yields 8% are students and

20% are unemployed. 50% of those who are employed have been at the same job for over one year. 60% of the respondents stated that exercising truthfulness and honesty about the past has helped rather than hurt employment prospects.

- 60% of the respondents were either under the jurisdiction of the court and subject to community supervision or had charges pending when entering Teen Challenge. As of their current legal status, 76% are free of legal interference.

- One of the major areas that was researched to determined the success rate of Teen Challenge was the drug free status of the respondents. The survey indicated from the respondents that 75% are abstaining from illegal drugs and alcohol.

- 76% of the respondents attend church regularly. 60% have become members of a local church.

- Over 60% of the respondents indicated that their relationship with their family was categorized as being good in comparison to fair or poor or no change.

- 92% of the respondents claim that Teen Challenge has had a great impact upon their life.

- The main focus of Teen Challenge of Chattanooga, Inc. is that of being a spiritual growth center where biblical principles are taught. 80% of the respondents credited developing a personal relationship with Jesus Christ as a major influence in helping them stay off drugs.

As a result of this survey, indicators of success include: stabilized lifestyle due to their personal commitment to Jesus Christ, employment with some level of stability, financial independence, an absence of trouble with the police, an ability to enjoy freedom without condition or supervision and little need for additional drug treatment once completing the Teen Challenge program.

We express our thanks to Dr. Roger Thompson for conducting this independent survey for Teen Challenge of Chattanooga, Inc.

You may receive a condensed version of this survey upon request.

Another Teen Challenge Research Project
A Comparative Evaluation – Northwestern University

In 1975, NIDA conducted a research project and found that 86% of those who completed the Teen Challenge program remained drug free.

In 1994, the University of Tennessee conducted another study and found that Teen Challenge had phenomenal success.

Well friends, it has happened again!

Research just completed June 1999, done by Northwestern University Illinois, once again showed that 86% of those who complete the Teen Challenge program have remained drug free. (pg. 118)

The study took 3 years. They interviewed TC graduates from the east coast to the west coast.

They found that Teen Challenge graduates were more likely to be living normal lives, holding down jobs and not needing further treatment. (pg. 222)

They found that nearly all have escaped the "revolving door phenomenon" of substance abuse treatment. (pg. 229)

They found that 84% attend church weekly. (pg. 228)

The researchers said that one of the most powerful features of Teen Challenge is the work training and strict discipline. (pg. 240)

The research compared Teen Challenge to other drug programs, and of the other group only 41% were employed one and two years later, while 90% of the Teen Challenge graduates were employed one and two years later. (pgs. 172, 229 & 232)

They found that the students in the program have an attitude of "It's a privilege to be here" and were very thankful for the chance they had to participate in the Teen Challenge program. (pg. 235)

The interviewer said that the Teen Challenge graduates seem to describe their experience at Teen Challenge as something revolutionary. (pg. 222)

When asked why they no longer use drugs, the Teen Challenge graduates said that Jesus Christ filled a void in their lives. (pg. 222)

Other graduates were asked "Why do those that come to Teen Challenge do so well?" The graduate said, "He who has been forgiven much, loves much." (pg. 227)

Another graduate said "The Teen Challenge program taught me how to keep God first-place in my life." (pg. 228)

Other graduates said, "They helped me in every way possible, from introducing me to God, to teaching me how to work, and they even helped me get a high school diploma." (a composite from responses)

The recent research also said that the Teen Challenge staff had a positive effect on our graduates' lives. (pg. 222)

Researchers found that other programs cost from $7,500 to $35,000 just for one month. Teen Challenge averages $1,000 for one month. (pg. 232)

The researchers concluded that society need not write off drug abusers; cures can be expected. Productive participation in society by former addicts is not unrealistic. (pg. 231)

This survey once again credited the success of the program to our faith – the Jesus Factor. (pg. 178, 182, 261 & numerous other places)

Teen Challenge has ***living proof*** that today Jesus Christ is still healing wounded, broken lives.

*The pages referenced above refer to the page in the research where these estimates can be found.

The research is known as "Northwestern University, The Teen Challenge Drug Treatment Program in Comparative Perspective, A Dissertation Submitted to The Graduate School in Partial Fulfillment of the Requirements for The Degree Doctor of Philosophy, Field of Political Science, by Aaron Todd Bicknese, Evanston, Illinois, June 1999."

These pages prepared by Dennis Griffith, Teen Challenge International, Southern California.

Mr. MICA. The next witness is Dr. Charlotte Giuliani. She is director of the Substance Abuse Treatment Center in Seminole Community Mental Health Center.

Welcome. You are recognized.

Dr. GIULIANI. I am director of Substance Abuse Treatment Services in Seminole County.

Seminole County, as you well know, is a county of 330,000 approximately residents. And at this point there is only seven funded beds in that county.

It is estimated that over 722,000 adults and 247,000 children are in need of treatment in the State of Florida. Florida's State-administered adult treatment capacity is only 6,933 beds, and 3,000 of those beds are available in State-funded programs such as mine and the balance in the Department of Corrections. The average waiting period for these beds is in excess of 3 months. At this time it is estimated that at least 700 adults are on these waiting lists.

So, as you can see, getting help can often be a confusing or frustrating ordeal that appears to create barriers for those wanting help with their addiction. Many alcoholics or addicts are lost when treatment is not readily available or accessible.

The use of drugs and alcohol among our children is staggering. Most children first try alcohol or drugs at the ripe old age of 9. The increase in the number of children that abuse alcohol or drugs has tripled since 1992 and a juvenile justice program struggles to deal with the huge number of adolescents committing crimes.

47 percent of 13-year-olds say that their parents never discuss the dangers of drug use. This is credited in part to the fact that a large percent of those parents are abusing drugs themselves. Addiction is a family disease and has to be treated as a family disease.

I realize that because of the daily consequences we as a society experience, this is not a very popular, nor is it a very tolerated disease. The total economic cost of drug abuse in our Nation is estimated at $246 billion.

That is $965 for every man, woman, and child in the State of Florida. The cost of substance abuse is incurred by emergency rooms, hospitals, increased instances of HIV and other substance abuse related illnesses, rising criminal activity, and a staggering decline in productivity that affects all businesses.

For every $1 spent on treatment, $7 is saved. So treatment is a bargain.

Treatment, without a doubt, works. Studies done over the last 20 years indicate that treatment returns people to productive lives, promotes responsibility, and accountability, reduces criminal behavior and violence.

I want you to hold me accountable for the services I provide and the way I spend our money. I only ask that you allow me the resources to provide services to the large number of people needing treatment. The drug issue is about all the things that we value the most, family, children, businesses, churches, communities, and treatment, education and prevention.

I could tell you some wonderful success stories, but I am here before you on behalf of the ones whose faces I have looked at that are no longer with us or no longer alive because of drugs or alcohol.

This constitutes my own personal war on drugs because too many have been lost. It will require the partnership of you, our Federal Government, our State governments and our communities to stop drug abuse.

I thank you.

[The prepared statement of Dr. Guiliani follows:]

Testimony
Charlotte Guiliani, Director
Substance Abuse Treatment Services
Seminole Mental Health Center

Good Morning, I am Charlotte Giuliani. I currently am the Director of Substance Abuse Treatment Services at Seminole Mental Health Center, Inc. in Seminole County Florida. As a result of Federal funding, we are able to provide help to those adults that are in need and desirous of treatment for their chemical dependency. It is estimated that over 722,000 adults and 247,000 children are in need of treatment in the State of Florida. Florida's state administered adult treatment capacity is only 6,933 beds: 3,000 available in State funded treatment programs such as mine, and the balance in Department of Corrections. The average waiting period for these beds are in excess of 3 months. At this time it is estimated that at least 700 adults are on these waiting lists. So, as you can see, getting help can often be a confusing and frustrating ordeal that appears to create barriers for those wanting help with their addiction. Many alcoholics and addicts are lost when treatment is not readily available or accessible.

The use of alcohol and drugs among our children is staggering. Most children first try alcohol or drugs at the ripe old age of 9. The increase in the number of children that abuse alcohol or drugs has tripled since 1992 and the juvenile justice programs struggle to deal with the huge numbers of adolescents committing crimes. 47% of 13 year olds say that their parents never discussed the dangers of drug abuse. This is credited in part to the fact that a large percent of those parents are abusing drugs themselves. Addiction is a family disease.

I realize that because of the daily consequences we as a society experience, this is not a very popular or maybe I should say tolerated disease. The total economic cost of drug abuse in our Nation is estimated at 246 Billion Dollars. That's $965 for every man, woman and child in the state of Florida. The cost of substance abuse is incurred by emergency rooms, hospitals, increased instances of HIV and other SA related illnesses. rising criminal activity and a staggering decline in productivity that affects all businesses. For every $1 spent on treatment - $7 is saved. So treatment is a bargain!

Treatment, without a doubt works. Studies done over the past 20 years indicate that treatment returns people to productive lives, promotes responsibility and accountability, reduces criminal behavior and violence. I want you to hold me accountable for the services I provide and the way I spend our money. I only ask that you allow me the resources to provide services to the large number of people needing treatment. The drug issue is about all the things that we value the most: family, our children, businesses, churches, communities, treatment, education, and prevention. I could tell you some wonderful success stories, but I stand before you today on behalf of the ones whose faces I looked into, that are no longer alive because of drugs and alcohol. This constitutes my own personal "war" on drugs, because too many have been lost. It will require the partnership of you, our federal government, our state governments and our communities, to stop drug abuse. I thank you for your time and your support.

Mr. MICA. Thank you for your testimony.

I will now recognize JoAnne Murwin, who is a resident of the Seminole community. Welcome. You are recognized.

Ms. MURWIN. Thank you, Mr. Chairman. Good morning. I am a little nervous.

Does treatment work? This is a long way from the streets of Seminole County for me. My name is JoAnne Murwin and I have a story to tell you.

I am a recovering alcoholic and drug addict who is here before you today by the grace of God and a good foundation from the treatment center that I went through. I won't go into all the war stories, as all you have to do is turn on the news or pick up a newspaper and my story of abuse is there.

What I would like to say is that, although I think education plays an important part of recovery, it doesn't do much for the prevention of this disease. You can educate anyone all you want on the facts of diabetes, but it will not keep them from getting it.

My mother started the recovery process in our family by going to Al-Anon. My father is an alcoholic and this is why I inherited my disease. Addiction is a disease, and the minute I put that first drug into my body my disease started to progress. My sisters and I went to Al-Teen for years, and we would discuss what was going on with my father and in the family. We would swear we were never going to be like him, and then we would leave the meeting and smoke pot on the way home.

Well, we were right to some degree. We weren't like him, we were worse, because we added the drugs to the alcohol.

I started using drugs when I was 13 in 1972. I went to treatment when I was 32 in 1992. I used it for 20 years. So believe me when I tell you that I am an expert on the subject.

By the time I went into treatment, the only worldly possessions I had were some clothes and pictures I had managed to hang on to. I was being evicted, had just gotten fired again, had no car, no money, no self-esteem, and nowhere to go. If you want the youth today to not start, teach them about self-esteem in school. Don't tell them that they are wrong or different. They get enough of that in their own homes. It does no good to educate children on the dangers of drugs if they live with them at home. It is all they know and it is in their blood already.

Funny how the disease of addiction, and I quote from the Orlando Sentinel, is still being addressed as "willful misconduct." Do you honestly think that I, as a little girl growing up, I said to myself, I think I will use drugs and ruin my life just to be bad? Give me a break. I used so I wouldn't have that feeling of not being good enough, which came from the shame of having an alcoholic father.

I also find it rather interesting that our government insurance, Champus, does not cover treatment for this disease. Do you know how most people get into treatment? They have to hit rock bottom and be threatening to kill themselves to anyone who listens.

I have worked in a number of treatment centers since I got sober, and we used to tell people to threaten suicide so they could get help. This is an outrage. All I know is that, without the treatment I received, I would probably be dead right now or in jail, as my habit was becoming increasingly hard to support and it

wouldn't have been much longer before I was on the streets doing whatever it took to be able to get my next fix.

Today I am proud to say that I am a productive member of society. I own my own business, am a registered voter, have a valid driver's license and insurance. These are the kinds of things a drug addict never even thinks about. I play softball 2 nights a week. I take care of my 91-year-old grandmother, who is unable to care for herself. I am a member of the American Business Woman's Association. And I continue to sponsor and help other addicts seeking recovery.

You cannot start just by educating the children. You have to stop this vicious cycle by treating everyone in the family so that it does not continue to be passed down to future generations.

Working together on this, we might be able to really help a lot of future alcoholics and addicts. I beg you to continue your support and do all that you can to help us, that never knew what hit us.

Does treatment work? I have stayed clean through my grandfather's death, the hurt of a broken heart, and the savage rape by a stranger who broke into my house one night wearing a stocking mask on his head. I then had to endure the re-victimization of the system, and I continue to struggle with this issue today.

Did I want to have a drink to calm my nerves that night or dull the pain from the beating I took? You bet I did. But I didn't do it, and I owe it all to the treatment center that taught me how not to use drugs and my God.

Thank you for listening and helping people like me who went to treatment using one of your funded beds.

[The prepared statement of Ms. Murwin follows:]

Testimony of Jo-Anne Murwin

Good Morning,
My name is Jo-Anne Murwin and I have a story to tell you. I am a recovering alcoholic and drug addict, who is here before you today by the grace of God, and a good foundation from the treatment center I went through. I won't go into all the "war" stories; as all you have to so is turn on the news or pick up a newspaper and my story of abuse is there.
What I would like to say is that although I think education plays an important part of recovery, it doesn't so much for the prevention of this disease. You can educate anyone all you want on the facts of diabetes, but it will not keep them from getting it. My Mother started the recovery in our family by going to Al-Anon. My Father is an Alcoholic, and this is where I inherited my disease. Addiction is a disease, and the minute I put that first drug into my body, my disease started to progress. My sisters and I went to Al-Ateen for years, and we would discuss what was going on with my Father, etc.... We would swear we were never going to be like him, and then we would leave the meeting and smoke pot on the way home. Well, we were right to some degree. I started using drugs when I was 13 in 1972. I went to treatment when I was 32 in 1992. I used for 20 years, so believe me when I tell you that I am an expert on the subject. By the time I went into treatment, the only worldly possessions I had were some clothes and pictures I had managed to hang on to. I was being evicted, had just gotten fired again, and had no car, no money, no self-esteem and nowhere to go. If you want the youth today to Not Start, teach them about self-esteem in school. Don't tell them that they are wrong or different. They get enough of that in their own homes. It does no good to educate children on the dangers of drugs, if they live with them at home. It is all they know, and it is in their blood already.

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I also find it rather interesting that our Government insurance, Champus, does not cover treatment for this disease. Do you know how most people get into treatment? They have to hit rock bottom, and be threatening to kill themselves for anyone to listen. I have worked in a couple of treatment centers after I got sober, and we used to tell people to threaten suicide, just so they could get in. It is an outrage!

All I know, is that without the treatment I received, I would probably be dead right now, or in jail, as my habit was becoming increasing hard to support, and it wouldn't have been much longer before I was on the streets, doing whatever it took to be able to get my next fix.
Today I am proud to say that I am a productive member of society. I own my own business, am a registered voter, have a valid drivers license, and insurance! These are the kinds of things a drug addict never even thinks about. I play softball two nights a week,

and take care of my 91 year old grandmother, who is unable to care for herself, an a member of the AIWA, and continue to sponsor and help other addicts seeking recovery. You cannot just start by educating the children. You have to stop the viscous cycle, by treating everyone in the family, so that it doesn't continue to be passed down to future generations. Working together on this, we might be able to really help a lot of future alcoholics and addicts. I beg you to continue your support, and do all that you can to help us, that never knew what hit us.

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Sincerely,
Jo-Anne Murwin

Mr. MICA. I thank all of our witnesses. And we will start questioning.

I am going to yield first to Mr. Souder. Mr. Souder, you are recognized.

Mr. SOUDER. I thank the chairman. I have a plane to catch and I appreciate your generosity.

First let me say, Ms. Murwin, I heard years ago from a State Senator friend of Richard Worman in Indiana that many legislators either turn to God or booze with our problems. They are nothing compared to your problems. And I really uphold you and praise you for being able to struggle and confront many of the worst things that could possibly hit an individual, as coming from a child to the rape and everything else, and being willing to stand as an example for others and hold your commitment to God and your commitment to staying clean. And I think you will continue to be as successful as you are. And I thank you for your willingness to speak up.

Congressman Ramstad has a bill to try to make sure that in insurance we can get drug and alcohol treatment covered, and we will continue to try to do that. It is a slow process because it is very expensive and health insurance costs have been going through the roof. And some of the programs, quite frankly, have been fairly marginal in their returns and there is a big difference in types of programs. But we are doing the best we can. I thank you.

I wanted to pursue with Mr. Nance a couple of questions, because for the last few days I have been immersed with this whole charitable choice question because we have been dealing with over in the Education Committee Even Start, and I have read either the summaries or every court case dealing with faith-based organizations right now, and particularly as it relates to a number of these things.

First, I want to ask you a technical question. Were you receiving the food stamps or were individuals in your program?

Mr. NANCE. The individuals in the programs.

Mr. SOUDER. And then they would turn them over to you?

Mr. NANCE. And then they would turn them over to us.

Mr. SOUDER. Is the Federal requirement that it has to be State licensed, or is this a State decision?

Mr. NANCE. We understood it from the State agency that the Food and Drug Administration had set down these laws and the States were mandated to follow them, as I recall.

Mr. SOUDER. We will attempt to get this clarified, and I also would raise this with Governor Bush, because it may be a State application that relates to that.

Mr. NANCE. I have raised it with Governor Bush.

Mr. SOUDER. What was his answer?

Mr. NANCE. Through Jim McDonough with the drug czar, he said he turned it over to a staff person and we have not been able to resolve it.

Mr. SOUDER. Also, you had in your testimony that you would like to see a study of faith-based programs and how they can work in cooperation with State guidelines without violating separation of church and State.

This is a quagmire. And let me suggest a couple of basic principles. First off, be very wary. I am familiar with the cross and a

switchblade and it has impacted many people's lives with success of Teen Challenge and the Victory Life Temples in Texas with Freddie Garcia and Juan Rivera and others. But you need to be very careful about getting the Government's hands on any program that is successful because it is amazing how they can make them less successful. We may be tolerant of faith-based organizations as long as the faith does not get too much. We are a little nervous about that.

As I understand the court decisions, which are evolving every day and which are not clear, is that you cannot, while receiving any direct Federal funds, ever require mandatory chapel time as a condition for entering a program, and that is not likely to change, which is right at the heart of many of these programs. It is unlikely because proselytization clearly cuts multiple directions. As somebody who represents and I am a baptist, we usually lose in any type of State religion. And we are not too hot on it, either, and you need to be careful about funding it.

At the same time, we have made progress on staffing requirements, because there is nothing that says that religious people cannot administer programs that help people if you are not teaching religion with government funds. So there can be separation of programs, but if you had somebody come in that did not participate in that, now, that is different. In other words, you probably will not be eligible for any program that is a direct grant program as long as that is a key component, and I believe probably the most critical component of your program.

Mr. NANCE. It is.

Mr. SOUDER. But vouchers for food stamps do not make sense because vouchers are viewed differently as direct grants. Vouchers should be the individual's decision where they go.

You posed the ridiculous question which one possible solution would be, put a bunch of men in cars in an empty lot and then they could get the food stamps and come over to your program. It does not even make any sense.

Mr. NANCE. Well, that's what we said to them: What if we brought the 140 men and put them on your parking lot and they went one at a time into your office and filled it out? They said, well, if they put your address down, they are not going to get them.

Mr. SOUDER. We should be able to look at this question. It looks like an overzealous person coming after Salvation Army and rescue missions, your program and others. Because, quite frankly, we give vouchers for multiple programs that are faith-based, and even education, which is the most controversial. For IDEA, we do it for buses and materials for religious-based schools.

When it is something that an individual makes a decision, there is a different standard than when it is a grant coming from alcohol and mental health and antidrug funds.

I had one other question, and that is, and I just wanted to clarify this. You get 20 percent of court ordered—could you explain again. When you say, "medical care," you are not getting any dollars for the court ordered students, on the other hand, that is because you view this as a mission?

Mr. NANCE. Absolutely. We accept, and based on our approval of that person coming into the program, we will do an interview with

them. Before they come into the program, the courts or the public defender or prosecuting attorney will call us and ask us to do an interview with this person, and then we'll work with them, and the judge sentences them to Teen Challenge for a year.

Mr. SOUDER. You would have to have, and I gave you some of the guidelines with that, is that if you were in those court structures programs, able to delineate certain things, like bus services or things where there is not proselytization with government funds, you might be able to recoup some costs. But as long as they are going to the substance of the program that ultimately is dependent on individuals committing their lives to Christ or changing through some court commitment, we are not likely to ever clear that, for reasons to protect Teen Challenge as well as the government.

I thank you for testifying today and also thank you for your work in central Florida. I wish I could hear the next panels. I went through your written testimony. And will continue to work on the treatment.

Mr. MICA. Thank you, Mr. Souder.

I am pleased to recognize the ranking member of our subcommittee, Mrs. Mink, at this time.

Mrs. MINK. Thank you very much, Mr. Chairman.

I would like to join my colleague, Mr. Souder, in expressing our profound respect for your mission, Jo-Anne Murwin, for your uplifting testimony and for your recitation of your enormous personal struggle, which you have translated to a social dimension, and by doing so, emphasize the importance of our treatment and prevention programs.

So we cannot lose sight of that essential ingredient, in whatever we do regarding drug policy, it is important to look at the worldwide production and interdiction by law enforcement programs. But our primary goal must be helping and finding a way to rescue all the people in our society who are troubled by drug abuse and drug addiction. So I commend you for the steps that you have taken, your determination and you are certainly an example and role model for the program and for all the people that we are trying to get help, you are certainly a shining example. So I want to commend you personally for what you have done.

Mrs. MINK. Dr. Giuliani, I am interested in the State funded programs that you mentioned in Florida, that the State has only 6,933 beds?

Dr. GIULIANI. Yes.

Mrs. MINK. Is that with only State funds?

Dr. GIULIANI. That is Federal and State funded.

Mrs. MINK. What is the estimated total need for the State of Florida?

Dr. GIULIANI. I would estimate there is probably a need for about 12,000 beds.

Mrs. MINK. 12,000 beds, even though you say there are 722,000 adults that are in need of treatment in Florida?

Dr. GIULIANI. Not all of these people are seeking treatment at the same time. As you can see, there are only 700 on the waiting list right now. That means that those people are the only ones desirous of help and seeking treatment at the time.

Mrs. MINK. To what extent is residential treatment necessary for treatment of addiction? Can you have an outpatient kind of program that is going to work as well?

Dr. GIULIANI. I won't say that outpatient does not work, because it does work in some instances. The people I personally see, and the clients I have, normally have lost everything. So you are looking at—they have nowhere else to be. It is difficult to come into an outpatient session for 2 hours a day and then go back to the community or stand on the corner where everybody is using and selling drugs.

So being an inpatient, it brings them out of that environment and makes them feel safe and protected. It also gives them a chance not to have the contact, to be able to change themselves and see that there are other people and other ways to change.

Mrs. MINK. What is the total cost of the Florida treatment program? How much is the State spending?

Dr. GIULIANI. I can't answer that right now. I can tell you how much I get from——

Mrs. MINK. I am sure that the chairman can provide those figures.

Mr. Nance, I am concerned also, as Mr. Souder indicated, about how within the constitutional requirements of the separation of church and State we can provide such basic things as food and health care while not transgressing the requirements of the law to keep religion and State separate. So I am curious about the fact that 20 percent of your cases are court ordered. If they are court ordered, then there is a compulsory conjunction of a State service with your agency.

How do they justify that then if they are not going to justify your licensing?

Mr. NANCE. I think basically they are looking for beds to place people that have addiction problems; and the court system, I think 80 percent of the inmates in the State of Florida are drug-related inmates. Because of that, they don't have beds and they are looking for programs that will help people; and when a public defender or a prosecuting attorney offers this as an option to a judge, it gives a judge an opportunity to do something. They know that they are not going to pay us for our services, but it is basically, as Mr. Souder mentioned, that is our mission to help people.

We interview the student and let them know that it is a faith-based program, and if they are in agreement with what we are doing and how they will be treated in the program, we will accept them, based on that. And whether they choose Christ or not, they are still accepted in the Teen Challenge. That is part of the program. We are not going to cut the chapel out.

Because of that, every time we look at a relationship with the Department of Corrections, there is always the required chapel that we will not compromise because we feel that the faith in God is an absolute, key part. We accept them and that is a good place to put some of the individuals coming before the judges that are seeking help.

Mrs. MINK. Has there been any inquiry with respect to the constitutional compliance of the courts ordering residential care in your youth challenge?

Mr. NANCE. We have not done any.

Mrs. MINK. There has not been any constitutional question?

Mr. NANCE. Not to my knowledge.

Mrs. MINK. The State doesn't pay you at all for housing these youth offenders so that there is no expenditure of State funds?

Mr. NANCE. That is correct.

Mrs. MINK. So you can't use the court order as a basis for qualifying for food stamps and anything else?

Mr. NANCE. Not so far, because we are not State licensed. In our adult programs, we are licensed.

Mrs. MINK. How does the court get away with commissioning the courts to an unlicensed facility?

Mr. NANCE. Our juvenile programs are licensed under the Florida Christian Child Care Agency. I don't know how they figure that all out.

Mrs. MINK. Thank you very much.

Mr. MICA. Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Ms. Murwin, I would like to congratulate you on your accomplishments. As I was listening to you, I couldn't help but think about the neighborhood that I live in where there are so many people who have not been able to overcome the challenges that you have, and they are in so much pain that they don't even know that they are in pain. And I want to thank you for your example, because I think your example is one that will say to other people that they can do it too. So I really do appreciate what you have done.

I appreciate the fact that you have come here and divulged information that all of us would consider personal, but through your example, I think you will touch and continue to touch other people.

I guess, as I was listening to our witnesses today, I am just curious, Mrs. Mink asked the question about whether in-house treatment was more effective. What do you all see as working? What works? I am convinced as I said a little earlier that there are folks when they see the almighty dollar, and our Federal dollars, when they see that dollar they will come up with facilities to do a job. And that is not to take away from those organizations that I know are doing a good job, but when it does when they are not doing what they are supposed to do, it causes Congress to say, why are we spending this money?

I am one who is really protreatment, but I also know that is what I have heard over and over again ever since I have been here, are we wasting our dollars? Are we really affecting anybody or are we affecting the people that we think that we are?

What do you all see from your experiences that works? I know it is not going to work for everybody and I understand that. But to get maximum effectiveness, I guess that is what I am trying to get to.

Mr. NANCE. I can only speak for Teen Challenge, but I know that a crack addict who is addicted to crack cocaine is not going to make it in an outpatient program. It is not going to happen. If you find one, it will be a very rare person that can stay off crack cocaine; or someone that is mainlining heroin, they are going to have a very difficult time.

Mr. CUMMINGS. Why is that?

Mr. NANCE. It is the nature of the drug. It consumes every emotion. Every thought of the day is consumed with that addiction. They wake up in the morning asking the question, where am I going to get the money for the crack? They know where they are going to get it; the question is, what am I going to steal today? How am I going to get that money? That is what they are thinking; they are not thinking about, how can I get treatment? It is because the nature of crack cocaine does that to their person.

Long-term treatment is the success of Teen Challenge. Of course, we believe in the faith-based component of the program, but also it is the time. We are a 1-year residential program for adult men and women and even longer for some of the juveniles. Because of the length of stay—and when you say you are going to get a crack addict off of drugs in 18 to 28 days, I am going to tell you, good luck. Even though there are some very good 28 day programs, most crack addicts need longer care than 28 days to get free from drugs.

I think there are individuals that can get help in outpatient kinds of programs. We have some of those, but by and large, if they are in a community where there are drugs available, they find it very, very difficult not to use.

Mr. CUMMINGS. What is done once they are in treatment to get them where you are trying to get them to?

Mr. NANCE. I can only speak for Teen Challenge.

It is discipline. It is healing their relationships with themselves and with their families because they have got a lot of burned bridges. We work with them to heal that. Then we try to help them accept themselves, that they are not losers and forever damned to addiction. We teach them job skills and job training so when they graduate Teen Challenge they will have a career that won't pay minimum wage, and can have a career in computers or whatever, that they can make a living beyond.

Because it is just like the prostitute in the street, you tell her that I will put you on minimum wage and they make $300 in a week, they can make that in a night or an hour. It is real hard to survive on $300 a week in America.

We have to meet that need while they are in treatment of giving them life skills that they can make, and that is why the values training, the biblical training of honesty and trust and not manipulating, those are the principles; and a lot of the State programs teach the same principles of dealing with your anger and the issues of life, you have kids growing up—we have a kid at 7 years, his father put a rubber strap on him and stuck the first shot of heroin in his arm and laughed at him as he fell around the room. We have other guys with cigarette burns on their skin. These kids are angry and they are mad as heck at the world. They want drugs to just deal with the pain.

Mr. CUMMINGS. Mr. Nance, what kind of area do the young people that you work with come from? Is it a rural area?

Mr. NANCE. It is everything. It is costs—there are inner city kids and country boys. There are kids and young adults coming from all walks of life. We have people flying in Learjets, dropping their kids off, and people sleeping behind trash cans. Take your pick.

Mr. CUMMINGS. How long have you been doing this?

Mr. NANCE. Eighteen years.

Mr. CUMMINGS. We get all of these reports from the drug czar from everybody. We get report after report telling us teen usage is down. Teen usage is up; we get a whole lot of data.

In your 18 years, can you kind of tell us—and this will be my last question—what you have seen? The differences in who you see, what kind of people you see, was there one time, for example, just about the only people you saw were African Americans or Hispanics, and now do you see a change? Has it been constant? Was there a point in time when you saw things sort of explode? Can you answer that for us?

Mr. NANCE. Yes, there are a lot of questions there. There are all different races that come. Fifty percent of our student population are black, 40 percent are white and the other 10 percent are Hispanic in Florida and Georgia. Across the Nation, that range will differ.

There have been changes. We are seeing more and more heroin addicts coming to Teen Challenge for help, but the last 10 years it was crack cocaine, 90 percent of the students coming to Teen Challenge for help; and these would be predominantly 18 years old and above, were coming because of crack cocaine.

We had an executive with Winn Dixie Corp. that came to Teen Challenge for help. He had gone through several short-term programs and had gotten fired and kicked out because of drugs, because of short-term programs. But now we are seeing more and more heroin.

We don't see as many addicted—the juveniles didn't used to be addicted, but we are seeing more and more juveniles addicted coming to us than we used to see. The ones that started playing around at 9, 10, 11 years. They tend to do that during the experimentation stage, and by the time they are 17 and 18, they are addicted. We are seeing 14- and 15-year-old kids addicted to drugs. They don't care about anything in the world but getting drugs. They will stab you, sell their body, whatever they need to get drugs. And the youth are more violent today than ever before.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. MICA. Dr. Giuliani, do you receive State or Federal assistance?

Dr. GIULIANI. Yes.

Mr. MICA. Both?

Dr. GIULIANI. We have Federal block grants, and then we receive Department of Children and Families funding.

Mr. MICA. Have you ever gotten a discretionary grant?

Dr. GIULIANI. No.

Mr. MICA. Let me ask you a question. How much do your expenditures in your program total?

Dr. GIULIANI. About $255,000.

Mr. MICA. For the year?

Dr. GIULIANI. Yes.

Mr. MICA. How much is your program, Mr. Nance?

Mr. NANCE. For 12 facilities and 350 beds it is $3.6 million.

Mr. MICA. Ms. Murwin, did you go through both public and private treatment programs, or just public?

Ms. MURWIN. Public.

Mr. MICA. How many?

Ms. MURWIN. Just one.

Mr. MICA. Was that one successful the first time around or did you ever have repetitive experiences?

Ms. MURWIN. No, it was successful the first time, but I did end up staying there for 6 months. It was supposed to be a 30-day treatment, and after 30 days I knew that I was not ready to go out into the world so I stayed there 5 more months.

Mr. MICA. Did you have to wait for treatment?

Ms. MURWIN. Yes. I had to go home and wait, and I continued to use drugs. The only reason that I ever ended up in treatment was because my sister was already clean. She had gone through a couple of treatment centers herself, and she grabbed a hold of me and kept me. She, like, baby-sat me until I got into treatment.

Mr. MICA. So long-term treatment, once you got it, was successful?

Ms. MURWIN. Yes, sir.

Mr. MICA. Are you familiar with others who participated in these programs?

Ms. MURWIN. Yes, sir.

Mr. MICA. And similar success?

Ms. MURWIN. Yes, sir.

Mr. MICA. Thank you.

One of the frustrations we have is we have almost doubled the amount of money in treatment in the last 7 years, and I think, in the last 5 years, have had substantial increases, I think somewhere in the neighborhood of 26 percent trying to get the money to the programs.

Your $255,000 and your program—in my opening statement I showed the way the dollars are spent in Washington. What do you think of 73 people in the administrators office of the national program, what do you think about 11 percent of the staff being used to administer 80 percent of the funds in the program, and then 89 percent of the staff—now, this is not peanuts; this is $155 million in administrative costs.

$155 million in administrative costs going to Washington. I was absolutely stunned at the cottage industry that is built up around the Beltway. That is just the administrative costs. If we adjust the amount of money in some of these evaluation programs which, in my estimation, may be duplicative of NIDA's efforts and some other efforts, you have $64 million or 64 percent of the contracts specifically identified for technical assistance and evaluation for the grants. We are up to a quarter of a billion dollars in overhead.

What do you think?

Dr. GIULIANI. Sir, it is way too much. I know that when——

Mr. MICA. Doesn't that warm the cockles of your heart to go back and know that your Congress is increasing the money, and we have created an incredible bureaucracy? These people are feeding off of—I could name the firms here in contracts to help even prepare the forms to give to the bureaucrats to review.

Dr. GIULIANI. For every dollar I receive, and speaking to Mr. Nance, if I spend 1 hour with a client, I am spending 45 minutes doing paperwork on that client.

Mr. MICA. I'm sorry, would you repeat that for the record?

Dr. GIULIANI. For every 1 hour I spend with a client, I am spending 45 minutes on paperwork for outcome measures, reporting to the State, reporting to the District and reporting to the Federal Government. And it is not uniform.

Mr. MICA. What is absolutely incredible to me for the benefit of the ranking member, who is with me, and the record, I attended the drug summit we held at the State level and asked the department, Florida Department of Children and Family Services, to list—to give me a list of the programs; and there are 22 State grant programs awarded to Florida, 19 received by organizations that already either receive block grants or State funds for providing substance abuse services.

So we are spending all of that money and all of that administration to do basically the same thing over again. It is absolutely mind-boggling.

I am going to put the subcommittee and the House on notice that when their appropriation comes up, I will do everything, including stopping the proceedings of the House, by calling for successive motions to adjourn until we take the money from this overhead and put it into these treatment programs.

So everybody is on warning here. We are going to find a way to get that money out of these bureaucracies and these blood-sucking Beltway bandits into the programs.

I thank you for coming. You won't get anything out of this, Mr. Nance, because you don't even participate, nor do you get the opportunity to fill out those forms. That is a blessing. But we will see what we can do to try to make your programs eligible for some of the requests that you have made that sound reasonable.

I appreciate your coming here and helping us do a better job to serve those who need service and particularly thank you, Ms. Murwin, for your testimony today.

Mr. NANCE. Thank you.

Ms. MURWIN. Thank you.

Mr. MICA. We will excuse this panel.

I would like to call the second panel.

Ms. Janet Heinrich, U.S. Health Finance and Public Health issues with the GAO; Mr. Paul Puccio, executive deputy commissioner of Alcoholism and Substance Abuse Services, Albany, NY; Dr. John Keppler, clinical director of the Commission on Alcohol and Drug Abuse, Austin, TX; Dr. Kenneth Stark, director of the Division of Alcohol and Substance Abuse of Olympia, WA; and Dr. Martin Iguchi, co-director, Drug Policy Research Center, RAND Corp.

Mrs. Mink, I am going to excuse the third panel today, Dr. Camille Barry, and ask them to come back; and if necessary, I am going to also subpoena the Director of the office, Mrs. Chavez, who is the administrator and who we invited today and is not coming today. So I am excusing at this point—with your permission, we will have her back, and Camille Barry, to respond to both of us and also have a full opportunity to respond to what has been brought up here today.

So this will be our final panel.

Mrs. MINK. I agree with that, Mr. Chairman.

Mr. MICA. Thank you.

At this time, as I mentioned to the previous panel, if you didn't hear me, this is an investigations and oversight panel. I would like you to all rise, please, and be sworn.

[Witnesses sworn.]

Mr. MICA. As I informed the previous panel, if you have lengthy statements or documents you would like entered into the record, upon request, we will grant that accommodation. I think we have everybody seated now.

I would like to start with the General Accounting Office, Ms. Janet Heinrich. You are Associate Director of Health Finance and Public Health Issues. Welcome, and you are recognized.

STATEMENTS OF JANET HEINRICH, ASSOCIATE DIRECTOR, HEALTH FINANCE AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE; PAUL PUCCIO, EXECUTIVE DEPUTY COMMISSIONER, ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, ALBANY, NY; JOHN KEPPLER, CLINICAL DIRECTOR, COMMISSION ON ALCOHOL AND DRUG ABUSE, AUSTIN, TX; KENNETH STARK, DIRECTOR, DIVISION OF ALCOHOL AND SUBSTANCE ABUSE, OLYMPIA, WA; AND DR. MARTIN IGUCHI, CO-DIRECTOR, DRUG POLICY RESEARCH CENTER, RAND CORP.

Ms. HEINRICH. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to have the opportunity to testify on the Substance Abuse and Mental Health Services Administration's efforts to support an effective drug abuse treatment system.

We are releasing the report to you that you requested on SAMHSA's funding for drug abuse treatment-related activities and efforts to determine whether funds provided to States support effective drug abuse treatment programs. I will summarize the key findings of our report in which we described the activities supported by SAMHSA for drug abuse treatment, both the block grant and the knowledge development and application grant programs, SAMHSA and State mechanisms for monitoring fund use, and SAMHSA and State efforts to determine the effectiveness of drug abuse treatment supported with block grant funds.

The Federal Government has made a considerable investment in drug abuse treatment-related activities, about $581 million in fiscal year 1996 which is the latest year of complete block grant data. Of these funds, more than 80 percent was spent by all States for treatment services funded through the block grant program.

To better understand the types of services States provide, we surveyed 16 States that received at least $25 million for their fiscal year 1996 block grant. The States we surveyed support a range of services, primarily in outpatient settings. Methadone treatment expenditures ranged from 2 percent to 50 percent, in part demonstrating the flexibility States have in determining the services supported by block grant funds. States also use State funds, other Federal funds, such as Medicaid, and county funds to support drug abuse treatment services.

Block grant set-aside dollars, about $25 million were used for technical assistance contracts requested by the States and program evaluation efforts. Examples of technical assistance include redesigning treatment policies and procedures, establishing cost-effec-

tive treatment models, and training seminars. SAMHSA spent the remaining funds, approximately $78 million, for KDA grants to determine the effectiveness of selected treatment practices, expand the availability of treatment services for specific locations and populations, and promote the adoption of best practices in treatment techniques. To help improve the overall quality of substance abuse treatment and facilitate the adoption of current knowledge about effective interventions, SAMHSA has developed treatment protocols by bringing together clinicians, researchers and policymakers. This effort is coordinated with the National Institute on Drug Abuse.

SAMHSA monitors grantee use of funds through onsite reviews, and reviews of independent financial audit reports and grant applications. These mechanisms are used to monitor grantees' compliance with program requirements, identify grantees' technical assistance needs, and provide grantees guidance for improving program operations. The current accountability system for the block grant is mostly based on a review of State expenditures designed to determine whether States comply with statutory requirements.

SAMHSA does not track States' responses to deficiencies to determine if they are resolved, nor does SAMHSA focus on the outcomes or effectiveness of States' drug abuse treatment programs.

Several State and SAMHSA efforts are under way to determine the effectiveness of drug abuse treatment programs, using client outcome measures such as substance use, employment, and in criminal activity. Nine of the States we surveyed conducted such assessments, but the outcomes measured, the populations assessed, methodologies used and availability of results vary from State to State, making an overall program evaluation impossible.

SAMHSA is funding a pilot effort with 19 States to develop and report on uniform core client outcomes. SAMHSA has also asked all States to voluntarily report client outcome data in the year 2000 SAPT block grant application. This effort will not yield consistent data because some States are not currently collecting the outcome data requested.

SAMHSA has supported two national studies that suggest some drug abuse treatment can be effective in improving outcomes, such as decreasing substance use and criminal activity.

In conclusion, there are efforts under way to determine program effectiveness. While SAMHSA monitors State expenditures to determine whether block grant funds are used in accordance with statutory requirements, monitoring is not designed to determine the effect State drug abuse programs are having on client outcomes. A few States have systems in place from which lessons could be learned about measuring the effectiveness of treatment, using client outcomes. All of these efforts should help to determine what additional actions are needed to obtain uniform State reporting on the results of drug abuse treatment.

Mr. Chairman, this concludes my statement and I will be happy to answer any questions that you or other Members may have.

Mr. MICA. Thank you. We will withhold questions until we have heard from all of our witnesses.

[The prepared statement of Ms. Heinrich follows:]

United States General Accounting Office

GAO

Testimony

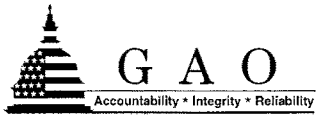
Before the Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Thursday, February 17, 2000

DRUG ABUSE

Efforts Under Way to Determine Treatment Outcomes

Statement of Janet Heinrich, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



GAO/T-HEHS-00-60

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to testify on the Substance Abuse and Mental Health Services Administration's (SAMHSA) efforts to support an effective drug abuse treatment system. We are publicly releasing our report today on SAMHSA's funding for drug abuse treatment-related activities and efforts to determine whether funds provided to states support effective drug abuse treatment programs.[1] I will summarize the key findings of our report, in which we describe (1) activities supported by SAMHSA's Substance Abuse Prevention and Treatment (SAPT) block grant and Knowledge Development and Application (KDA) grant funds for drug abuse treatment; (2) SAMHSA and state mechanisms for monitoring fund use; and (3) SAMHSA and state efforts to determine the effectiveness of drug abuse treatment supported with SAPT block grant funds.

National survey data show that in 1998, 13.6 million Americans reported that they had used an illicit drug in the past month. Further, the costs of drug abuse to society--which include costs for health care, drug addiction prevention and treatment, drug-related crime prevention, and lost resources resulting from reduced worker productivity or death--are estimated at $67 billion annually. As part of its efforts to combat drug abuse, the federal government spent more than $3.2 billion for treatment-related programs in fiscal year 1998. The SAPT block grant and KDA programs are SAMHSA's major programs that fund drug abuse treatment activities accounting for more than half a billion dollars of fiscal year 1996 expenditures.

The federal government has made a considerable investment in states' drug abuse treatment programs, and although there is currently little information on their effectiveness, SAMHSA and some states have efforts under way to determine program outcomes. About $581 million in SAMHSA's fiscal year 1996 grant funds was spent on drug abuse treatment activities. Of these funds, more than 80 percent ($478 million) was

[1] Drug Abuse Treatment: Efforts Under Way to Determine Effectiveness of State Programs (GAO/HEHS-00-50, Feb. 15, 2000).

spent by the states for treatment services funded through the SAPT block grant program. The 16 states we surveyed[2] reported that SAPT funds supported both residential and outpatient drug abuse treatment services, including detoxification and methadone maintenance. For half of the states in our survey, outpatient drug abuse treatment services accounted for 57 to 85 percent of their block grant expenditures; the average of the remaining states' expenditures for outpatient services was 31 percent. All the states we surveyed reported providing methadone treatment services -- the pharmacotherapy treatment most widely used for heroin addiction -- almost exclusively on an outpatient basis. SAMHSA spent $25 million of the SAPT block grant for technical assistance and evaluation activities related to drug abuse treatment. The remaining $78 million of SAMHSA's fiscal year 1996 grant funds were KDA funds provided to community-based organizations, universities, and state and local government agencies to develop and disseminate information on promising drug abuse treatment practices.

SAMHSA monitors grantees' use of these funds through on-site reviews, reviews of independent financial audit reports, and application reviews. These mechanisms are used to monitor grantees' compliance with program requirements, identify grantees' technical assistance needs, and provide grantees guidance for improving program operations. The current accountability system for the SAPT block grant is mostly based on a review of state expenditures designed to determine whether states comply with statutory spending requirements for use of funds, such as those that stipulate that a certain percentage of SAPT block grant funds be spent for alcohol prevention and treatment, drug prevention and treatment, and special populations. SAMHSA monitoring has not focused on the outcomes or effectiveness of states' drug abuse treatment programs.

Several state and SAMHSA efforts are under way to determine the effectiveness of drug abuse treatment programs using client outcome measures, such as drug use, employment, criminal activity, and living conditions. Nine of the 16 states that we surveyed have

[2] In addition to discussions with SAMHSA officials, we surveyed the 16 states that received at least $25 million for their fiscal year 1996 SAPT block grant award, the latest year of complete data. The surveyed states were: California, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, New

conducted such assessments, but the outcomes measured, populations assessed, methodologies used, and availability of results vary from state to state. SAMSHA is funding a pilot effort to help 19 states develop and uniformly report on a core set of client outcomes. SAMHSA has also asked all states to voluntarily report client outcome data -- using measures such as drug use, criminal activity, and employment status -- in their fiscal year 2000 block grant application. However, this effort is not likely to result in uniform state data because some of the states we surveyed reported that they are not currently collecting the requested data.

BACKGROUND

SAMHSA, an agency within the Department of Health and Human Services, has responsibility for supporting substance abuse treatment and prevention, and mental health services. SAMHSA's fiscal year 1999 budget was about $2.5 billion, of which about $1.6 billion was for the SAPT block grant program. SAMHSA allocated another $329 million to fund prevention and treatment discretionary grant programs. A portion of SAMHSA's budget is appropriated for administrative expenses--about 6 percent ($155 million) for fiscal year 1999. The majority of the appropriation for administrative expenses supports contractual services that include technical assistance and program evaluation activities. Administrative expenses also include personnel compensation and costs related to travel, communications, printing, supplies, and rental payments. As of December 1999, SAMHSA employed a total of 538 people.

SAMHSA awards 95 percent of SAPT block grant funds to states and U.S. territories; awards are determined by a statutory formula based on several factors including a state's personal income data, taxable resources, population estimates, and service costs. States have broad discretion in how they distribute SAPT block grant funds to cities, counties, and service providers; the services supported; and the specific amount spent on drug abuse treatment services. SAPT block grant legislation specifies that at least 35 percent

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Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, and Washington. These states represent about 60 percent of SAPT block grant expenditures for drug abuse treatment services.

of the state award be used for alcohol prevention and treatment activities and 35 percent be used for other drug abuse prevention and treatment activities. The remaining 30 percent can be used at the state's discretion for drug programs, alcohol programs, or both.

SAPT block grant legislation requires that 5 percent of the SAPT block be set aside at the federal level to support data collection, program evaluation, and technical assistance to the states. This set-aside funds, among other things, four major surveys required by the Public Health Service Act: the National Household Survey on Drug Abuse, the Drug Abuse Warning Network, the Drug Abuse Services Information System, and the Alcohol and Drug Services Survey.

The KDA program is a discretionary grant program that replaced SAMHSA's demonstration grant program in 1996. KDA program grants are designed to bridge the gap between knowledge and practice in order to transfer research findings to community practitioners and to provide new, more efficient ways to deliver services. The KDA program is also used to expand the availability of treatment services for specific locations and populations.

DRUG ABUSE TREATMENT FUNDS SUPPORT SERVICES, TECHNICAL ASSISTANCE, AND EVALUATION

About $581 million of SAMHSA's fiscal year 1996 grant funds was used to support activities related to drug abuse treatment with state SAPT block grant awards accounting for about $478 million of these funds.[3] In addition to block grant funds, states use other revenue sources to fund drug abuse treatment services, including state funds; other federal funds, such as Medicaid; and county funds and insurance payments. The proportion of total drug abuse treatment expenditures accounted for by SAPT block grant expenditures varied considerably among the states we surveyed. For example, New York

[3] In addition to state expenditures for drug abuse treatment, states spent about $681 million in block grant awards to support alcohol treatment, primary prevention, and tuberculosis and HIV early intervention services, as well as administration.

reported that SAPT block grant expenditures accounted for 18 percent of its total funds for drug abuse treatment compared with 76 percent reported by Indiana.

SAPT block grant set-aside funds for technical assistance contracts and program evaluation efforts specifically related to drug abuse treatment accounted for $25 million. Of these funds, SAMHSA spent about 93 percent to support technical assistance activities, including $11 million for technical assistance contracts and $12 million to help states better allocate treatment funds and improve their ability to assess and report treatment needs. SAMHSA funds technical assistance contracts at the request of states for a wide range of activities, which include training seminars, redesigning treatment policies and procedures, and assisting states in establishing cost-effective treatment models. The remaining $2 million of fiscal year 1996 set-aside funds for drug abuse treatment supported program evaluation activities.

In fiscal year 1996, SAMHSA spent $78 million for KDA grants to determine the effectiveness of selected treatment practices, expand the availability of treatment services for specific locations and populations, and promote the adoption of best practices and treatment techniques. These funds supported 13 specific KDA programs through grants and cooperative agreements to 111 community-based organizations, universities, and state and local government agencies. In fiscal year 1998, SAMHSA spent about $98 million to support 27 specific programs. For example, SAMHSA funded programs to evaluate the effectiveness of integrating treatment services with primary health care or early childhood services, treatment interventions for marijuana and heroin abusers, and treatment for women with histories of violence who have both substance abuse and mental health problems. Final results have not been reported on the effectiveness of selected treatment practices for specific KDA programs.

To help improve the overall quality of substance abuse treatment and facilitate the adoption of current knowledge about effective treatment approaches, SAMHSA develops and publishes best practice guidelines. For example, SAMHSA brings together clinicians, researchers, policymakers, and other federal and nonfederal experts to reach consensus on promising treatment practices. SAMHSA has published specific treatment

improvement protocols that recommend strategies to enhance treatment services for individuals with co-existing mental health and substance abuse disorders. The protocols also provide guidelines for the design and delivery of effective treatment services for adolescents; and for planning, providing, and evaluating detoxification services. SAMHSA also developed a treatment improvement protocol to assist state agencies in developing, implementing, and managing outcome monitoring systems to increase accountability for treatment expenditures. SAMHSA also publishes technical assistance publications, which compile materials gathered from various federal, state, programmatic, and clinical sources, that provide guidance and information related to providing drug abuse treatment.

SAMHSA coordinates its KDA efforts to develop and disseminate promising treatment practices with the National Institute on Drug Abuse (NIDA). These coordination activities include periodic meetings and interagency agreements to ensure that NIDA research is considered in the development, application, and dissemination of KDA information and that the agencies' efforts are not duplicated. Further, some KDA programs test NIDA research to establish the effectiveness of treatment approaches and to identify and address barriers to the use of these approaches in different communities and with different populations. SAMHSA also routinely involves NIDA in selecting treatment improvement protocol topics and reviewing the protocols before they are published.

SAMHSA USES SEVERAL MECHANISMS TO MONITOR SAPT BLOCK GRANT AND KDA GRANT FUNDS

SAMHSA uses on-site reviews; reviews of independent financial audit reports required by the Single Audit Act; and reviews of grant applications to monitor grantees' use of SAPT and KDA funds and their compliance with program requirements. The accountability system for SAPT block grant funds is primarily based on whether states spend funds as required by federal law. SAPT monitoring does not focus on the outcomes or effectiveness of states' drug abuse treatment programs.

SAMHSA is statutorily required to use on-site reviews to ensure states comply with requirements for the use of their SAPT funds, such as "the maintenance of effort" requirement, which stipulates that states must maintain a certain level of expenditures for drug abuse treatment. These reviews are required to be conducted in at least 10 states each fiscal year. SAMHSA hires contractors to conduct these reviews that examine grantees' fiscal monitoring of providers and compliance with SAPT block grant requirements. The contractor works with SAMHSA program staff and state officials to develop a report detailing findings. Currently, SAMHSA does not collect corrective action plans from states or track states' responses to deficiencies identified to determine if they are resolved. SAMHSA officials said that corrective action plans and SAMHSA's monitoring of them are needed, but the agency has not yet decided how it will address this issue. SAMHSA uses the results from the on-site reviews to identify states' technical assistance needs. States must request this assistance which SAMHSA also meets through contractors. For both the SAPT block grant and KDA grant programs, SAMHSA staff conduct periodic site visits to identify grantees technical assistance needs and provide program guidance.

SAMHSA also monitors grantee compliance with program requirements by reviewing their annual financial audits required by the Single Audit Act.[4] In general, this audit is designed to determine if a grantee's financial statements are fairly presented and grant funds are managed in accordance with applicable laws and program requirements. SAMHSA reviews independent financial audit reports to identify grantees in noncompliance with program requirements who need to take corrective actions. If the audit report has recommendations, SAMHSA will request a corrective action plan from the grantee and review the grantee's submission for adequate resolutions. If a grantee does not submit an audit report or resolve an audit finding, SAMHSA has the authority to

[4] Under criteria established by the Single Audit Act, independent auditors use expenditure limits and risk-based guidelines to identify the programs that will be audited. SAPT block grant and KDA grant programs whose annual expenditures fall below $300,000 -- or 3 percent of total federal expenditures -- are generally not audited in that year.

suspend or terminate a grant award, or require the grantee to submit additional financial reports in order to receive additional grant funds.

SAMHSA project officers also review annual SAPT block grant applications to determine if states have complied with statutory program requirements. For grantees that do not comply, SAMHSA can impose conditions. In the past, however, SAMHSA project officers approved applications for some states that reported noncompliance with maintenance of effort[5] requirements. SAMHSA has developed a plan to improve its oversight of maintenance of effort issues that includes making maintenance of effort compliance the highest priority for initial staff review, initiating weekly status reports on states with compliance issues, and conducting periodic meetings to review SAPT block grant documentation. State SAPT grantees use mechanisms, similar to those used by SAMHSA, to monitor the use of block grant funds provided to treatment providers and counties. Some states also use management information systems and review cost reports to monitor providers.

EFFORTS ARE UNDER WAY TO DETERMINE THE EFFECTIVENESS OF STATE DRUG ABUSE TREATMENT PROGRAMS

Several efforts are under way to determine whether states receiving SAPT block grant funds are supporting effective drug abuse treatment programs. Some state assessments of drug abuse treatment show improved client outcomes, but the assessments vary in the outcomes measured, populations assessed, methodologies used, and availability of results. SAMHSA officials believe that the collection of uniform state-level client outcome data is critical to monitoring and reporting to the Congress the results of states' drug abuse treatment programs supported with SAPT block grant funds.

[5] The state's principal agency for drug abuse treatment is required to maintain aggregate drug abuse treatment expenditures at a level that is not less than the average level of such expenditures for the 2-year period preceding the fiscal year for which the state is applying for the grant.

One of SAMHSA's current efforts to collect uniform client outcome data is the Treatment Outcomes and Performance Pilot Studies Enhancement grant program, referred to as TOPPS II. This program funds 19 states'[6] collection of information on SAPT block grant funded treatment services. SAMHSA and the TOPPS II states agreed on a set of client outcome measures that will be incorporated into participating states' databases and monitored. Some of these measures are substance use, health services utilization, employment status, living arrangements, and criminal behavior. As a condition of receiving TOPPS II funding, each state is required to report client outcome data to SAMHSA using the agreed upon measures of treatment effectiveness.

SAMHSA's other major effort to determine the effectiveness of state drug abuse treatment programs is to have all states voluntarily report client outcome data in their fiscal year 2000 SAPT block grant application. States are asked to use specific indicators to report on a core set of outcome measures including drug use, criminal activity, employment status, and living arrangements. States are asked to report the percentage change in each measure that occurred between admission and discharge for clients completing treatment, by age and race/ethnicity. This effort, however, will not yield consistent and uniform data across states because some states said that they are not currently collecting all the outcome data that SAMHSA is requesting. SAMHSA is also asking states to report the source of the data, reasons for not being able to report the data, and whether information is available to measure outcomes after treatment is completed. SAMHSA plans to use some of the information it collects to determine the availability of state outcome data, the complexities of measuring client outcomes, and states' infrastructure needs for measuring outcomes.

SAMHSA has supported two national studies--the Services Research Outcome Study and the National Treatment Improvement Evaluation Study[7]--that suggest drug abuse

[6]The 19 states that applied and were selected to participate in TOPPS II are Arizona, Arkansas, California, Connecticut, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Oklahoma, Rhode Island, Texas, Utah, Virginia, and Washington.

[7] The Services Research Outcome Study is the first national study of substance abuse treatment outcomes to include a representative sample of drug abuse treatment programs in rural, suburban, and urban

treatment is effective at improving certain outcomes including decreased drug use, criminal activity, and unemployment. However, the overall response rate in these studies was low, influencing the ability to draw firm conclusions about treatment effectiveness.

CONCLUSIONS

Although there is little information on the outcomes of states' drug abuse treatment programs, SAMHSA and some states have efforts under way to determine program effectiveness. SAMHSA monitors state expenditures to determine whether block grant funds are used in accordance with statutory requirements. However, this type of monitoring is not designed to determine the effect state drug abuse treatment programs are having on client outcomes--an important aspect in ensuring federal and state accountability for program results. Some states are assessing the effectiveness of their treatment programs using various outcome indicators, but the data are not uniform—which, according to SAMHSA officials, is essential for determining the effectiveness of drug abuse treatment programs and for reporting the information to the Congress. SAMHSA is trying to determine the availability of client outcome data from all states and has awarded grants to some states to help improve their data collection systems. These efforts should help identify states' views about and some of the complexities associated with collecting and reporting uniform client outcome data. SAMHSA's efforts should also help to determine what additional actions are needed to get uniform state reporting on the results of drug abuse treatment programs supported with SAPT block grant funds.

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locations. The National Treatment Improvement Evaluation Study, a 5-year study, examined outcomes such as drug use, criminal activity, and employment before and after treatment.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members of the Subcommittee may have.

CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Janet Heinrich at (202) 512-7119. Key contributors include Veronica Henry, Janina Johnson, and James O. McClyde.

(201030)

Mr. MICA. I recognize Mr. Paul Puccio, executive deputy commissioner, Alcoholism and Substance Abuse Services from Albany, NY.

Mr. PUCCIO. Thank you, Mr. Chairman. It is a pleasure to be here. I am going to speak the highlights of my written testimony and sort of summarize the basic points we want to make.

First, I want to set a context. The New York State system is a large and comprehensive delivery system. It is approximately $1.3 billion on an annual basis to pay for prevention and treatment services. That is the publicly funded system. The block grant approximates about $100 million of that amount. There are about 125,000 people on any given day in the treatment system; about 250,000 people are treated annually. It is a very large and comprehensive system.

But I want to point out two very important factors. One is that the gatekeepers for admission to the system are very diverse and multiple in a State like New York. We have judges from drug courts to the traffic courts to family court; DAs, you mentioned the DTAP program, on the social welfare side, employment side, all of them have authority to mandate people into treatment. Approximately 40 to 50 percent of all the people in the treatment system are there because of some form of mandate.

Also, the system does not exist in isolation of other human service systems. Successful alcohol and drug treatment services don't arise only out of the treatment system; they arise out of a complementary set of services associated with the provision of health care, mental health services, housing services, child welfare services, and it goes on. Systems operate in some sort of synergistic fashion in order to make a difference for the lives of people enrolled.

The other thing to understand is that all of these systems that send people to us, all of the gatekeepers are demanding expectations of the system. They all are looking for points of accountability and for good outcomes of treatment. That is an important understanding because it relates directly to the reporting requirements that fall to the system. Everyone is accountable to multiple gatekeepers and there are multiple systems of accountability that are cumbersome and difficult for our providers, and for States and county governments, as we deal with these demands for accountability.

I would also point out that one of the things that happens in a State like New York is that we, as the single State agency, play a very significant role as systems managers. We are not only managing our own system of services, which is very complex and extensive, but we are also doing it in relation to other service delivery systems; and that is an important understanding about what we do at the State government level.

This system did not get built without a long-term partnership with the Federal Government. Federal agencies working with State agencies, working with county governments and providers helped build the system over a long period of time. The block grant sustains a portion of that system, and KDA local funding was used to incrementally improve the system with an infusion of technology, as well as to provide additional services which complemented and added to the richness of the service delivery system.

It is also important to know that technical assistance that is provided by SAMHSA is a valuable commodity to the States. We in New York use technical assistance to provide managed care training to our providers as they begin to enter the world of managed care. They needed to get up to speed, and that was an important element in terms of using those resources to train those providers.

The system is very accountable. We have shared with the committee copies of our evaluation studies. We are doing very well in terms of demonstrating the effectiveness of our service delivery system. That effectiveness is enhanced by the multiple points of accountability. Everyone wants the same things in terms of outcome, and we are beginning to see significant improvement.

We are beginning to allocate our resources in the State of New York based upon provider performance. Not only must you do well, but you must be increasing standards and do so in a cost-effective, cost-efficient manner. We are pleased with that.

I would say to you that we have a concern with regard to the future of the system, in particular our relationship with the Federal Government. We have a very rich and diverse system. It is unique to New York; no two States are the same in terms of the service delivery system. It is important when moneys flow into the State of New York, there is a dialog and discourse with the State agency about how things will fit; if they don't fit well, there is the potential that there will be ineffective use of those resources. It is important that money flow through the State in a way that allows us to assure its integration into the system.

We also are very concerned about data reporting, and this is a major issue for us. As I mentioned, the multiple systems of accountability, we see a lot of that and we cannot have multiple systems lying on top of multiple systems.

We in New York have built a significant information system that supports accountability in our State. As we look to the future for new reporting requirements that come from the Federal level, it has to be integrated carefully with what we do, and we need that to occur so there is not an inappropriate disinvestment in the already expensive information systems that we have in place.

The bottom line is that we see the need, as we look to the future, for increased flexibility in the use of the block grant in terms of being able to accommodate the emerging needs and the changing needs. We need systems of accountability that integrate Federal, State and local and provider concerns and are not competitive and result in dislocation and disruption; we also need a continuing partnership with the Federal Government that basically produces an effective local service delivery system such as we believe that we have in the State of New York.

Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Puccio follows:]

NEW YORK STATE OFFICE OF ALCOHOLISM
AND SUBSTANCE ABUSE SERVICES

GEORGE E. PATAKI, GOVERNOR
JEAN SOMERS MILLER, COMMISSIONER

"HHS DRUG TREATMENT SUPPORT: Is SAMHSA Optimizing Resources?"

Testimony Delivered on February 17, 2000

GOVERNMENT REFORM COMMITTEE
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

By:

PAUL S. PUCCIO
Executive Deputy Commissioner
NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Introduction

Chairman Mica, and distinguished members of the Subcommittee on Criminal Justice, Drug Policy and Human Resources, my name is Paul Puccio. I am the Executive Deputy Commissioner of the New York State Office of Alcoholism and Substance Abuse Services (OASAS). I wish to thank Chairman Mica for inviting me to provide testimony at this public hearing entitled, "Health and Human Services Drug Treatment Support: Is the Substance Abuse and Mental Health Services Administration (SAMHSA) Optimizing Resources?"

My testimony will address the questions raised in the letter of invitation regarding the impact of SAMHSA's programs on the state and local levels, the obstacles, challenges, and future needs, including improvements.

Background

It is important that I place my remarks in the appropriate context by providing some background information on the New York State addictions prevention and treatment system.

OASAS is responsible for licensing and regulating the entire prevention and treatment system in New York State, and for oversight of those programs which are publicly funded, including the use of Substance Abuse Prevention

and Treatment (SAPT) Block Grant and other SAMHSA funds. The publicly financed prevention and treatment system approximates $1.3 billion in annual expenses. Just over one-half of this amount is financed through the Medicaid program. Of the balance, approximately $100 million is comprised of SAPT Block Grant funds; $270 million is state general fund appropriations; $100 million is public welfare funding; $50 million is local government contributions, and the rest is made up of miscellaneous receipts. There are more than 700 organizations that are licensed and regulated by OASAS, and New York State's program capacity encompasses more than 1,300 specific treatment sites and 2,000 prevention sites under the auspices of these licensed and funded organizations. On any given day, approximately 125,000 people are in the treatment system. Over the course of one year, approximately 250,000 people are served by the treatment system. This is the largest, most comprehensive addiction system in the nation.

It is essential to note that OASAS' treatment and prevention system does not exist in isolation of other systems. Specifically, access to treatment is often managed by a variety of other government agencies and jurisdictions. Between 40 and 50 percent of all people served in OASAS' system are "mandated" into treatment. Judges in traffic, family, criminal, and drug courts

have the authority under New York State law to mandate individuals into treatment. Statutory changes under welfare reform recently permitted local county officials to mandate to treatment those individuals who receive public assistance and are unable to work due to addiction problems. Individuals may also be mandated to treatment under the jurisdiction of District Attorneys, in programs such as the nationally recognized Drug Treatment Alternatives to Prison Program (DTAP), and as a condition of probation or parole.

The significance of this understanding relates directly to OASAS' responsibility to other jurisdictions and service delivery systems which can mandate individuals to treatment. These systems have expectations with regard to the outcomes of treatment and anticipated improvements in the lives of the persons who participate in OASAS' treatment system. In addition to the requirements for data reporting emanating from OASAS under New York State and federal SAPT Block Grant authority, the treatment providers also have a responsibility to submit information that supports their accountability to the various service systems.

Further, New York State's treatment system does not exist in isolation of the services offered in other systems. The child welfare, criminal justice, public assistance, housing, health care, mental health, and other systems

play complementary and supporting roles in assisting a client to succeed. For example, an addicted mother with three children, who is on probation and without a job cannot succeed in treatment, return to her family, and lead a productive life without a variety of other systems supporting her and her children. Those supports include: child care, housing, vocational training, job placement, etc. In this regard, a significant role is played by single state agencies for addiction treatment, such as OASAS, in building the linkages and bridges that are essential to achieve the systems integration that bring about successful outcomes of treatment.

Role of Federal Grants

In many respects, the development of this comprehensive system arose out of a strong partnership among federal, state, and local governments, with community-based providers. State government took advantage of federal funding initiatives to fill gaps and develop the system as we know it today. The SAPT Block Grant provided ongoing support while categorical funds, and recently the KDA's, were used to target the expansion of capacity or to infuse new technologies to address the needs of special populations or public health concerns like HIV and Tuberculosis. Over time, the focus on special need and targeted expansion initiatives has embedded itself into the ongoing

administration of the SAPT Block Grant which now has more than 20 set-asides and other restrictive requirements. While this has clearly created problems for states in terms of decreased flexibility to accommodate emerging state and local service needs, it must be recognized that this emphasis did contribute to the development of a comprehensive service system.

Furthermore, SAMHSA and its predecessor agency, have played a significant role in providing valuable technical assistance to states and local providers. Many states rely on technical assistance grants and contracts through SAMHSA to provide specific training to providers to assist them assimilate knowledge or adapt to a changing environment. In New York State, OASAS used SAMHSA's technical assistance to make available training to our providers to assist them in adapting to the new world of managed health care.

How Are State Systems Doing?

OASAS is extremely proud of the advancements that have been made with regard to performance monitoring and outcome measurement. OASAS complemented the federal SAMHSA requirements for admission reporting with discharge reporting and monthly status reporting. This has allowed

OASAS to monitor the success of providers in meeting treatment goals. OASAS has furthered this effort by building into funding contracts, requirements for specific outcome reporting for each program. And, we have begun to develop comprehensive community based data systems which allow OASAS to assess the impact of alcohol and drug abuse in communities by reviewing information such as arrest data, probation data, hospitalizations, and a variety of other data elements which serve as surrogate measures of the consequences and extensiveness of the impact of addiction on communities.

With specific regard to performance management of its providers, OASAS has now completed two sequential studies of the success of treatment programs. OASAS is proud to report that, across the board, there are significant improvements in client outcomes through treatment. The ranges of improvement which follow are associated with the experience in four different treatment modalities in our system for all of the following statistics. Reductions in the numbers of clients arrested ranged from 64 to 94 percent. The percentage reduction in the number of days clients were incarcerated ranged from 79 to 97 percent. As a result of participation in treatment, reductions in the use of inpatient detoxification services were

reduced from 66 to 98 percent. The percent reduction in the number of days that clients spent in hospitals for related health care conditions ranged from 52 to 87 percent. Finally, the percentage of clients who maintained or improved upon their employment status ranged from 35 percent to 53 percent.

As a further advancement, OASAS has begun to allocate its publicly funded resources based upon performance and client outcomes. Our objective is to raise standards and expectations and to encourage providers to meet these expectations. In this regard, training, technical assistance, and the peer review process which is required under the SAPT Block Grant, among other techniques, are used to assist providers to improve the quality of their treatment programs and outcomes for their clients. In addition, OASAS adjusts its resource allocations when necessary, to maximize its investment in the service delivery system.

The overall effort to improve performance and outcome measures has been carried out through a variety of projects and SAMHSA grants, such as TOPPS and TOPPS II. In collaboration with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), OASAS has engaged with SAMHSA's Centers for Substance Abuse Prevention (CSAP) and Treatment

(CSAT) in furthering their understanding of performance measures and OASAS' and other states' ability to implement them.

This ongoing discourse between state and federal partners in building systems of accountability has been valuable, although at times frustrating. As previously mentioned there are a variety of service systems which can mandate individuals into treatment. Each one has their own expectations for performance and outcomes. Similarly, at the federal level, different federal agencies and funding programs create separate and parallel tracks of interest and accountability which yield the potential for confusing, duplicative, and sometimes incompatible reporting requirements. Notwithstanding this, OASAS' progress has been significant and has resulted in a valuable contribution that demonstrates that addiction treatment does work.

Obstacles, Challenges and Impediments

Perhaps the most significant concern that state authorities like OASAS have regarding the role of the federal agencies is the need for greater understanding of the system's management functions carried out by the single state addiction agencies. We manage our system, and do this in relation to the other systems that complement and support successful treatment. This requires an understanding of the unique attributes and

structures of the state and local governments. Compounding this complexity is the knowledge that no two states are the same. Recently, OASAS has witnessed an increase in frequency in which SAMHSA goes directly to providers with funding opportunities, absent input from the state addiction agency. This eliminates the opportunity for all of the partners to engage in an appropriate discussion about how the federal initiative fits within the state system and how it complements state and provider efforts to sustain and improve quality in those systems. OASAS understands the need for federal agencies to exercise more accountability for the funding that goes to providers. However, without input from the state addiction agencies there exists the potential for not maximizing these resources or incorporating federal initiatives into the state and local system. Given the complexity of state systems and the diversity among the states, OASAS believes that federal programs will have the greatest impact when state agencies like OASAS are engaged with federal agencies in initiating programs and changes.

Another concern of OASAS is associated with the pervasiveness of the accountability requirements upon state agencies and providers. As SAMHSA carries out its intentions to develop comprehensive performance and outcome

reporting, it must recognize that there are other gatekeepers and systems interested in the same issues of accountability. It would be extraordinarily beneficial if there were one agreed upon data set that meets everyone's interest. Care must be given to assure that in the pursuit of one federal agency's interests, the interests of other agencies and other jurisdictions also seeking improvements in performance measurement and outcomes are not dismissed or impeded. More coordination at the federal level can meet this objective.

Further, SAMHSA and the ONDCP must recognize the fact that many state's technology systems and capacities for data reporting are systems and technologies that have been built up over many years, updated as necessary. States like New York have already made significant investments in data systems which cannot be abandoned or modified without considerable cost and disruption. Time, money, and provider training are essential ingredients in the successful investment and reinvestment required to achieve uniform national performance and outcome reporting.

Finally, the specific focus of a federal agency like SAMHSA on addiction treatment and prevention is extremely beneficial. It provides a clear focal point for all concerned to engage with the federal government in discussions

on matters of partnership around prevention and treatment issues. That focal point must not be lost, and OASAS encourages reauthorization of SAMHSA with that specific purpose in mind. Despite this necessity, OASAS believes that there must be broader recognition of the inter-system dependencies that are associated with successful treatment. Just as OASAS is responsible for building linkages and bridges to systems at the state and local level, so must there be an integrated and comprehensive approach at the federal level. This must be part of the understanding in the reauthorization. Further, it is recommended that the SAPT Block Grant be made more flexible, that the use of funds supporting treatment can be appropriately integrated into unique state circumstances. OASAS believes that this can be done without a loss of accountability or desired impact. Lastly, SAMHSA's role in promoting technology transfer and system improvement through KDA's and technical assistance to states and providers remains a necessary component of that agency's role in support of all the stakeholders in the system.

Future Needs

OASAS offers three areas of need that must be addressed in order for us to build upon our successes toward an even better future.

First, we must continue to work together amongst all the partners to

improve systems of technology transfer. Advances in research in both the basic and applied levels must be translated into easily understood curriculum and training materials; and systems for dissemination must be developed to assure rapid and broad-based assimilation of new knowledge. OASAS is strongly encouraged by the recent "Research Practice Collaborations" which have been stimulated by CSAT in order to address this concern, and in New York State we believe that coupling this collaborative, which includes community providers and OASAS, with the Clinical Trials Networks being developed by NIDA offer an example of the type of effort that can yield rapid and successful knowledge transfer to the benefit of improved treatment outcomes.

Second, OASAS believes that states must be given greater flexibility in the use of federal funds. The set-asides and other restrictive requirements in the SAPT Block Grant are creating increased barriers to using our resources to improve effective outcomes. Our systems are undergoing changes driven by the assimilation of new technology and from inter-system linkages. OASAS trusts that we will have a federal partner in this process whose requirements and set-asides do not impede the successful implementation of change in a flexible and responsible way.

Finally, we need improved data and information systems that support all of our interests. These are not just systems associated with addiction treatment, but also information systems that address the needs arising from other human service and criminal justice systems. We must be cautious and act in partnership as we further develop data and information systems that will support our objectives.

Closing

On behalf of OASAS, I would like to thank the Chairman and the members of the subcommittee for the opportunity to submit this testimony and trust that we have provided valuable information that will assist the committee in its oversight responsibilities.

Mr. MICA. Dr. John Keppler, clinical director, Commission on Alcohol and Drug Abuse from Austin, TX.

Welcome, and you are recognized, sir.

Dr. KEPPLER. Mr. Chairman and members of the committee, I thank you for allowing me to be here. At the outset, I am submitting this packet of information from Texas for the record.

Mr. MICA. Without objection, that information will be made part of the record.

Dr. KEPPLER. I will summarize some of my thoughts from my little prepared talk today.

I spent 15 years in the direct delivery of service both in private practice at the faculty of a medical school and rehabilitation medicine and being a medical director and direct service provider to individuals with this problem, both in detoxification and active treatment, both inpatient and outpatient in the public and private sector. And so in my last 2½ years of going into different kind of public service, it has been an interesting perspective to see the struggles which the country faces.

Texas, as does the rest of the country, faces an immense struggle with what I prefer to call an epidemic of substance abuse. The availability of the substance throughout our society as an agent that causes many people to fall ill, like any other illness that we face. Against the overwhelming need and demand for these services are rising health care costs and costs shifting from private to public sector, where the public-sector dollar for substance abuse literally becomes one of the few places you can obtain what one would refer to as adequate substance abuse treatment services.

Again, the dollars being so precious, the quality of outcome and the quality those services provided is very important. The substantial portion of total available publicly funded substance abuse services outside criminal justice comes from the substance abuse prevention and treatment block grant in our State.

We have worked closely with SAMHSA over the years on several policy matters, including the difficult issues surrounding services to those with both mental health and substance abuse problems; and Texas is about to implement the children's health insurance program, and is proud of the excellent benefits for substance abuse prevention and treatment that it contains. It is perhaps one of the largest benefits in the country for our children.

We are grateful for SAMHSA's clear leadership on that and very grateful for the collaboration between SAMHSA and NIDA, for the excellent technical assistance we have received; and we appreciate their publications. That has helped and trained a lot of folks in the public sector. They are very readable and extremely helpful.

We served about 40,000 people with the substance abuse prevention and substance abuse block grant, and as you heard from the doctor who was here before, you can quintuple that number who actually need and want services. There is more than just need, but as we define want, you can quintuple that number to around 250,000.

We have some concerns. We are concerned about the KDA projects. They are well intentioned, but SAMHSA's involvement is time limited. When SAMHSA is out, it is up to the State to continue the program, a program that may not fit into our service

plan. In Texas, SAMHSA has helped us develop a strong data collection system, and that system coupled with our knowledge and need surveys puts our State in the unique position to make the best and most efficient use of funding currently being awarded through Federal KDA grants.

We are excited, though, about the 19 States participating in the treatment outcome and performance pilot studies, and we believe this project has a great potential to develop standardized methods to measure the effectiveness of our programs, particularly in the area of looking at outcomes from the aspects of case mix adjustment, which I believe we need to do in our field very strongly. We have collected outcome data, performance outcome data since 1985 and get outcome data on 70 percent of our clients, which I have included in this packet. We know it works in Texas. We also know where the problems are.

With the support of SAMHSA, we utilize a great deal of epidemiological data to help us monitor the drug trends in our State. I believe our emerging epidemiologic studies are very important.

I would like to say how much we appreciate SAMHSA's national leadership. Certainly that leadership has helped Texas strengthen and develop our data collection tools. Now we would like to use these tools to be able to make all of the relevant funding decisions in the State.

Giving the States control over the money currently set aside for KDA will preserve the best parts of this program. The money will meet the needs of the most vulnerable populations and develop innovative services. That is what we are already doing at the State level. We need the added flexibility to ensure that the money devoted to these projects are pursuant to our State delivery plan. This change would help us better meet the unique needs of Texans struggling with addiction, and that is a mission that I share with the Federal.

Thank you for an opportunity to testify today. On a personal and professional level, I have struggled with this issue in the private and public sectors. I relate extremely strongly to the previous panel members, who are out there on the front lines, and respect their work. Thank you.

Mr. MICA. Thank you.

[The prepared statement of Dr. Keppler follows:]

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"HHS Drug Treatment Support: Is SAMHSA Optimizing Resources?"
House Subcommittee on Criminal Justice, Drug Policy and Human Resources
February 17, 2000
Testimony of Dr. John Keppler, Texas Commission on Alcohol and Drug Abuse

Mr. Chairman and Members of the Committee:

I'm Dr. John Keppler, the clinical director at the Texas Commission on Alcohol and Drug Abuse. I want to thank you for the opportunity to be a part of this important process.

Texas, as does the rest of the country, faces an immense struggle in dealing with the epidemic of substance abuse. This problem manages to affect almost every aspect of our lives – our schools, individual health and healthcare institutions, criminal justice systems, employment/welfare issues and our families.

We also face an overwhelming need and demand for services against the backdrop of rising healthcare costs. This clearly makes each dollar available for services quite precious. It also raises the stakes for accountability in terms of the quality and the outcome of services purchased.

In Texas, federal funding accounts for more than 80 percent of the total available for publicly funded substance abuse services in our state. The bulk of that money -- $122 million -- comes from the Substance Abuse Prevention and Treatment Block Grant. As you know, the Substance Abuse and Mental Health Services Administration distributes that block grant. Today, I'd like to focus on our state's relationship with SAMHSA.

We have worked closely with SAMHSA over the years on several policy matters, including the difficult issues surrounding providing services to those with both mental health and substance abuse problems. Texas is about to implement the Children's Health Insurance Program and is proud of the excellent benefits for substance abuse prevention and treatment that it contains. We are grateful for SAMHSA's clear leadership and help in these matters. We also are grateful for the collaboration between SAMHSA and NIDA. It makes our jobs a little easier at the state level. And we have received excellent technical assistance from SAMSHA on a variety of issues.

On the whole, I think the relationship between SAMHSA and the states is a productive one that greatly benefits the lives of many people struggling with the disease of addiction. In Texas, we served almost 40,000 people in our treatment programs last year and almost 700,000 people in our prevention and intervention programs.

We do, however, have one concern that I'd like to talk about. SAMSHA devotes 14 percent of its budget to so called KDA projects (discretionary grants). These projects are well intentioned, but SAMHSA's involvement with these programs is generally time limited. When SAMSHA pulls out, it's up to the state to continue the program – a program that may or may not fit into our service plan.

Mailing Address: P O Box 80529•Austin, TX 78708-0529
9001 North IH35, Suite #105 • Austin, TX 78753-5233 • tel (512) 349 6600 • fax (512) 837 8500 • web http://www.tcada.state.tx.us

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In Texas, SAMHSA has helped us develop a very strong data collection system. We believe that system – coupled with our knowledge of our state's unique needs – puts the state in the best position to make the best, most efficient use of the funding currently being awarded through federal categorical grants.

We're very excited to be one of 19 states participating in the Treatment Outcome and Performance Pilot Studies, and we believe this project has great potential to develop standardized methods to measure the effectiveness of our programs, particularly in the area of looking at outcomes from the aspect of case mix adjustment. Refining this aspect of outcomes will allow substance abuse outcomes to be judged fairly against outcomes for other healthcare services. We've been collecting and using this type of data since 1985.

We know what works in Texas.

We also know where the problems are. With the support of SAMHSA, we utilize a great deal of epidemiological data to help us monitor drug trends in our state. This information plays an integral role in our funding formula and in our service plan. In Texas, we continually identify regional needs and gaps in our service array.

Again, I'd like to say how much we appreciate and respect SAMHSA's national leadership. Certainly, that leadership has helped Texas strengthen and develop our data collection tools. Now we'd like to be able to use those tools to make all the relevant funding decisions in our state.

Giving the states control over the money currently set aside for KDA projects will preserve the best parts of this program. This money still will be devoted to meeting the needs of the most vulnerable populations and developing innovative services. That's what we're already doing on the state level. However, we need the added flexibility of ensuring that the money devoted to these projects fits into our state's service delivery plan. This change would help us better meet the unique needs of Texans struggling with addiction, and that's a mission I know we share with the federal government.

Thank you once again for the opportunity to testify today. I will be happy to answer any questions.

Mailing Address: P O Box 80529•Austin, TX 78708-0529
9001 North IH35, Suite #105 • Austin, TX 78753-5233 • tel (512) 349 6600 • fax (512) 837 8500 • web http://www.tcada.state.tx.us

Mr. MICA. Now I recognize Kenneth Stark, director, Division of Alcohol and Substance Abuse from Olympia, WA.

Mr. STARK. Thank you. I will try to be as brief as possible. I would like to take a few minutes to respond to some of the questions that came up during the previous panel. When I speak about those issues, I will touch on them relative to Washington State because, as has already been stated by Paul from New York, each State is somewhat different. There are different needs and resources and different systems that have been built, although they all try to focus on serving the best practice possible, given the demands for those resources.

Let me first mention that our division is the single State agency responsible for managing block grant resources. In the State of Washington, we get about $30 million a year for the block grant, out of a total of $110 million per year budget for prevention, treatment and related support services. So you can see that the block grant is a part of our budget but not by any way, shape or form the largest part. We have a fairly substantial State investment in services.

One of the things I heard earlier is that treatment is expensive, and part of the context of that is, compared to what? When you look at alcohol, drug problems, and particularly when you get to issues of chronic addictions, we know at least in Washington State, and I am sure that these numbers are not that different nationally that more than 50 percent of all emergency room visits that are related to trauma are alcohol- or drug-related. We know that a good 82 percent of the kids locked up in our State juvenile correctional facilities have a substance abuse disorder. Seventy percent of the people in jails and prisons have a major problem.

We know that when we provide treatment, those numbers are substantially impacted. People get better. So the question is: Is alcohol/drug treatment expensive? Well, in the context of spending nothing else, maybe it is, but in the context of spending money on the consequences of not funding alcohol/drug treatment, alcohol/drug treatment is cheap.

In the State of Washington, in the public sector, the average cost of alcohol-drug treatment per client is about $2,500. That includes our so-called failures and our so-called successes; it is not that expensive. We know from a lot of data collection and a lot of research that we have done—and this is not just self-reported data, but this is verifying data from other records, including criminal records, vital statistics, birth records, medical records—that when you provide alcohol/drug treatment compared to a population that needed that treatment that is comparable and didn't get it, there are significant cost savings. Even after accounting for the cost of the alcohol and drug treatment, it more than pays for itself. And in Washington we have been fortunate to have major support from the Governor and major support from our State legislature and some of the other program areas that have seen our data and know that when you fund alcohol/drug treatment, you are funding health promotion/crime prevention. It is a key issue.

Treatment standards were mentioned earlier. It is important to have treatment standards. I can't tell you a thing about programs that are out there in the State of Washington that are not certified

and accredited by us because we don't monitor and regulate them, and so we don't research them; so I can't tell you about those. I can only tell you about the ones that we fund, we regulate and we accredit.

Faith-based services, we do fund faith-based services, but there is that issue, and it is a Federal one, about you cannot force somebody to go to chapel or go to church. So we have got faith-based organizations who are accredited by us and are funded by us, but the faith-based part of the program for the clients that we fund has to be optional.

Six percent SAMHSA administration, is that good or bad? I couldn't tell you by looking at that chart. I can tell you that the administration in our division is 6 percent, and I don't see that as expensive, assuming that you know what the other services are that get funded with that. In our division, 6 percent covers budgeting, contracting, contract monitoring, evaluation, training, technical assistance.

So is 6 percent expensive? In our division, no. As a general number, I would say no. In this case, on that chart, I can't tell you; I would have to look at all of the details.

What are some of the issues? SAMHSA positive stuff. I am moving faster now. Clearly technical assistance is helpful. Clearly the studies on evaluation are helpful. The State needs assessment grants that SAMHSA has funded are very helpful. What is problematic, the block grant is not a block grant, it is "blockegorical." It has so many set-asides and requirements it is incredibly cumbersome to manage.

Then the second bullet in my written testimony talks about the block grant application. You, Mr. Chairman, have talked about 400 hours to fill it out. Part of the reason is because the block grant itself, the congressional requirements are so categorical. SAMHSA has to require us to report on a number of different things, so they can get some relief by that.

There is also a big push that I would like to make relative to a comprehensive research strategy and outcome-performance-based strategy. We lack one. There are a lot of activities going on, but we lack a comprehensive strategy within SAMHSA, as well as across the Federal agencies working in partnership with the States, to truly look at how we can best measure outcomes utilizing resources available. One of the problems is the institute funding for research, although it does a lot of good research it has very little relationship to the SAMHSA block-grant-funded programs. Why is that? The red light is on. I will close and answer questions later.

Mr. MICA. You can finish. We give a little bit of breathing time.

Mr. STARK. On the KDAs, good news and bad news. They have funded a number of good programs. The challenge with the KDAs is that there needs to be a stronger relationship between SAMHSA and the States relative to developing the priorities for funding with the KDAs, as well as the reporting protocols, and how it fits into a comprehensive strategy. So we think we could use some increased partnering there.

I already talked about the NIDA stuff. There needs to be a closer link between the Federal institutes research and the block-grant-funded prevention and treatment programs.

The national household survey, while it is a great tool for a national macro picture of the alcohol-drug use patterns and the problems, even with the new proposed State sort of monitoring processes, it will not be useful for States. Again, the number of people that will be included from the individual States are so small to render them useless for counties to be able to look at individual county-level needs. So there is a problem there.

And the national household survey is not what I would consider low cost. It is a fairly expensive study, and it seems to me maybe we could look at how that could be made more efficient, and some money could continue in the SAMHSA budget to fund State needs assessment projects where you can get lower-level, county-level needs which at the local level you need.

And then finally, my last point in the written testimony, how do we get more State representation in policy development relative to SAMHSA's activities? One of the ways to do that is on committees, including the current SAMHSA advisory committees, and having been on one of those committees, I can tell you, although they do good work and I appreciated being on it, there is minimal participation from States on those advisory committees. But there is significant grantee participation on those committees, and I think there needs to be more balance, since States are the predominant receiver of SAMHSA funding.

With that, I will close.

Mr. MICA. Thank you.

Now I would like to recognize Dr. Martin Iguchi, co-director of the Drug Policy Research Center of the RAND Corp.

You are recognized, sir.

Dr. IGUCHI. Thank you, Mr. Chairman, and thank you for this opportunity to testify. I ask that my written statement be entered into the record.

Mr. MICA. Without objection, so ordered.

Dr. IGUCHI. As a member of CSAT's National Advisory Council, as a NIDA treatment researcher, as a psychologist and former drug treatment program administrator, and as co-director of the Drug Policy Research Center at RAND, I have spent considerable time thinking about SAMHSA's role as it relates to the provision of drug treatment in America.

I am going to focus on one question: Is SAMHSA helping local and State communities to make the best use of their scarce drug and alcohol treatment resources? My discussion on this question involves three areas of SAMHSA activity in support of the community decisionmaking: one, helping communities to identify treatment costs, treatment utilization, and treatment outcomes; two, are they helping communities to determine where treatment is most needed; and three, are they helping communities to identify best treatment practices? SAMHSA plays a vital role in these areas, and as I will discuss, they continue to face many challenges.

In the first area, communities need information to assess what treatment resources are in place, the cost of those resources and how those resources are performing. This is a very complicated process, as a single individual may utilize services from a variety of systems. For example, a single person may be enrolled in drug treatment, they may be getting treatment for depression at a com-

munity mental health center, they may be on Medicaid, and they could be involved with a criminal justice diversion program. Each system contacted by that individual keeps its own records in its own separate data base. In order to understand the coordinated cost of services utilized by a given individual requires a single data base integrating information from multiple systems.

Recently in partnership with the States of Oklahoma, Washington and Delaware, SAMHSA developed a data base system capable of merging cost and utilization information from Medicaid, mental health and substance abuse systems. This integrated data base system represents an important step forward in that it overcomes significant technical obstacles and recognizes the multitude of agencies and resources that must be coordinated to evaluate service delivery.

Although it would be ideal for all health delivery programs to monitor outcomes as a matter of routine, doing so can be an expensive and complicated proposition. This is particularly true for substance abuse treatment because followup is complicated by a distinct lack of resources in existing agencies to collect this information, by the illegal nature of the problem, by the low socioeconomic status of many in treatment, and by the multiple life dimensions positively influenced by treatment that need to be measured to fully reflect the effect of treatment.

For example, treatment may reduce substance use, it may diminish criminal activity, it may diminish violent behavior, it may improve mental health, it may increase the likelihood of employment, or it may prevent the birth of a drug-exposed child.

Recognizing the complications and expense of ongoing outcomes monitoring in community settings, SAMHSA has commissioned a working group specifically to address this issue, and they have entered into numerous partnerships with States to develop performance measures for a variety of treatment interventions. Quite appropriately, these groups have focused, to date, on a number of drug treatment process measures that may be used by communities as predictors of outcome. These intermediate measures might include, for example, the amount of substance use reduction, treatment retention, treatment engagement, patient satisfaction, or quality-of-life improvement.

While significant progress has been made in the development of tools for assessing cost and performance, much work remains to be done in integrating cost and effectiveness measures. While this is not an issue for SAMHSA alone, the lack of consensus among economists regarding the best means for conducting economic evaluations of drug treatment programs means that the comparisons across different evaluations are compromised by a lack of reporting standards. This leads to decisionmaking guided by cost considerations alone—without adequate attention to effectiveness.

On my second point of helping communities to determine where treatment is most needed, in 1998, the U.S. GAO reported serious deficiencies in States' abilities to develop estimates of treatment need. This problem continues. States still do not have capacity for assessing treatment need. SAMHSA's recent expansion of the National Household Survey on Drug Abuse to allow for State-level analyses represents a potential improvement in the availability of

epidemiological data for communities. However, in order for this information to be useful to States, several problems must also be addressed.

First, SAMHSA needs to place considerably more emphasis on releasing the data as quickly as possible to State analysts in a form that allows for analysis of regional need.

Second, States require more technical assistance to develop systems for monitoring treatment need. SAMHSA needs to provide leadership in the development of analytic models that will allow States to make use of their own data. At this point, there is very little capacity.

On the third point of helping communities to identify best treatment practices, SAMHSA has done an excellent job in the promotion of evidence-based practices. The addiction technology transfer centers and the treatment improvement protocols all play an important role in the dissemination of "best practices" guidelines.

Another mechanism for promoting treatment quality is through accreditation. In the treatment of chronic opiate abusers, SAMHSA's new role in accrediting methadone treatment providers, formerly an FDA function, represents a tremendous move forward for the field and holds significant promise for the promotion of evidence-based practice.

In addition to dissemination, SAMHSA appears to recognize that many community treatment programs already provide excellent care. SAMHSA has several projects that document and evaluate these model programs. SAMHSA also has a number of treatment projects that take empirically validated treatments and apply them in multiple community settings. These studies are important as they help to identify barriers to implementation, they demonstrate the real-world utility of interventions known only to researchers, they provide important information regarding cost cultural relevance, and they serve as models for policymakers and other treatment providers to consider.

In summary, SAMHSA has clearly played a vital role in helping communities to make good decisions about their allocation of scarce treatment resources. However, and as might be surmised from my brief review, SAMHSA has several challenges ahead. In particular, SAMHSA has a great deal more work to do in helping communities to identify treatment gaps. In order for the expanded National Household Survey on Drug Abuse to be useful, a system must be put into place that will get the data to States in a form that they can use.

Further, there is a tremendous need to upgrade the analytic capability of States and to provide them with technical assistance to make use of the data. This challenge must be met if communities are to make optimal use of their resources, and if we are to have full participation as a Nation in achieving the goals established in healthy people 2010.

Thank you.

[The prepared statement of Dr. Iguchi follows:]

T E S T I M O N Y

RAND

What is SAMHSA Doing to Help Communities Make Good Decisions About the Allocation of Scarce Treatment Resources?

Martin Y. Iguchi

CT-167

February, 2000

Testimony presented to the Subcommittee on Criminal Justice, Drug Policy, and Human Resources of the House Committee on Government Reform, February 17, 2000

Drug Policy Research Center

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Testimony Before the House Government Reform and Oversight Committee

Subcommittee on Criminal Justice, Drug Policy, and Human Resources

Thursday, February 17, 2000

What is SAMHSA Doing to Help Communities Make Good Decisions About the Allocation of Scarce Treatment Resources?*

Martin Y. Iguchi**

Thank you for the opportunity to testify. I ask that my written statement be entered into the record. [1]

As a member of CSAT's National Advisory Council, as a NIDA treatment researcher, as a psychologist and former drug treatment program administrator, and as Co-Director of the Drug Policy Research Center at RAND, I have spent considerable time thinking about the Substance Abuse and Mental Health Services Administration's (SAMHSA) role as it relates to the provision of drug treatment in America.

I am going to focus on one question: Is SAMHSA helping communities to make best use of their scarce drug and alcohol treatment resources? [2] My discussion of this question involves three areas of SAMHSA activity in support of community decision-making: 1) helping communities to identify treatment costs, utilization, and outcomes; 2) helping communities to determine where treatment is most needed; and 3) helping communities to identify "best" treatment practices. SAMHSA clearly plays a vital role in these areas, but significant challenges are identified and will be discussed.

Helping communities to identify treatment costs, treatment utilization, and treatment outcomes.

Communities need information to assess what treatment resources are in place, the cost of those resources, and how those resources are performing. This is a very complicated process as a

single individual may utilize services from a variety of systems. For example, a single person may be enrolled in drug treatment, they may be getting treatment for depression at a community mental health center, they may be on Medicaid, and they could be involved with a criminal justice diversion program. Each system contacted by that individual keeps its own records in its own separate database. In order to understand the coordinated cost of services utilized by a given individual requires a single database integrating information from multiple systems. Recently, in partnership with the states of Oklahoma, Washington, and Delaware, SAMHSA developed a database system capable of merging cost and utilization information from Medicaid, mental health, and substance abuse systems [3]. This integrated database system represents an important step forward in that it overcomes significant technical obstacles and recognizes the multitude of agencies and resources that must be coordinated to evaluate service delivery.

Although it would be ideal for all health delivery programs to monitor outcomes as a matter of routine, doing so can be an expensive and complicated proposition. This is particularly true for substance abuse treatment because follow-up is complicated by a distinct lack of resources in existing agencies to collect this information, by the illegal nature of the problem, by the low socio-economic status of many in treatment, and by the multiple life dimensions positively influenced by treatment. For example, treatment may reduce substance use, it may diminish criminal activity, it may diminish violent behavior, it may improve mental health, it may increase the likelihood of employment, or it may prevent the birth of a drug-exposed child.

Recognizing the complications and expense of on-going outcomes monitoring in community settings, SAMHSA has commissioned a working group specifically to address this issue [4] and they have entered into numerous partnerships with states to develop performance measures for a variety of treatment interventions [5]. Quite appropriately, these groups have focused to date on a number of during-treatment process measures that may be used by communities as predictors of outcome. These intermediate measures might include, for example, the amount of substance use reduction, treatment retention, treatment engagement, patient satisfaction, or quality of life improvement.

While significant progress has been made in the development of tools for assessing cost and performance, much work remains to be done in integrating cost and effectiveness measures.

While this is not an issue for SAMHSA alone, the lack of consensus among economists regarding the best means for conducting economic evaluations of drug treatment programs means that comparisons across different evaluations are compromised by a lack of reporting standards. This leads to decision-making guided by cost considerations alone – without adequate attention to effectiveness.

Support for identifying treatment gaps.

In 1998, the US GAO reported serious deficiencies in states' abilities to develop estimates of treatment need [6]. This problem continues. States still do not have capacity for assessing treatment need. SAMHSA's recent expansion of the National Household Survey on Drug Abuse (NHSDA) to allow for state-level analyses represents a potential improvement in the availability of epidemiological data for communities. However, in order for this information to be useful to states, several problems must also be addressed. First, SAMHSA needs to place considerably more emphasis on releasing the data as quickly as possible to state analysts in a form that allows for analysis of regional need [7]. Second, states require more technical assistance to develop systems for monitoring treatment need [8]. SAMHSA needs to provide leadership in the development of analytic models that will allow states to make use of their own data.

Identifying and Promoting "Best Treatment" Practices.

SAMHSA has done an excellent job in the promotion of evidence-based practices. The Addiction Technology Transfer Centers (ATTC's) and the Treatment Improvement Protocols (TIPS) all play an important role in the dissemination of best practice guidelines.

Another mechanism for promoting treatment quality is through accreditation. In the treatment of chronic opiate abusers, SAMHSA's new role in accrediting Methadone Treatment Providers (formerly an FDA function) represents a tremendous move forward for the field and holds significant promise for the promotion of evidence-based practice.

In addition to dissemination, SAMHSA appears to recognize that many community treatment programs already provide excellent care. SAMHSA has several projects that document and evaluate these "model" programs. SAMHSA also has a number of treatment projects that take

empirically validated treatments and apply them in multiple community settings. These studies are important as they help to identify barriers to implementation, they demonstrate the real world utility of interventions known only to researchers, they provide important information regarding cross-cultural relevance, and they serve as model for policy makers and other treatment providers to consider.

Conclusion.

In summary, SAMHSA has clearly played a vital role in helping communities to make good decisions about their allocation of scarce treatment resources. However, and as might be surmised from my brief review, SAMHSA has several challenges ahead. In particular, SAMHSA has a great deal more work to do in helping communities to identify treatment gaps. In order for the expanded National Household Survey on Drug Abuse to be useful, a system must be put into place that will get the data to states in a form that they can use. Further, there is a tremendous need to upgrade the analytic capability of states and to provide them with technical assistance to make use of the data. This challenge must be met if communities are to make optimal use of their resources, and if we are to have full participation as a nation in achieving the goals established in Healthy People 2010.

ENDNOTES

* This work was supported by a grant from the Ford Foundation to RAND's Drug Policy Research Center and by RAND Health. The views expressed here are the author's and are not intended to represent the views of RAND or the Ford Foundation.

** Senior Behavioral Scientist, and Co-Director, Drug Policy Research Center, RAND.

[1] In the interest of time, this paper skirts the block grant allocation formula entirely. For a thorough review of the Block Grant Funding Allocation Formula, please see Burnam, et al., *Review and Evaluation of the Substance Abuse and Mental Health Services Block Grant Allotment Formula.* Santa Monica: RAND, 1997.

[2] I use the term communities to broadly refer to state and local governments, as well as other self-defined interest groups, neighborhoods, and coalitions.

[3] See CSAT/CMHS Contract #270-96-007, Contract deliverable for task 24 #: Report on the system requirements for the integrated database for mental health and substance abuse treatment service project, August 29, 1997.

[4] See the CSAT document: Garnick (1999) "Improving performance measurement by managed care plans for substance abuse: Year 1 report of the Washington Circle Group."

[5] States involved in the state performance and outcome measurement partnership include: Arizona, Arkansas, Connecticut, Kansas, Maryland, Massachusetts, Minnesota, Missouri, North Carolina, North Dakota, Oklahoma, Rhode Island, Utah, and Washington.

[6] USGAO, *Drug Abuse Treatment: Data Limitations Affect the Accuracy of National and State Estimates of Need.* Washington, DC: United States General Accounting Office, 1998.

[7] Although not within SAMHSA's area of responsibility, data from NIDA's Monitoring the Future study, with regional identifiers, should also be made available to communities as expeditiously as possible.

[8] There is a substantial need for the development of models to usefully integrate the NHSDA data with other data sources to derive useful regional estimates of drug use and drug use trends over time. For an example of just how complicated this can be, see, Ebener, Saner, & Anglin, *Building a Data & Analysis Infrastructure to Support Substance Abuse Policy Decisionmaking: A Strategic Plan.* Santa Monica: RAND, 1995.

Mr. MICA. I thank each of the witnesses for their testimony. Unfortunately, some of the other Members are not here. They canceled the floor proceedings, and there are other hearings, so we don't have the normal participation of all of the Members.

For that reason, also, I have concurred with the minority in asking the final witness, Dr. Camille Barry, and also the administrator, Dr. Chavez, to appear at a later date so that will be a continuation of this hearing. We suggested also to staff that we may ask Dr. Leshner, the head of NIDA, to also participate in that, since we may need to look at the cooperative effort of NIDA and SAMHSA.

With those comments, let me, if I may, ask some questions.

First, for GAO. I notice on the GAO report table, for the 27 of the 29 contracts, over $1 million are awarded to Washington, DC area contractors.

Does this practice raise an issue of limiting business and range of knowledge to a particular area? Did you all look at that at all?

Ms. HEINRICH. We did not evaluate the contracting practices at your request. We simply obtained from SAMHSA the listing of the contracts that they do support. And as you state, I think almost 99 percent of them are in the Washington, DC area.

Mr. MICA. How might GAO ascertain the level of satisfaction of the States with SAMHSA's involvement and contributions to their efforts?

Ms. HEINRICH. Well, we certainly could go out to the States and ask those types of questions. And certainly you have some wonderful representatives here that will be able to give you information on that, as well, I am sure.

Mr. MICA. Could a comparison be made of States' support for increased block grant assistance versus discretionary funding?

Ms. HEINRICH. Yes, a comparison could be done.

Mr. MICA. Now, I looked through the report, Mrs. Mink did too, and we may want to re-craft additional requests for GAO's study. It provides us some preliminary information, but I think not in the depth or scope that we would like to obtain. But I appreciate your cooperation with this subcommittee.

I heard, New York and Texas and Washington, a little bit about your programs. Now, if you could recall for us on the committee the dollars that come from block grant and Federal sources versus State.

Mr. Puccio of New York.

Mr. PUCCIO. Our total system is about $1.3 billion. Half of that is Medicaid. About $100 million is the block grant and it is about $270 million in general fund tax dollars.

Mr. MICA. $100 million is block grant?

Mr. PUCCIO. Right. And about $700 million is Medicaid program.

Mr. MICA. And the balance is State?

Mr. PUCCIO. State, local tax levy, and miscellaneous receipts from public assistance funds and a variety of mixed revenues.

Mr. MICA. How about you, Dr. Keppler?

Mr. KEPPLER. I prefer—I can get you the information on Medicaid because that is administered by the Health and Human Services Commission, which is our umbrella agency. So our agency does not control the Medicaid substance abuse dollars, nor the dollars

our legislature dedicates for the in-prison treatment, our criminal justice system.

It is $122 million of the Federal substance abuse block grant, and I believe $27.5 general revenue for the programs we fund, publicly community-based projects outside Medicaid.

Mr. MICA. Mr. Stark, for Washington?

Mr. STARK. In Washington State, it is $110 million total budget. $30 million of that is Federal block grant funding. A little over $50 million are several sources of State funding, and the remainder is a blend of Medicaid and direct Federal grants.

Mr. MICA. In looking at the regulations that pour out and the constraints that are put on these programs, it appears that many of the programs are driven by Federal regulation requirements. Is that correct, Mr. Puccio?

Mr. PUCCIO. It is more driven in New York by our regulatory structure. Every treatment program is licensed and regulated and monitored by us. Whether it is faith-based or not, if they provide treatment in the State of New York, they are going to be subject to one of our licensing requirements.

Mr. MICA. How does that overlap with Federal regulations? Are State regulations pretty much a mirror of Federal?

Mr. PUCCIO. State regulations pretty much govern the service delivery side of things. Where the problem arises is that the set-asides and the other requirements that are inherent in the block grant basically put in place requirements and restrictions in terms of how it is that we use money. Any money that goes into the treatment system has to follow our regulations, but some of it has to be targeted at HIV, at people who are IV drug users, pregnant women. It goes on and on like that.

With all the different set-aside requirements, depending upon the locality, they may or may not have demand or service requirements that fit that mix; and it's the mismatch of the requirements against the local need that sometimes causes the problem.

Mr. MICA. So all of you three agree we need, first of all, more flexibility in the block grant program? All right.

What about in discretionary grants? How do they work? Mr. Keppler, how does that work for you in Texas?

Mr. KEPPLER. Well, as I tried to explain, I think it's somewhat problematic for us. In fact, we are oftentimes loathe to apply because it even limits our flexibility more. If we decide to go after something that has been decided upon that seems to fit what we might need, at some point in time it may go away and then we have to figure out how to shift things to pick that up and then catch the next one. So our desire to go after a significant sum of money which we would just prefer it go through the formula of the block grant and be distributed for us to plan, it is very hard to pick it up.

Mr. MICA. Now, in your States, I asked Florida to provide me with a list of all the programs that receive grants and then see how many they were already funding. Would the pattern be similar that most of the discretionary grant money goes to programs that you already are supporting?

Mr. PUCCIO. Absolutely. That is absolutely correct.

Sometimes what happens is that the KDA may actually add an element of service that is missing from the service delivery system, especially in certain geographic areas. So we may have a need for specialized women's beds that serve women and their children in a particular area, and a KDA might fit that particular requirement, and then it does complement with what takes place in that geographic area, even though we may already have substance funding with that provider. It fills a gap.

Mr. MICA. So in New York, in most instances, there is already going to be a program that is supported by the State?

Mr. PUCCIO. Yes.

Mr. MICA. Texas?

Mr. KEPPLER. Again, I want to emphasize, some of the clinical ideas have been extremely helpful, they have been extremely helpful ideas, ideas about how to put processes in.

Mr. MICA. If we had the cash, I think you could probably come up with some pretty good programs.

Mr. KEPPLER. I wouldn't argue with that.

Mr. MICA. Now, Mr. Stark, are most of the discretionary programs funded by the Federal Government that receive money in your State already funded also by the State?

Mr. STARK. I would say probably around 60 to 70 percent. And sometimes within that 60 to 70 percent, what you end up going through the KDA is helping us expand capacity.

One of the problems that results, though, is that expanded capacity is generally reimbursed at a rate higher than we usually pay; and then the other difficulty is, within the 30 percent that are not tied to our system, without there being a connection when the Federal money runs out, they come to us and want to continue and, of course, they are not part of the existing system.

Mr. MICA. So they may not be a part at the beginning, but you get them in the end?

Mr. STARK. Well, in the end the pressure, once the Federal money goes away.

Mr. MICA. Once it starts, someone is going to have to pick up the slack or the program. Not that these programs are not all worthwhile, but the astounding figure to me is the bureaucracy that is required, $155 million in overhead, the pure number of administrators to administer a smaller program.

Now, I guess, Dr. Keppler, you gave quite an encouraging statement to fund these programs, and without these programs what a disaster we would have. That is not really the question before us. I have some pretty conservative members on the panel, and I have some pretty liberal members on the panel. I think to a man and woman on the panel, they will spend whatever is necessary no matter how conservative. Now, the liberals, it is easier for them to do just philosophically. But that is not the question here. The question is, the money that we are spending, is it being spent as efficiently as possible?

I also could spend the rest of the afternoon talking about the bureaucracy to support the bureaucracy that we have created. I mean, I would imagine that many of the things that your folks in New York or Austin or Olympia, I would imagine we have forced you to employ administrators and evaluators. Maybe they are not

spending 45 minutes filling out forms for an hour of treatment, as you heard, but I know that there is duplication in this.

Then the other thing, too, I think everyone would agree we need some evaluation or measures of performance. We have got to have some accountability. About how many levels of this?

Then, the thing that is astounding to us, too, is the lack of possible coordination between NIDA and SAMHSA in, say, research is important, some of the other things that are going on. So I think that maybe as a result of this hearing we might bring NIDA into the mix and see if anything can be consolidated.

Again, the intent of the hearing is to see how we can get the money to the programs that are most successful, retain some accountability, provide the maximum amount of flexibility. And it sounds like most of the programs you are overseeing on a day-to-day basis, New York sounds like they have a pretty awesome control on these programs. And then there are probably areas, and maybe you could summarize these for me, there are some areas that only the Federal Government can provide assistance, and resources where it cannot be done effectively by the States or the local programs?

Mr. Puccio, I will put you on the spot. Dr. Keppler is second. Mr. Stark, tell me what would be the best things we could do at the Federal level that would fill a gap and provide assistance, things that should be done at our level?

Mr. PUCCIO. Two things, one of which is to focus on research and target it at the needs that are arising in the States. Good basic research is fine, but it also has to fit the needs that are arising out of the populations that are using drugs and out of the needs of the treatment providers.

Mr. MICA. How is that filtered to SAMHSA or NIDA?

Mr. PUCCIO. I think they have a variety of mechanisms, advisory committees and so forth, to surface that.

Mr. MICA. One of the criticisms that I think Mr. Stark made is that we do not have a balanced representation. Would you agree with that?

Mr. PUCCIO. I think that's fair. I'll also give you an example of sort of what I'll call an inventive approach to things. NIDA has been working to develop clinical trial networks which deal with the fusion of technology arising out of their research.

There is an effort to look at research practice collaboratives, which we have used in the State of New York to build a relationship between our treatment providers and the State agency. We had discussions internally about how to fit these two things together in order to expedite the process of technology transfer and the rapid deployment of new technology that we hope will be there on the pharmacological side into the treatment system, and that has always been a concern of ours. And we think that by building partnerships that allow research to move State systems into the provider community in a much more rapid fashion is something that could be done.

It is not easy. Each agency at the Federal level and sometimes at the State level has its own interest and jurisdiction. But if we could figure out ways, like we are attempting to in New York, to

build those linkages to go rapidly deploy technology, we may be able to make some significant gains.

Mr. KEPPLER. I would be loathe to say that the universities and the brain research and things and practical clinical research in Texas wasn't the equal of any other States or any other domain. I would be loathe to say that.

At the same time, some of the directed work on developing best practices, and I sometimes wish they would be a little more forthcoming in what they think they might be, but I think it is deeply tied to the outcome study.

I hopefully have some faith in TOPS too in that, even though it sounds like bureaucratic jargon, that mixed case adjustment work they are trying to do where they find out where under each kind of addict which treatment works for them. Well, all addicts are not the same. Alcoholics are different within those subgroups, which goes to your question, sir, before regarding how do we know what works.

Well, we've got to know what works for different subtypes of those people. Then you can say what works. I think that needs to go on and it needs to be organized.

That being said, our State agency itself was mandated by our legislature, develop best practices within Texas and we're working on that. And the brain research and biochemical and biological research at NIDA is invaluable, I think, in medications; and I salute that highly. This is a unique specialty that they are doing there.

Mr. MICA. Mr. Stark, did you want to comment?

Mr. STARK. Sure. You know, I'm sitting here thinking about what I was going to say and I realize that there is only one way to say what you're thinking, and that's say it and not try to tone anything down or cover anything up.

Mr. MICA. I do that all the time. It gets me in trouble.

Mr. STARK. Yeah, it does me too.

When I really look at the whole issue of does treatment work, which has come up today at the table, and you look at the block grant and we've been criticized in some of our publicly funded treatment programs about a mixed bag of program that may work or those that don't work, the question comes to my mind of, why is it that we do not know, every one of us, definitively that these programs work? Why don't we know that?

We've been funding block grant programs for quite a while. We've been funding research for a long time. Why don't we know the answer, and why isn't it consistent from one person to the other? And it gets back to what I said earlier, that there has been a disconnect between the research money and the publicly funded block grant programs.

And I don't mean that as a negative slam on any of the agencies, it is simply a matter of there's been a disconnect. The research money has gone predominantly over history to university researchers. Although most of it goes to biomedical, and I agree that we really need to look at that, some of it has gone to services research and applied research, but much of that services research and applied research has been funded toward theoretical models, always looking for that magic bullet, looking for some new thing.

Well, why are we looking for a new thing if we haven't answered the question about whether what we're doing right now works or doesn't work? Why would I want to run off and find something new if I believe what I'm doing now works?

So we need to do some research on what's being funded today and verify does it work or does it not work. If it does not work, then, by all means, change it. If it works, then expand it.

Mr. MICA. Mr. Iguchi, did you want to say something?

Mr. IGUCHI. Yes, I would very much like to say something.

I think there are such a multitude of agencies and a multitude of levels of government involved here that all are requiring information and answers and, in fact, requests for information and answers have multiplied remarkably with many recent changes of government asking for much more accountability with real numbers.

We have the general over at ONDCP now putting together a wonderful plan with performance measures, the PME plan, and you have all these different plans and goals and different guidelines being put together and being mandated by very, very many people; and, so, everybody is trying to respond at once with their best possible answer. But, with all these different voices, all that you're hearing right now from every level is chaos.

And I think the role of the Federal Government is to help cut through that and help find some simpler answers and simpler ways of doing things. But to do that you have to bring all these different voices together, and you actually have to sift through a lot of that chaos. I think that to a great extent, from what I can see, SAMHSA's efforts of trying to put together evaluation instruments and to model things that are being done well and in the States that are doing them well and bring them to the attention of other States, that that actually has been an effective way for disseminating information. And they are getting a lot better at it.

So I think that from where I sit as an evaluator, I actually have been very pleased that there have been States, like the State of Texas, that are doing this really very well, but they have no way of getting out and telling other States how they are doing it.

Most of the different treatment programs that I've come to know as being excellent treatment programs in the community I knew nothing about until they were brought to my attention by different technology transfer mechanisms at SAMHSA.

And so for researchers and others to find out about what is going on right in the field and try to figure out what they are doing, for all these different pieces of information to come together, I think there is a role for the Federal Government, and I think it's actually that it is actually taking place at SAMHSA right now.

Mr. MICA. Are you on the advisory committee at SAMHSA?

Mr. IGUCHI. Yes, I am.

Mr. MICA. You're an evaluator?

Mr. IGUCHI. I am an evaluator, yes.

Mr. MICA. Well, there is no question there is chaos. And Congress has helped create the chaos, and it has magnified.

Mr. Puccio, did you say we have multiple systems on multiple systems and we have multiple evaluation systems, we are creating more and we are creating a huge bureaucracy?

I mean, they are well-meaning folks and they are mandated either by law or regulation, but what I am hoping to achieve this year is to figure out some way to bring order to the chaos so that we simplify the system.

I am going to ask one last question, and then see if Mr. Cummings wanted to ask questions.

If we went to, like, a 90–10, 90 percent of all this money went to block grants, and we included flexibility, a little bit of accountability, now we have got to have a little bit of accountability in there, but flexibility, and then, granted, there are some things that we said that the Federal Government could do best, research, there are other areas, providing data and things that would be beneficial to all, could you support that?

Mr. Puccio.

Mr. PUCCIO. Generally, yes.

Mr. MICA. Mr. Keppler.

Mr. KEPPLER. Generally, yes.

Mr. MICA. Mr. Stark.

Mr. STARK. [Witness nods head in the affirmative.]

Mr. MICA. I do not want to ask you. You are an evaluator. Well, what do you think? Go ahead.

Mr. IGUCHI. I require, I guess——

Mr. MICA. My goal is to put you out of business, you understand.

Mr. IGUCHI. And that would be impossible to do, as you know, because better numbers just means we get better analysis.

Mr. MICA. Not all of you, just we want enough and at the right level.

Mr. IGUCHI. And in fact, I think that many States are doing very good treatment. But the issue isn't so much are they doing good treatment. Can they do it better is the issue, and more effectively.

Mr. MICA. Well, we are studying the hell out of this. Again, Mr. Stark, how many times and over and over and year after year in study. We do not want to put money in programs that do not work. We want to fund those that are most successful. But at some point, how many times do you reinvent the wheel?

Mr. IGUCHI. I think that there are emerging problems that one of the things about the drug abuse problem is that it is constantly evolving, and that there are always new challenges that we have to face. And actually, as far as science being brought to the world of drug abuse treatment, it is a fairly new phenomenon. So that there is a long way to go yet before we can say we're there and we are providing the most effective service. We can do this a lot better. And so, there is a huge role here for continued research and for a better evaluation.

Mr. MICA. I think everyone agreed that there are some things that have to be done at that overall level, and even at subsequent levels.

Mr. IGUCHI. But they are very different. I mean, each of these States has a position that, yes, they can spend their money most effectively and they do know what's best. The problem is that there are a lot of issues that come up that cross a lot of different borders that they are not able to solve by themselves and that there is a role for Federal leadership in. There are also a lot of very small

subpopulations whose voices are not heard even in their own States.

Mr. MICA. Most people have said that most of what they get that is helpful is from NIDA.

Mr. IGUCHI. I'm not sure that that's what you heard.

Mr. MICA. Well, a little bit. They said they got some things, but they also said there is duplication.

Mr. IGUCHI. I think one of the things that SAMHSA has done very well in terms of improving treatment and bringing good treatment to the attention of other States is going out in the community and highlighting the problems.

Mr. MICA. I think we want to do that and that should be one of that 10 percent responsibilities.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I had to run to another meeting, but I am sorry that you dismissed the SAMHSA people because that is why I am here. I wanted to hear from them.

Mr. MICA. I did that at the request of Mrs. Mink.

Mr. CUMMINGS. Mr. Chairman, that doesn't matter to me.

Mr. MICA. We wanted to give them full opportunity. She cannot be here, so we will have them back and we will have a full panel. We also do not have the administrator today, which we requested. So we are going to request the administrator, the individual that was assigned today in a full hearing, and possibly Dr. Leschner, if the minority would agree.

Mr. CUMMINGS. I understand, and I thank you for clarifying that. I just wanted to make sure.

You know, I guess from where I come from, you know, when you have accusations flying, I would like to be able to have the person who is being accused to be able to defend themselves. Because in my neighborhood I have seen so many people accused of things and were not able to defend themselves. So I just wanted to make sure that we are clear on that and that we will have that opportunity. And I want to thank you, Mr. Chairman, for that. I understand, and I appreciate it.

One of the things I think that concerns me as I listen to this discussion is that, you know, if you were to go to my neighborhood and if you were to talk to the people on the corners and you were to talk to them about drug treatment, what they would say is that there are a lot of people making a lot of money, but we are not getting much better. A lot of people making a lot of money, a lot of people being experts on this, experts on that.

We can send people to the moon, we could send a ship to Mars, we can do all kinds of things; and you cannot convince me that we cannot figure out what works and what does not work and cannot get that information out. It is incredible to me.

And I have got to tell you that I do not think that it takes—and I do not know that much about it—but I do not think it takes a rocket scientist to figure this thing out, in other words, what works for certain populations dealing with certain drugs.

And again, I think that what happens, and I think the thing that worries me, Mr. Chairman, is that, if we have situations where the tools that we have are not properly evaluating, and even if they are

and if that information is not getting out, then what happens, and I am telling you I have seen it over and over again in this Congress, what happens is people, say, let us not spend the money on it, let us not do it because it is not working. And I think that is so unfair to some people like the lady who sat up here, Ms. Murwin, the lady who sat up here a few moments ago and talked about her overcoming.

So I want to ask a few questions so we can kind of get through this a little bit so I can be clear. Some you all apparently feel that treatment works. Is that true? Treatment works.

There was a recent study and I cannot even remember, I think 60 Minutes did it, I know it was in the Washington Post, where they talked about how the research is done a lot of times on projects like this and the research apparently is oftentimes put on a shelf and never used. And even things that work a lot of times may not be refunded, they may not get their proper due, or things that do not work do not get put to the side because nobody uses them.

Again, it goes back to what the guys in my neighborhood are saying, people are getting rich off of us, but are those dollars really getting to the people that they need to get to?

Let me tell you, the biggest problem with all of this is that if there is not integrity within the system, then what is going to happen is that we are not going to stand still, but we are going to go backward because you are going to have all these people saying, I have got treatment, I have got treatment, I have got treatment and the addicts are going to get sicker and sicker; and then we are going to move from generation to generation to generation, as I see in my neighborhood of addicts.

And so, to the GAO people, did your report issue recommendations on how SAMHSA could improve oversight in monitoring the block grants?

Ms. HEINRICH. No, sir, we did not have any recommendations. What we did was describe the programs as they currently exist in terms of the block grant and the KDA grant programs. And we also were asked to determine how SAMHSA and the States were actually monitoring their programs from a perspective of accountability. And the systems that we have currently in place really do seem to focus more on assuring that the States are complying with the statutory requirements. We were also asked to describe SAMHSA and the States' efforts to determine the effectiveness of drug abuse treatment supported with block grant funds. And what we found there is that there are activities going on at SAMHSA level, and there have been at least two large SAMHSA-funded national studies and then several States have really exemplary programs in terms of evaluating program effectiveness, patient outcomes. And three of the States that are doing the most are here today.

Clearly, there are many other States that are not doing nearly as much in terms of determining program effectiveness.

Mr. CUMMINGS. How do you determine, since you just gave those wonderful compliments to these States, what is the standard for saying that my program works and works well? I mean, is it like, we treated 10 people and, after 5 years, 6 of them are still off of drugs? I mean, how do you measure that?

Mr. CUMMINGS. How does somebody go around saying what you just said, they have got the greatest programs in the country?

I need to know that. And the reason I need to know it is because, if you have got something that is working, and assuming that you have a reasonable kind of measuring tool, then what you said, Mr. Stark, is what we ought to be doing, using the best practices of things that work.

Let me just give you a little example that upsets me. In my school system in Baltimore, they go around asking everybody all over the world, how can we educate poor kids, when we have got schools with kids from the very kinds of neighborhoods that these kids come from there are not doing well, who are doing well.

It seems to me, and maybe I am missing something, that somebody would say, well, if we have got school *X* 2 miles away in the same kind of neighborhood, children with the same kinds of backgrounds in the same city, that we might just want to make a phone call over to school *X* and say, now, *X,* we are having problems over here with *Y;* what are you doing that we are not doing?

And yet, still we are spending thousands and thousands of dollars exporting experts from everywhere, and going back to what you said, Mr. Stark, maybe, maybe we have the answer of what works. Maybe we have the measuring tools of what works.

And so, I want to know how do you measure, to say, how does somebody come to the conclusion that was just stated, that you all are some of the best programs, and how do you measure yourselves? Or do you measure yourselves?

Mr. STARK. In the State of Washington, we very much do measure ourselves. Just to give you an example, although we do some of the rigorous scientific studies that would be funded by NIDA, working with researchers from the University of Washington and Washington State University and some private researchers, although we do some of those very expensive studies that actually do track the client population and interview them pre and post and have comparison groups. That data, although good and whatnot, is still self-report data and clients are simply answering, are they still using drugs? Are they getting in trouble with the law? Are they participating in work? Are they using health care services at the rate that they used to be or not? Are they living now in a shelter versus a house versus whatever?

Although those questions get asked, we continue to get challenged even by our State legislature, even on those rigorous scientific studies, yeah, but that's self reports. What's the real impact? Did it really cost us, the people of the State of Washington, less money for those individuals that you treated compared to those that needed treatment that were similar and didn't get it?

So, about 10 years ago, we began to look at tracking and integrating multiple data bases. We said, what are the consequences of addictions? And you've already described a number of those. There is crime and there is health problems and there is violence and there is poverty and there is a whole lot of consequences related to true addictions.

So if those, in fact, are the consequences, we ought to be able to measure those. And if alcohol and drug treatment has an impact in improving in those areas, we ought to be able to measure that.

So we began taking clients who received assessments but no treatment and then those that received different types of treatments, residential treatment followed by outpatient, or residential treatment only, or outpatient only, and then compared treatment completers to treatment non-completers, then looked at subpopulations, pregnant women versus kids versus chronic SSI, supplemental security income clients, and we began to look at those outcomes. Prior to them coming into treatment, what did they cost the State of Washington? Post treatment, what did they cost the State of Washington. In some of the studies, we only looked at 6 months post treatment. Some we went as far as 5 years out.

And in virtually every case, every study we did showed significant positive outcomes with the aggregate. Now, that isn't to say that some of those clients didn't fail. Some of them did. But through the aggregate, taking the failures and the successes together, those treatment programs had major reductions in real health care expenditures, real reductions in crime and jail and prison time, real improvements in employment and earnings, and I could go on and on.

So we measure it a variety of different ways. We do use SAMHSA funding, and we very much appreciate it. SAMHSA has done a good job working with us in helping us build this infrastructure. And we also use NIDA, National Institute of Drug Abuse, dollars by partnering with researchers and going after that money to do this research.

Part of the question is, if you are going to evaluate and evaluate effectively, there is no free outcome; it costs money to collect data, analyze data, and put out reports.

The other question, Chairman Mica, was about why do so many of these things end up on the shelf? Well, part of it is that there is lot of the expensive research that has been done, and in some cases it answered questions that nobody else was interested in quite frankly. In some cases, it answered questions everybody else might be interested in, but it was written academically, not from a policy perspective. And when it got done, they met their need for publish or perish, if you are in higher-ed you know what that is all about, and then it got shelved.

We need to have a national strategic plan and some coordinating committee that comes together and looks at maximizing those research results and look at how do we move from research to policy and to practice. And there are some activities going on now, but they need to be coordinated.

Mr. PUCCIO. If I can, I am going to draw a distinction between outcome measure and impact measure and give you an example of those two things.

A drug court judge is going to be interested in whether or not a treatment program is effective in terms of reducing criminal behavior. So we actually do measure whether or not our programs produce reductions in criminal behavior along with gains in employment and a variety of other measures.

We then take those measures and we deploy them in rank order and compare one program to another. So you may have in a community three or four or five providers that are providing similar kinds of services. The question then arises that are the outcomes

of provider A better than B and then, if so, why; and then how do we work that through?

One of the things we have done is use the peer review requirement that is under the block grant and use that to have providers work with providers on sharing their technologies to make sure they are, in fact, improving. That is very different than looking at what I will call impact.

I am a school board member and I know what it is like to live in a community where you struggle with trying to understand what is happening in terms of the overall impact of drug prevention and treatment services in your community.

In the State of New York, we have begun to take, and I know Ken has done this in Washington, take surrogate data, we have looked at PINS petitions, we look at drug arrests, we look at emergency room visits, we look at a whole variety of different indices that get at this impact measure, aggregate it at the county level, and then rank order counties to be able to compare and contrast those counties that are suffering more or less from the consequence of outcome drugs and then begin to talk about prevention strategies on the level that make a difference in terms of achieving better outcomes and match that up on a State-wide basis.

The problem you run into is that, at the subcounty level, the collection of that data is extraordinarily difficult. So with my school district, with 1,000 kids in it, the collection of PINS information at the county-wide information, which is children that are in protective service under probation, this is a very difficult thing to go have available. We have it at the county level but we don't have it broken down into smaller jurisdictions.

We are trying in New York City, for example, to break it down into the zip code level. But even then, that is a very large aggregation of a community.

It is a very difficult thing. It is time consuming. It is expensive. But I think we are all working hard at building the data systems that allow us to say yes, it works, and then to compare and contrast providers so that we can begin to get at the components of what are the treatment differences that make for better outcomes beyond what we have right now.

Mr. CUMMINGS. If you had a situation where you took your criteria, your measuring tool, and discovered that drug treatment center A, had according to your measuring tool a 10-percent success rate; and B, had a 75-percent success rate; and C, had a 70-percent success rate, what happens to the guy with the 10 percent?

Do you follow what I am saying? I mean, does somebody say, look, you are not even close? And let us assume that you have got some complaints going along with it. I mean, does that person get kicked out or are you all trying to help them, too? Because the thing that I am worried about is that if we do not begin to look at those kinds of things, all of you are going to be out of a job. I am serious, not because of me, but because the Congress will say, wait a minute, it is not working.

And you all provided some wonderful testimony today that really I am sure helps Mr. Mica, and I know he feels a lot better than he has in a long time because you all have said some very positive things about treatment. But I can tell you that if that word gets

around and everybody begins to feel up here that treatment is not working and folks are operating on a 10 percent level with a few 70 and 65 percents, you have got a problem, because there are some people who have the opinion that once on drugs, never off.

Do you understand the question? Is there a mechanism in your States to kick somebody to say, look, you are not doing it. It is not getting done. We are spending a lot of money on you. We are wasting taxpayers' dollars. We have had people that have come into your program, they thought they were being treated, they weren't being treated, they came out of the program, they are still on drugs, and they are worse off than they were before, because now they go around saying, see, treatment does not work. Why should I be bothered?

Mr. KEPPLER. I agree with that. And I certainly will say this, yes, we do monitor them. We go out and look at them. We have a compliance visitor if they are not doing it. That kind of outlier would very likely be defunded, with one proviso, sir. Unless that program was 10 percent, if I went there and I saw they were taking care of the sickest, most chronic people that had been treated before on multiple occasions, and as a choice at the State level we said we still have to have some commitments, we aren't ready to let them die yet, as opposed to another program that were first-time, younger people, who perhaps were just substance abusers and not yet fully dependent for a year, for 10 years, for 15 years, I'd look at that a little differently. In other words, what kind of cases are they treating?

That being said, if they are treating the same kind in each one, look the same, no difference in their history, I would certainly go after the 10 percenter. They would be done. They would have to move on.

One more thing, and this will leave me Dr. Clark and Dr. Leschner, who I both deeply respect, this is a complex neurobiological disorder. I'm sure you have heard that. We don't fall under necessarily the criticism we have for some other terminal brain diseases which have taken years and years to cure and treat. We are just coming into the place of learning new ways to treat stroke, new advances in Parkinson's disease, new advances in multi-infarct dimension, new advances in schizophrenia, all these types of complex neurobiological disorders of which substance dependence disorders are just one, so we are on that same playing field.

Mr. CUMMINGS. Is it State law that will allow you to kick them out?

Mr. KEPPLER. It would be our State auditors, probably akin to who would look at what we are doing in our legislature that makes us do this performance-based contracting with progressive sanctions.

Mr. CUMMINGS. Do you think most States have those kinds of mechanisms? I mean, do you?

Mr. STARK. Washington State does.

Now, there are two levels in Washington State. There is both the issue of contracts. There is also the issue of accreditation. We accredit both publicly funded as well as private-pay treatment programs through our division in the State of Washington. So, with

the 10 percent issue, if it were the first time we had done an evaluation of that program and discovered only 10 percent, we would probably start with some training, technical assistance. But if it was clear that there was only 10 percent success and they were satisfied with 10 percent success and it wasn't changing, then if it was a contracting agency, we would be looking at getting rid of the contract. And if the program continued and it was quality of care issues, we would be looking at the issue of accreditation.

But I want to point out another thing that is different. There are times, many times, when somebody who needs maybe a year of treatment starting off in maybe short-term residential treatment followed by continuing outpatient treatment, they need that multilevel care, high intensity, then low intensity. And they get into the high intensity program and when they finish that level, they can't get into the next level because it's full, there are no open slots.

Mr. CUMMINGS. Like after-care.

Mr. STARK. It is continuing care. It can be fairly intensive outpatient. So the question becomes one of, can you punish treatment program, No. 1, because the rest of the treatment that that individual needed wasn't available? So that's another issue you have to consider in this when you are comparing one treatment program to another. It is not only the issue of case mix adjustment and are you, in fact, comparing the same client across different systems, but it is what else did that individual need and did they or did they not get it?

It then becomes incumbent upon every level of treatment program to be working very, very diligently to identify the additional needs of the client they are serving beyond just the alcohol drug treatment need, whether that that be housing, food, shelter. I mean, you know as well as I do, we put people in prison and we let them out of prison and they have major drug and alcohol problems and family problems and poverty problems, and we let them out on the street and they walk out on the street with no job and no place to stay and we wonder why they got in trouble again.

Now, I don't know what you think about that, but clearly we're doing the wrong thing if we know that we are all going to strive to find a place to sleep and eat to get our basic needs, and if they are not met through some mechanism, we have a job, we have training to get a job, we have a place to stay that is a safe place, then we will figure out a way to get that, whether that's through medicating ourselves with drugs to forget about our problems or committing crimes to get the money to pay for the basic needs.

Mr. CUMMINGS. Before I came to Congress a few years ago, a group of men in my community volunteered to do an after-care program for people coming out of the boot camp system. And one of the reasons why I have asked the chairman to make sure that when they come to Baltimore that we bring the New York program up, the one that the State's attorney up in New York started, and I am hoping we will be able to do that, Mr. Chairman, is because, one of the things that we noticed for recidivism, and I think in dealing with their drug problems, if we could get somebody a job, a job, and get them sort of reoriented toward their family, as opposed to the corner, toward their kids and get into sort of a self-help kind of discussion kind of thing, what we discovered is that

those guys who we could keep off the corner, get jobs, and get more oriented toward their family were more apt to really pursue treatment and were more apt to do well. And this was basically—I mean, it just worked.

Apparently there is a New York program which is basically an alternative to a prison program that works, I guess, you're familiar with. And one of the things, we had testimony from the folk up in New York, I was sitting there and I kept hearing the success rates and I said there has got to be more than just getting them into treatment. And finally, at the end of the testimony, the guy says, jobs, jobs, jobs, jobs.

And I said, that is it. I mean, not that that is the total cure, but when you think about it, one of you all said people get up in the morning, and what they are doing is they are going out and looking for their fix. They are basically going out trying to figure out how to kill themselves, to be frank with you, because that is what it is, is a slow death.

So if you could find things to occupy their time, give them a sense of value, give them a sense of whatever. But it is a complicated process. I understand that. If anyone wants to comment on that, you may. But I want to thank you all for your testimony. And would you all agree that there should be measuring tools?

Mr. KEPPLER. Yes.

Mr. IGUCHI. Yes.

Mr. PUCCIO. Yes.

Mr. STARK. Absolutely.

Mr. MICA. I thank the gentleman from Maryland. I want to associate myself with his remarks that we do need to find some way to better coordinate all of the efforts and the things that are required to make these programs successful, mental health, job training, social services, health care.

I did visit the DTAP program, and that is a totally integrated program. It is expensive, but the alternative is far more expensive. And many of these people, their lives are a total disaster, not only their lives, the lives of their families.

I could go on, Mr. Cummings, and tell you about some of the people I met. One guy spent half of his life in jail. He was 38 and in and out. The social cost. Another one, his wife had died of a heroin overdose. He was a heroin addict.

But we have got to figure out a way to make this all come together. We have got to figure out a way to try to eliminate some of the bureaucracy we have created. We want these programs evaluated, but we do not want paralyses by analysis. And we have got to figure out a way to make this whole thing function.

As I said, I do not know if you heard me, there are some conservative members and some liberal members, but I think they all want to see that everyone who needs treatment has treatment and that it is effective and that we hold the programs properly accountable.

The good news is that we will have a continuation of this hearing. In fact, I will leave the record open. And I would also like a copy of all of this hearing transcribed, if possible, on an expedited basis so that the administrator can see the comments from this hearing and then respond to them.

I want the administrator here, not only the deputy that was supposed to be here. And we can also invite Dr. Leschner to see if there are some things we can do more effectively in a cooperative effort.

So, with those comments, I do want to thank each and every one of our witnesses today, thank GAO for their report. And also, for the record, I think we need to ask some additional questions of GAO and, hopefully, get some more answers so we can do our job more effectively in an oversight capacity.

There being no further business to come before the subcommittee at this time, again, I thank our witnesses, they are excused, and this hearing is adjourned.

[Whereupon, at 1:04 p.m., the subcommittee was adjourned.]

HHS DRUG TREATMENT SUPPORT: IS SAMHSA OPTIMIZING RESOURCES?

TUESDAY, MARCH 14, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Mink, Cummings, and Tierney.

Staff present: Sharon Pinkerton, staff director, chief counsel; Steve Dillingham, special counsel; Don Deering and Frank Edrington, professional staff members; Lisa Wandler, clerk; Cherri Branson, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. MICA. Good morning. I'd like to call this hearing of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources to order. I apologize for being late.

Mrs. Mink, as you know, we have many folks from our districts in town, and while I love people with the various agencies in Washington, I have a certain appreciation of the people back home.

Mrs. MINK. Apology is noted and accepted.

Mr. MICA. Thank you. For that, we'll begin our hearing today. This hearing is actually a continuation of the February 17 hearing, and the hearing is entitled, "HHS Drug Treatment Support: Is SAMHSA Optimizing Resources?"

I will have a brief opening statement, and then yield to our ranking member, Mrs. Mink, for her statement. Then we'll hear from our witnesses.

Today, our subcommittee is resuming its oversight hearing on programs and operations of the substance abuse and mental health services administration, also referred to as SAMHSA, which is located within the Department of Health and Human Services.

We began this hearing on February 17, but both the majority and minority agreed to adjourn the hearing and continue at a later date, so we could obtain a more detailed response to some of the issues that were raised, and also to hear directly from the administrator of SAMHSA, Dr. Nelba Chavez. Since we'll discuss the topic of agency-sponsored research on drug abuse and treatment, we also decided to invite the Director of the National Institute of Drug Abuse, also known as NIDA, Dr. Alan Leshner. NIDA funds drug

abuse research, and it's important that we have him for this discussion while we also have the administrator of SAMHSA.

A startling statistic that we discussed in our last hearing was that the national estimates of Americans in need of drug treatment range from 4.4 to 8.9 million people, yet less than 2 million people reportedly receive treatment services. We're most concerned about this gap in treatment services and how to address it. In that regard, I noted that SAMHSA's block grants are key to reducing the treatment gaps, as each grant block dollar spent on treatment generates $1.5 in additional State and local treatment spending. We heard from State and local providers the successful drug treatment programs are now in place, and every drug treatment dollar is so vital to our efforts.

I was concerned to learn that participants in a successful faith-based treatment program lost their eligibility for food stamps. We must do everything possible to prevent such absurd results and also to fund more successful drug treatment programs that, in fact, serve more clients. We learned that SAMHSA has huge administrative and contractual operational costs, and that oftentimes the agency also imposes unnecessary burdens and red tape on States and providers.

We also heard from the General Accounting Office [GAO], which reported on what SAMHSA is doing with its resources. This data raises questions regarding agency efficiencies and effectiveness. The data indicates that 80 percent of SAMHSA's substance abuse grant funds flow to the States through block grants, and they are managed by 11 percent of that agency's staff. The remaining 89 percent of SAMHSA's staff are engaged in something else, and those activities include research and technical assistance, which seem to be inordinately based in Washington, DC.

To me, this raises a red flag and many questions. Do we have reason to believe that only Washington area consultants know what works best for our States? Driving in from the airport yesterday, I was looking at some of the massive buildings and so-called Beltway bandit operations that have grown up around the Capital. It seems nice to have those high-paying activities in the shadow of our Nation's Capital. But are they providing the treatment and funds to those programs and individuals out there beyond the Beltway?

I'm aware that fine public and private universities train drug treatment professionals and researchers. I believe they are quite capable of assisting programs in that regard. Witnesses have testified from various States with programs that are successful in breaking the chains of drug addiction, restoring families, rebuilding job skills, and saving lives. The States included Florida, New York, Texas, and Washington. GAO commended these States for their successes in a number of drug treatment areas. Today, we have as a witness the Administrator of SAMHSA, which I said, Dr. Nelba Chavez. Dr. Chavez has testified that CSAT-funded treatment programs are working resulting in a 50 percent reduction in drug abuse among their clients 1 year after treatment. She further concluded and stated, "we know what works in prevention and treatment."

Despite the success and others that she will mention, I think that Dr. Chavez will agree with me that we cannot be complacent in our efforts or satisfied with a status quo. Significant challenges lie ahead, and our future successes depend on how efficiently and how effectively we allocate our resources to accomplish shared goals in preventing and treating drug abuse.

Let me outline some of the issues that I hope we'll address at this hearing today. If we can't cover them today, we can followup with another hearing after today. With regard to SAMHSA's operation, my concerns include: agency administrative costs, organizational staffing, contracting practices, how our research and evaluation dollars are expended, and are we getting good results, discretionary spending practices, grant application, the whole process, and processing award efficiencies.

With administrative costs of over $150 million annually, we must ask what is being accomplished and at what price. Again, if you go back and look at 89 percent of the expenditures and grants being administered by 11 percent and the other 11 percent of the funds consuming a tremendous administrative overhead costs, something is wrong. What concerns me also is that many of the projects that we and GAO reviewed and are already funded by either State government or other Federal block grant programs for which we're incurring this huge administrative overhead.

Something is wrong. I just learned from SAMHSA that GAO staffing figures do not include dozens of contract employees who augment SAMHSA's staff. SAMHSA now employs almost 600 people. I'm concerned about reported staff reductions and turnover in the agency's three centers, and whether this contributes to low staff morale.

Also, I'd like to ask the staff to conduct a review and investigation of how many of the former staff are now some of these contract officials. I found, while investigating other agencies, that some of the former employment of the agency personnel turns into cottage industry on a contract basis.

We also need to examine what value SAMHSA has received from its hundreds of millions of dollars in research and evaluations. I'm a strong supporter of research and studies, particularly scientific studies that will lead us to do a better job and more effective, and I don't think we could ever spend enough to make certain that we've explored every research avenue, but we also must see that if we are duplicating activities, that we eliminate that duplication, and most cost effectively, expend these hard earned taxpayer dollars on effective research.

I think the administrator will share some highlights with us today. I have with me a copy of the "Handbook for Evaluating Drug and Alcohol Prevention Programs, Staff/Team Evaluation of Prevention Programs." It's called STEPP, I think is its acronym, published in 1987 by SAMHSA's predecessor agency ADAMHA. It looks like it would be very helpful to evaluate activities. I'm told that it was distributed and sold through the Government Printing Office for many years. Is this evaluation guide no longer useful? If not, why not? Should similar handy guidance be prepared and made available to treatment professionals? Is this an illustration of

my concern that the agency may unnecessarily be reinventing the wheel?

Let me mention another area that I'm most interested in that remains a drug treatment priority. That area is the nonviolent offenders who are eligible, motivated, and in need of treatment. It's my understanding that SAMHSA's discretionary grant programs provide some limited support for treating offenders who are not incarcerated. I'm very aware of the need for offering treatment to deserving nonviolent offenders who have a need and desire to break the chains of addiction, and who also hope to obtain productive employment and engage in law-abiding behavior.

In this regard, I have a copy of the report of the National Task Force on Correctional Substance Abuse Strategies entitled, "Intervening With Substance Abuse Offenders: A Framework for Action," published in 1991 by the Department of Justice. This national task force with participants from ONDCP, the Office of National Drug Control Policy, Justice, HHS, including ADAMHA, State treatment and correctional agencies, probation and parole organizations, and experts from institutions, such as Yale, outline promising correctional treatment strategies. This is back in 1991.

This project and its publication received extensive praise from treatment professionals, yet it only cost $100,000 to complete. Are we getting that return on our investment today? Has anyone paid any attention to this report? I ask SAMHSA to convincingly answer the question and to ask its expensive contractor "Where's the beef?"

Finally, we also need answers to the question of how well SAMHSA coordinates with NIDA. NIDA, as we know, is the primary agency with a responsibility for conducting drug abuse research, and we use NIDA in research in assisting States and local programs. Is NIDA research relevant and does it demonstrate its value to the States? If not, why not? How is SAMHSA documenting and expanding this contribution? I've raised a number of questions, a number of questions were raised in the hearing that we conducted previous to today's meeting, and I hope that we can hear from Dr. Chavez and Dr. Leshner on these and other issues today as we explore ways to improve our delivery of an effective and efficient drug prevention and treatment program and policy for our whole Nation.

[The prepared statement of Hon. John L. Mica follows:]

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OPENING STATEMENT
Chairman John L. Mica

Subcommittee on Criminal Justice,
Drug Policy and Human Resources

March 14th Continuation of February 17th, 2000 Hearing:

"Drug Treatment:
Is the Federal Government Optimizing Resources?"

Today, our Subcommittee is resuming its oversight hearing on programs and operations of the Substance Abuse and Mental Health Services Administration ("SAMHSA") within the Department of Health and Human Services ("HHS"). We began this hearing on February 17th, but both the majority and minority agreed to adjourn the hearing and continue at a later date so that we could obtain a more detailed response to some issues that were raised, and to hear directly from the Administrator of SAMHSA, Dr. Nelba Chavez. Since we will discuss the topic of agency sponsored research on drug abuse and treatment, we also decided to invite the Director of the National Institute on Drug Abuse ("NIDA"), Dr. Alan Leshner. NIDA funds drug abuse research.

A startling statistic that we discussed in our last hearing was that national estimates of Americans in need of drug treatment range from **4.4 to 8.9 million**, yet less than **two million** people reportedly receive treatment. We are most concerned about this "gap" in treatment services and how to address it.

In that regard, I noted that SAMHSA's block grants are key to reducing the treatment gap, as **each block grant dollar** spent on treatment **generates 1.5 dollars in additional state or local treatment spending**. We heard from state and local providers that successful drug treatment programs are now in place, and every drug treatment dollar is vital. I was concerned to learn that participants in a successful faith-based treatment program lost their eligibility for food stamps. We must do everything possible to prevent such absurd results, and to fund **more** successful drug treatment programs that serve **more** clients. We learned that SAMHSA has huge administrative and contractual costs, and imposes unnecessary burdens and red tape on states.

We also heard from the General Accounting Office (GAO), which reported on what SAMHSA is doing with its resources. This data raises questions regarding agency efficiencies and effectiveness. The data indicates that about 80% of SAMHSA substance abuse grant funds flow to the states through block grants managed by about 11 % of the agency's staff. The remaining 89% of SAMHSA staff are engaged in something else -- and that research and technical assistance seems to be inordinately based in Washington, DC. To me, this raises a red flag. I have no reason to believe that only Washington area consultants know what works best for states. I am aware that fine public and private universities train drug treatment professionals and researchers. I believe they are quite capable of assisting programs in this regard.

Witnesses have testified from various states with programs that are successful in breaking the chains of drug addiction, restoring families, rebuilding job skills and saving lives. The states included Florida, New York, Texas and Washington. GAO commended these states for their successes in a number of drug treatment areas.

Today, we have as a witness the Administrator of SAMHSA, Dr. Nelba Chavez. Dr. Chavez has testified that CSAT funded treatment programs are working, resulting in a **50% reduction in drug abuse** among their clients one year after treatment. She further concluded: "**We know what works in prevention and treatment.**"

Despite this success and others that she will mention, I think that Dr. Chavez will agree with me that we cannot be complacent in our efforts, or satisfied with the status quo. Significant challenges lie ahead, and our future successes depend upon how efficiently and effectively we allocate our resources to accomplish shared goals in preventing and treating drug abuse.

Let me outline some of the issues that I hope we will address during this hearing, and if we cannot cover them here today, we can follow-up after this hearing.

Regarding SAMHSA's operations, my concerns include: agency administrative costs, organizational staffing, contracting practices, research and evaluation expenditures and results, discretionary spending practices, and grant application, processing and award efficiencies.

With administrative costs of over $150 million annually, we must ask what is being accomplished and at what price.

I just learned from SAMHSA that GAO staffing figures do not include dozens of contract employees who augment SAMHSA staff. SAMHSA now employs almost 600 people. I am concerned about reported staff reductions and turnover in the agency's three centers, and whether this contributes to low staff morale.

We also need to examinee what value SAMHSA has received from its hundreds of millions of dollars in research and evaluations. Specifically, what major findings were obtained, and at what cost? I think the Administrator will share some highlights today. I have with me a copy of the **Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/ Team Evaluation of Prevention Programs (STEPP)** published in 1987, by SAMHSA's predecessor agency ("ADAMHA"). It looks like it would be very a helpful to evaluation activities. I am told that it was distributed and sold through the Government Printing Office (GPO) for many years. Is this evaluation guide no longer useful? If not, why not? Should similar handy guidance be prepared and made available to treatment professionals? This is an illustration of my concern that agencies may unnecessarily reinvent the wheel.

Let me mention another area that I am most interested in that remains a drug treatment priority. That area is with **nonviolent offenders who are eligible, motivated and in need of treatment.**

It is my understanding that SAMHSA's discretionary grants provide some limited support for treating offenders who are not incarcerated. I am very aware of the need for offering treatment to deserving nonviolent offenders who have a need and desire to break the chains of addiction, obtain productive employment and engage in law-abiding behavior. In this regard, I have a copy of **The Report of the National Task Force on Correctional Substance Abuse Strategies** entitled "**Intervening with Substance-Abusing Offenders: A Framework for Action**" published in 1991 by the Department of Justice. This National Task Force with participants from ONDCP, Justice, HHS (including ADAMHA), state treatment and correctional agencies, probation and parole organizations, and experts from such institutions as Yale University, outlined promising correctional treatment strategies. This project and its publication received extensive praise from treatment professionals yet cost only $100,000 to complete. Are we getting that return on our investment today? I hope so, because we are now spending hundreds of millions of dollars. I ask SAMHSA to convincingly answer the question, and to ask its expensive contractors: "Where is the beef?"

Finally, we also need answers to the question of how well SAMHSA coordinates with NIDA, the agency with primary responsibility for conducting drug abuse research, and uses NIDA research in assisting states and local programs.

Is NIDA research relevant and does it demonstrate its value to the states? If not, why not? How is SAMHSA documenting and expanding this contribution?

I look forward to hearing from Dr. Chavez and Dr. Leshner on these issues today, as we explore ways to improve our delivery of effective drug prevention and treatment across America.

Mr. MICA. With those opening comments and remarks, I'm pleased to yield now to the gentlelady from Hawaii, our ranking member, Mrs. Mink.

Mrs. MINK. Thank you, Mr. Chairman. First, I'd like to ask unanimous consent that a statement by our colleague, the Honorable Ed Towns of New York, be submitted for the record.

Mr. MICA. Without objection, so ordered.

[The prepared statement of Hon. Edolphus Towns follows:]

EDOLPHUS "ED" TOWNS
MEMBER OF CONGRESS
10TH DISTRICT, NEW YORK

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SUITE 2232
RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5936

BROOKLYN OFFICES:
26 COURT ST., SUITE 1510
BROOKLYN, NY 11242
(718) 855-8018

1110 PENNSYLVANIA AVENUE
STORE 5
BROOKLYN, NY 11207
(718) 272-1175

1670 FULTON STREET
BROOKLYN, NY 11213
(718) 774-5682

"HHS DRUG TREATMENT SUPPORT: IS SAMSHA OPTIMIZING RESOURCES?"

Subcommittee on Criminal Justice, Drug Policy and Human Resources

March 14, 2000

Opening Statement
by
Honorable Edolphus "Ed" Towns (D-NY)

MR. CHAIRMAN, TODAY'S HEARING OFFERS US AN OPPORTUNITY TO LEARN ABOUT THE IMPORTANCE OF DRUG TREATMENT PROGRAMS AND THE RESEARCH THAT SUPPORTS THESE ACTIVITIES.

PRIOR TO ENTERING THE POLITICAL ARENA, I WAS A HOSPITAL ADMINISTRATOR AT BETH ISRAEL MEDICAL CENTER IN NEW YORK CITY. AS THE DIRECTOR OF THEIR SUBSTANCE ABUSE TREATMENT CLINIC, I GAINED FIRST HAND KNOWLEDGE ABOUT THE PROBLEMS OF ALCOHOL AND DRUG ABUSE. AS DIFFICULT AS SUBSTANCE PROBLEMS WERE FOR THE PATIENTS WE SERVED 25 YEARS AGO, THE PROBLEM OF DRUG ADDICTION IN THIS COUNTRY TODAY HAS REACHED EPIDEMIC PROPORTIONS. IN 1998, 13.6 MILLION AMERICANS REPORTED USING AN ILLICIT DRUG. "CRACK-COCAINE" AND HEROIN NOW COMPETE WITH EACH OTHER FOR THE MOST "ABUSED" SUBSTANCE. DRUG

ADDICTION IS NOW A PROBLEM FOR OUR RURAL AND SUBURBAN COMMUNITIES AS WELL AS OUR INNER CITY NEIGHBORHOODS.

TO AID IN THE FIGHT AGAINST DRUG ABUSED, THE FEDERAL GOVERNMENT SPENDS A LITTLE OVER $3 BILLION ANNUALLY FOR TREATMENT PROGRAMS. ABOUT $1.6 BILLION OF THESE FUNDS ARE ALLOCATED THROUGH THE STATE BLOCK GRANT FOR LOCAL DRUG AND ALCOHOL ABUSE TREATMENT AND PREVENTION PROGRAMS. THE GENERAL ACCOUNTING OFFICE (GAO) FOUND THAT THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION (SAMSHA) PERFORMED WELL, HAD LOW ADMINISTRATIVE EXPENSES, AND RESPONDED TO THE NEEDS OF THE STATES IN PROVIDING TECHNICAL ASSISTANCE, SCIENTIFIC EXPERTISE AND TRAINING WITH THE ADMINISTRATION OF THE BLOCK GRANT. ADDITIONALLY, DURING THE FEBRUARY 17TH HEARING, THE STATE ADMINISTRATORS GAVE SAMSHA HIGH MARKS FOR RESPONSIVENESS AND ACCESSIBILITY. FURTHER, THE STATE ADMINISTRATORS TESTIFIED THAT EVALUATION AND MONITORING INFORMATION PROVIDED BY SAMSHA WAS GENERALLY HELPFUL IN ASSISTING THEM IN COORDINATING THEIR EFFORTS TO MEET TREATMENT NEEDS WITHIN THEIR RESPECTIVE JURISDICTIONS.

OVER $325 MILLION IS DEVOTED TO THE DISCRETIONARY GRANT PROGRAMS, CALLED THE "KNOWLEDGE, DEVELOPMENT AND APPLICATION" GRANTS (KDA). THESE GRANTS ALLOW SAMSHA TO TARGET UNDERSERVED POPULATIONS FOR PREVENTION AND TREATMENT. IN FY 1998, KDA TREATMENT EXPENDITURES INCREASED TO $98 MILLION AND SUPPORTED 27 SPECIFIC PROGRAMS, INCLUDING PROGRAMS THAT PROVIDE TREATMENT SERVICES FOR PREGNANT AND POSTPARTUM WOMEN AND THEIR CHILDREN;

PROGRAMS THAT PROVIDE TREATMENT SERVICES FOR ALASKAN NATIVES, AMERICAN INDIANS, AND NATIVE HAWAIIANS; AND A SPECIAL INITIATIVE SPONSORED BY THE CONGRESSIONAL BLACK CAUCUS TO PROMOTE TREATMENT SERVICES AMONG THE PERSONS INFECTED WITH HI. THESE POPULATIONS, WHO ARE TRULY "THE LEAST OF THESE", WOULD HAVE NO ACCESS TO DRUG TREATMENT WITHOUT THE DA GRANTS.

ADDITIONALLY, DA FUNDS ARE USED TO PROMOTE THE ADOPTION OF BEST PRACTICES AND TREATMENT TECHNIQUES AND SUPPORT GRANTS AND COOPERATIVE AGREEMENTS TO 111 COMMUNITY-BASED ORGANIZATIONS AND UNIVERSITIES. THESE "BEST PRACTICE" GUIDELINES ENABLE SAMSHA TO ADVISE MEDICAL PERSONNEL ON THE BEST TREATMENT MODALITIES FOR THE VARIOUS KINDS OF ADDICTION. WHETHER ITS "CRACK" IN NEW YORK, METHAMPHETAMINES IN FLORIDA OR HEROIN IN CHICAGO, TREATMENT ACTIVITIES CAN NOT HAVE A "ONE SIZE FITS ALL" APPROACH.

FINALLY, MR. CHAIRMAN, THERE CAN BE NO ARGUMENT THAT DRUG ABUSE IS A SERIOUS SOCIAL PROBLEM IN THIS COUNTRY. THE COST OF DRUG ABUSE TO SOCIETY INCLUDING COSTS FOR HEALTH CARE, PREVENTION AND TREATMENT, COSTS ASSOCIATED WITH THE CRIMINAL JUSTICE SYSTEM, AND LOST RESOURCES DUE TO DECREASED WORKER PRODUCTIVITY, ARE ESTIMATED AT $67 BILLION. THE COST-EFFECTIVENESS OF DRUG TREATMENT IS EQUALLY WELL-ESTABLISHED. FOR EXAMPLE, ONE STUDY FOUND THAT TREATMENT CAN GENERATE A SEVEN-TO-ONE RETURN ON INVESTMENT. THAT IS WHY THE STATE ADMINISTRATORS AT OUR FEBRUARY HEARING TESTIFIED THAT MORE, NOT LESS, TREATMENT FUNDING WAS NEEDED.

IT IS CLEAR THAT THESE ADMINISTRATORS BELIEVE THAT SAMSHA IS VITAL TO THEIR EFFORTS TO REDUCE DRUG ABUSE. AND, THE GAO APPARENTLY AGREED. I BELIEVE THAT IT IS SIGNIFICANT, MR. CHAIRMAN, THAT GAO DID NOT ISSUE ANY RECOMMENDATIONS FOR CHANGES OR IMPROVEMENTS IN THE ADMINISTRATION OF DRUG TREATMENTS BY SAMSHA. MANY OF THE AGENCIES THAT HAVE APPEARED BEFORE THIS COMMITTEE WOULD PAY GOOD MONEY TO HAVE HAD THIS KIND OF EVALUATION FROM THE GENERAL ACCOUNTING OFFICE.

AMERICANS NEED ACCESS TOT HE BEST ADDICTION TREATMENT PRACTICES AVAILABLE IF WE ARE TO EFFECTIVELY REDUCE DRUG ABUSE IN THIS COUNTRY. SAMSHA HAS PROVEN TO BE AN EFFECTIVE AGENCY IN WORKING WITH THE STATES TO MAXIMIZE THEIR TREATMENT DOLLARS. I REMAIN HOPEFUL THAT THE HOUSE WILL FOLLOW THE SENATE'S LEAD AND ACT ON A SAMSHA REAUTHORIZATION BILL BEFORE MEMORIAL DAY. THIS ACTION WOULD BE A FIRST STEP IN SUPPORTING OUR STATES' EFFORTS TO FIGHT DRUB ABUSE. IN THIS REGARD, I LOOK FORWARD TO THE TESTIMONY OF WITNESS PANEL. I WOULD HOPE THAT TODAY'S HEARING WILL GIVE US SOME FURTHER INSIGHT INTO HOW CONGRESS CAN BE MORE SUPPORTIVE OF SAMSHA'S EFFORTS TO ENHANCE THE QUALITY OF SUBSTANCE ABUSE TREATMENT SERVICES. THANK YOU, MR. CHAIRMAN AND I LOOK FORWARD TO HEARING FROM OUR WITNESSES.

Mrs. MINK. Mr. Chairman, it is of course the responsibility of this oversight committee as a subcommittee of the Government Reform Committee to pay attention to the ways in which the various agencies and departments of government function and whether they carry out the mission of their responsibilities as delineated by Congress. We have to be, I think, absolutely sure, in whatever criticisms we level against an agency, that we compare their functions and activities with what this Congress has charged them to do. The criticisms of their conduct would not be fair in my estimation. It did not take into contact the myriad of riders and charges and other kinds of mandates that they have been given either by authorizing legislation or through appropriation riders.

Having said that, I think it's also important to understand that in this particular agency of SAMHSA, our charge is drug treatment, but SAMHSA has responsibilities in mental health, so although its budget is $2.5 billion, about $400 million of that amount is spent in the mental health area, of which we are not making any specific inquiries today.

In addition, there is another area known as knowledge development and application, which is allocated $329 million, both of which are under considerable scrutiny by the Congress through its appropriation process.

The area that you have called attention to in this particular continuation hearing is the block grants and the outside contracts that have been awarded to ascertain whether the moneys are being well spent and doing research and a variety of other things. The block grants constitute $1.6 billion of the agency's funding, and as I understand it, these funds are distributed to the various State agencies based upon formula, based upon criteria elaborated by the Congress. And that the SAMHSA agency is the Administrator pursuant to those instructions laid down by the Congress.

The GAO report indicates that the administrative cost, which this agency has reported roughly at 6 percent, does not constitute an excessive administrative overhead. You have raised the question that perhaps the true cost of the manpower is the number of individuals that are assigned to specific tasks within the agency. In that context, you have raised the question as to whether the true criticism should be with the allocation of personnel, and you have outlined that perhaps 11 percent of the personnel is spent on the administration of the block grants.

So we have much to hear from the agency, and I appreciate the presence of Dr. Nelba Chavez at these hearings. I'm confident that she will adequately explain the various issues that you have raised, and I look forward to Dr. Chavez's testimony. Thank you.

[The prepared statement of Hon. Patsy T. Mink follows:]

PATSY T. MINK
SECOND DISTRICT, HAWAII

WASHINGTON OFFICE:
2135 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–1102
(202) 225–4906
FAX: (202) 225–4987
http://www.house.gov/writerep/

DISTRICT OFFICE:
5104 PRINCE KUHIO FEDERAL BUILDING
P.O. BOX 50124
HONOLULU, HI 96850–4977
(808) 541–1986
FAX: (808) 538-0233

BIG ISLAND: (808) 935–3756
MAUI: (808) 242–1818
KAUAI: (808) 245–1951

Congress of the United States
House of Representatives
Washington, DC 20515–1102

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EDUCATION TASK FORCE, CO-CHAIR

OPENING STATEMENT
CONGRESSWOMAN PATSY T. MINK
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Continuation Hearing on
"HHS DRUG TREATMENT SUPPORT:
IS SAMHSA OPTIMIZING RESOURCES?"
Tuesday, March 14, 2000 - 10:00 a.m.
2154 Rayburn House Office Building

Mr. Chairman, thank you for holding today's hearing. This is a continuation of the February 17th hearing held to examine federal drug treatment efforts. We are here today to hear the testimony from the SAMHSA Administrator and the NIDA Administrator.

At the February 17th hearing, the Subcommittee heard from several witnesses who had positive messages to deliver. We heard from a representative of GAO, individuals who had benefitted from drug treatment programs, and several administrators of state treatment programs which are supported through federal funding.

GAO testified that SAMHSA performed well, had 6% administrative expenses, and responded to the needs of the states in providing technical assistance, scientific expertise, and training.

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The state administrators testified that more treatment funding is needed and the block grant formula established by Congress could be changed to allow more flexibility for the states. Additionally, the state administrators gave SAMHSA high marks for responsiveness and accessibility. Further, the state administrators testified that evaluation and monitoring information provided by SAMHSA was generally helpful in assisting them in coordinating their efforts to meet treatment needs within their respective jurisdictions.

Finally, the individuals who had been undergone drug or alcohol treatment testified about the necessity of treatment programs.

Mr. Chairman, at the last hearing, the Chair raised several questions about SAMHSA's efficiency and effectiveness. I think it is significant that GAO made no findings or recommendations for agency improvement. I was troubled by the concerns raised by the Chair and so I asked GAO to look into the concerns you raised. Mr. Chairman, I want to introduce a letter from GAO into the record. This letter reiterates that SAMHSA has 6% overhead, explains the necessity for outside consultants for effective oversight, and explains why the KDA program is more cost and labor intensive than the block grant program. Mr. Chairman, GAO has found that SAMHSA does not have any significant problems. I am willing to accept their finding. I think that if we want to talk about the use of block grants as opposed to discretionary grants, we should have that discussion. It is a valid policy disagreement.

But what cannot get lost in the discussion is the necessity of treatment programs. We know they are effective. We know they change lives. And we know there are too few spaces and too many on the waiting lists. We need to spend our time talking about how we can expand access, cut costs and eliminate waiting lists.

I look forward to having that discussion and I look forward to hearing today's witnesses.

Mr. MICA. I thank the gentlelady. Now I'm pleased——

Mrs. MINK. Just one more comment. Following the hearing we had on February 17, I sent to GAO a series of questions which arose from the testimony that we received, and I would like to have the responses and my questions inserted in the record at this point.

Mr. MICA. Without objection, the responses from GAO will be made part of the record.

Mrs. MINK. Thank you.

[The information referred to follows:]

Enclosure

1. At the February 17th hearing, Chairman Mica stated that SAMHSA had overhead expenses of 11%. This 11% estimate was based on the number of employees assigned to the agency's Office of the Administrator. Is this an accurate method to determine agency overhead?

   Dr. Heinrich:. The Office of the Administrator includes staff operating in support of specific projects or programs, such as grant and contract review. However, overhead expense is generally defined as costs that may not be specifically related to any particular project or program. We focused our review on SAMHSA's administrative expense which includes personnel compensation and benefits, travel, supplies, and other contractual services. The staffing costs of the Office of the Administrator are included in SAMHSA's expenses for personnel compensation and benefits. We determined that SAMHSA's fiscal year 1999 administrative expense is $155 million or 6 percent of the agency's total budget of $2.5 billion.

2. At the February 17th hearing, Chairman Mica expressed concern about contractor information contained in the appendix of your report. Specifically, he questioned the need for these contractors and implied improprieties in the contractor selection process employed by SAMHSA.

   A. Why does SAMHSA use these outside contractors?

      Dr. Heinrich: According to SAMHSA officials, contractors are used for technical assistance and program evaluation because SAMHSA does not have adequate resources or in some cases, staff with the necessary expertise to perform these services.

   B. Did your examination of SAMHSA reveal any waste, fraud or abuse by outside contractors?
   C. Did your examination of SAMHSA reveal any improprieties in the procurement process the agency used to select outside contractors?

      Dr. Heinrich: Our review did not include an evaluation of the agency's contractual services or procurement process.

3. The KDA program requires a greater share of agency resources than the SAPT program.

   A. Based on your examination of the agency, can you provide an analysis which explains the higher administrative expenses for the KDA program as compared to the SAPT program?

      Dr. Heinrich: Our review did not include a comparative analysis of administrative expenses for the SAPT block grant and KDA grant programs. However, according to SAMHSA officials, non-block grant programs, such as the KDA program are much more staff intensive than block grant programs since non-

Enclosure

block grants are often conducted through cooperative agreements. Further, the KDA program is a competitive grant program for which proposals have to be reviewed and approved and grant awards determined. In contrast, state SAPT block grant awards are determined based on a statutory formula.

B. Did your examination of SAMHSA reveal any inefficiencies within the KDA program?

Dr. Heinrich: Our review did not include an examination of the efficiency of the KDA program.

4. Your report found that SAMHSA's administrative overhead expenses are 6%.

A. What factors did you consider in determining the agency's overhead expenses?

Dr. Heinrich: We reported on SAMHSA's administrative expenses, which include personnel compensation and benefits, travel, supplies, and other contractual services. This information was obtained from the HHS Fiscal Year 2000 Justification of Estimates for Appropriations Committees.

B. Is a 6% administrative overhead expense rate appropriate for an agency whose primary function is grant-making?

C. Please provide the name and administrative overhead expense rate for any other federal agency whose mission and function are similar to SAMHSA's.

Dr. Heinrich: A 6 percent administrative expense rate is consistent with t he Health Resources and Services Administration (HRSA) which is another agency within the Department of Health and Human Services whose major function is to support service delivery through block grants and other grant mechanisms. HRSA's administrative expenses for fiscal year 1999 were $255 million, or 6 percent of its fiscal year 1999 budget of $4.2 billion.

5. Is there a generally accepted method to determine the distribution of work and employees within an agency?

6. Please describe the methodology you would employ to determine the number of employees assigned to a specific program within an agency.

Dr. Heinrich: Decisions on the distribution of work and employees are generally agency specific and oftentimes vary by agency functions. Workforce planning is a tool for determining the number of employees needed for certain programs and managing human resources. When properly implemented, a workforce planning system ties human resource needs to the organization's ongoing budget and program goals.

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7. Are there any positions within the agency which are used by more than one program or to fulfill various functions within the agency?

   Dr. Heinrich: SAMHSA's grants management and audit staff support both block grant and discretionary grant programs. Also, according to SAMHSA, staff assigned to the Office of the Administrator include staff performing centralized functions serving the entire agency, such as program coordination, equal employment opportunity and civil rights, and grant and contract review activities.

8. In your examination of the SAPT program, did you note any program inefficiencies or problems which could be remedied by SAMHSA's administrative actions?

   Dr. Heinrich: Our review did not include an examination of the efficiency of the SAPT block grant program. However, in our report we noted that as part of SAMHSA's on-site reviews to monitor SAPT block grant fund use, SAMHSA does not currently collect corrective action plans from states or track states' responses to identified deficiencies to determine if deficiencies are resolved.

9. Please provide a brief description of the kinds of groups, organizations or projects that receive funding under the KDA program?

   Dr. Heinrich: KDA program funds are provided to community-based organizations, universities, and state and local government agencies. In Appendix III of our report, we include a list of the number of grantees and describe the projects funded in fiscal years 1996 and 1998.

10. How does the KDA program expand drug treatment availability to underserved populations?

    Dr. Heinrich: The KDA program expands the availability of drug abuse treatment to special populations by funding grants that target special populations such as rural remote and culturally distinct populations and pregnant and postpartum women and their children who suffer from alcohol and other drug use problems.

11. In your examination of the KDA program, did you note any program inefficiencies or problems which could be remedied by SAMHSA's administrative actions?

    Dr. Heinrich: Our review did not include an examination of the efficiency of the KDA program.

Enclosure

12. Much of SAMHSA's monitoring and evaluation activity is conducted by private firms and companies operating under contract to the government. In your review of the agency, did you find any evidence of waste, fraud or abuse in these evaluation and monitoring contracts?

    Dr. Heinrich: Our review did not include an evaluation of SAMHSA's contractual services or procurement process.

13. Your report did not issue any findings or recommendations for the agency. Why not?

    Dr. Heinrich: Our work did not identify any findings that warranted a GAO recommendation. We reported that SAMHSA does not currently know the outcomes of states' drug abuse treatment programs supported with SAPT block grant funds, however, the agency is trying to determine the availability of client outcome data from all states and has awarded grants to some states to help improve their data collection systems. While SAMHSA's current efforts will not yield consistent and uniform data from all states, it should help determine the additional actions that are needed to get uniform state reporting on the results of drug abuse treatment programs.

Mr. MICA. Thank you. I would like to now recognize the gentleman from Massachusetts, Mr. Tierney, for the purpose of an opening statement.

Mr. TIERNEY. Thank you, Mr. Chairman. I'll just associate my remarks with those of the ranking member, and I look forward to the testimony of the witnesses and thank them for being here today. Thank you.

Mr. MICA. Thank you so much, Mr. Tierney. Welcome back, Dr. Leshner. I think you know the procedures. This is an investigations and oversight subcommittee of Congress. We do swear in our witnesses. If the witnesses will please stand and be sworn. I'm sorry, I don't know this gentleman's name. Could you identify yourself for the record and let's get a name plate.

Mr. WHITE. I'm Timothy White from the General Counsel's Office from the Department of Health and Human Services.

[Witnesses sworn.]

Mr. MICA. The witnesses have answered in the affirmative.

I would like to welcome the witnesses this morning. I understand we just have two opening statements. First, Dr. Nelba R. Chavez, and she is the Administrator of the Substance Abuse and Mental Health Services Administration with the Department of Health and Human Services. The second witness will be Dr. Alan I. Leshner, and he is the Director of NIDA, the National Institute on Drug Abuse, also under the Department of Health and Human Services. We'll recognize first Dr. Chavez. We won't run the clock on her since we only have two Members.

STATEMENTS OF NELBA R. CHAVEZ, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JOSEPH AUTRY, DEPUTY ADMINISTRATOR FOR SAMHSA; AND DR. ALAN I. LESHNER, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. CHAVEZ. Thank you very much, Mr. Chairman, good morning to you and members of the subcommittee. I do want to thank you for the opportunity to testify and provide the subcommittee with information on the operation and effectiveness of SAMHSA's programs. Before I proceed, however, I would like to enter our written testimony for the record.

Mr. MICA. Without objection, the entire statement of the witness will be made part of the record.

Dr. CHAVEZ. Thank you, Mr. Chairman. Also testifying with me today is Dr. Joseph Autry, who is our Deputy Administrator for SAMHSA. I want to thank you for the meeting and also it is indeed a pleasure and honor to be here with Dr. Alan Leshner.

There are some people that I would very quickly like to just recognize for the wonderful work that they do throughout the United States for individuals and families and children who are in need of substance abuse services. First, I'd like to recognize General Arthur Dean from the Community Antidrug Coalitions of America; Sue Thau from the Community Antidrug Coalitions of America; Tom McDaniels from the Legal Action Center; Dr. Linda Wolf-Jones from the Therapeutic Communities of America; Jennifer Pike

from the National League of Cities; and Mr. Jack Gustafson from the National Association of State alcohol and Drug Abuse Directors. Also Crystal Swann, who is with the U.S. Conference of Mayors; and finally, Dr. Westley Clark, who is SAMHSA's Director for the Center for Substance Abuse Treatment. He is in the audience as well.

Thank you, Mr. Chairman. It is an exciting time for the fields of substance abuse and mental health. We have established SAMHSA over the past 7 years as a critical component of our Federal health and human service system. We have improved prevention and treatment services across the country and, at the same time, streamlined our management. For example, we reduced the number of administrative offices from 20 to 7 through consolidation. We were able to reassign 44 FTEs and transferred to the centers for program support. Never before has the potential been so great and pride in our efforts so strong. The data attest to the fact that our strategy is reaping dividends. Recent studies show that drug use among teens is no longer on the rise. It may, in fact, be declining and without exception, our treatment programs, across the board, are helping people triumph over addiction and are leading to recovery. We have accomplished a lot for a small and lean organization. Most of our budget is distributed by formula set by Congress that limits flexibility to target funds based on need. However, with the tools and the limited discretionary resources available, we are clearly and capably carrying out our mission with success.

Despite the Nation's recent success in preventing and treating substance abuse, we are far from declaring victory. Unfortunately, the stigma of substance abuse and mental disorders persists. Lack of health insurance parity combined with limited government resources prevent people in need from receiving treatment services, and we still have much to do to improve service system performance and quality because of past emphasis.

Much of the work done to date is focused on male hard-core addicts. The demographics of substance abuse are changing. We often think of substance abuse as the province of adolescent and early childhood, of boys and not girls. Well, the girls have caught up with the boys and as the youth of the 1960's grow older, the number of older persons who abuse illicit drugs and alcohol may increase simply because the rates of substance abuse for this age group are higher than they were for previous generations.

Our systems are not prepared for an aging group of drug abusers, and at the same time, treatment for teenagers, male or female, is far from its potential. Our predictions, combined with the potential cost to society, argue strongly for an approach to prevention and treatment that balances the need to fund services with the need to improve the services available and to ensure services are targeted and relevant to the populations in need.

To help address the needs, we are working to give States increased flexibility with their block grants. As you may know, SAMHSA has a reauthorization proposal on the table. The Senate has already acted and approved the measure. I hope the House will act soon.

SAMHSA's role is clear. The findings from KDA grants offer service providers and purchasers of prevention and treatment services including Federal, State, and local government, access to improved, more efficient, and more effective prevention and treatment models. Targeted capacity expansion offers a way to target prevention and treatment services to the areas of greatest need. Block grants provide a way to help support States and maintain their prevention and treatment delivery systems. And data collection and evaluation provides accountability for the Federal resources entrusted to SAMHSA. This four-part strategy is the balanced approach that we need to continue if we are to make progress.

Again, Mr. Chairman, and members of the subcommittee, thank you for the opportunity to appear today. I'll be pleased to answer any questions you may have. Thank you.

Mr. MICA. Thank you for your testimony and remarks.

[The prepared statement of Dr. Chavez follows:]

TESTIMONY

NELBA CHAVEZ, Ph.D.

ADMINISTRATOR, SUBSTANCE ABUSE AND

MENTAL HEALTH SERVICES ADMINISTRATION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON GOVERNMENT REFORM

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

MARCH 14, 2000

WASHINGTON, D.C.

INTRODUCTION

Good morning Mr. Chairman and Members of the Subcommittee. I want to thank you for the opportunity to testify and provide the Subcommittee with information on the operation and effectiveness of SAMHSA's programs.

It is an exciting time for the fields of substance abuse and mental health. We have established SAMHSA over the past seven years as a critical component of our Federal health and human service system and have improved substance abuse prevention and treatment, and mental health service programs across the country. Never before has the potential been so great and pride in our efforts so strong.

In particular, I want to thank Department of Health and Human Services Secretary Donna Shalala for her leadership, guidance and support. Her commitment to ensuring that substance abuse and mental health services are a visible and vital part of comprehensive health and human services for children, youth and families is unsurpassed. In the area of substance abuse, we welcome the added leadership and support the Director of the Office of National Drug Control Policy (ONDCP), General Barry McCaffrey, has brought to our work. SAMHSA and ONDCP staff work together daily to coordinate Federal demand reduction efforts to achieve the goals of the President's National Drug Control Strategy. In the area of mental health, we are pleased that the Surgeon General, Dr. David Satcher, has focused the spotlight on our work to improve mental health and provide services for mental illness. Through the publication of the first ever Surgeon General's Report on Mental Health, he has made mental health services a national priority.

We also acknowledge and appreciate the work of our State partners and the organizations representing the State agencies responsible for substance abuse and mental health services: the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD). Their efforts have helped guide and shape SAMHSA's work to fulfill its mission. We further appreciate the recognition of

the importance of our work by the U.S. Conference of Mayors, American Public Health Association, Council of State Governments, National League of Cities and the many other groups that have supported this Agency and helped it exercise its leadership role.

SAMHSA ROLE AND RESPONSIBILITY

To understand the role and responsibility of SAMHSA, it is important to examine the Agency's history. As Federal investments have advanced the fields of substance abuse prevention, addiction treatment and mental health, the organizational structure of Federal programs responsible for continuing the progress has changed. Most recently, SAMHSA was created in 1992 as a result of the growing recognition by our Nation's leaders that increasing access to quality substance abuse and mental health services is central to improving national health and productivity. Before 1992, the major Federal substance abuse and mental health services delivery and research activities were combined under one agency, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Through bipartisan legislation, Congress created SAMHSA under Public Law 102-321 on October 1, 1992. This reorganization of ADAMHA moved the research institutes - National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health - that were part of ADAMHA to the National Institutes of Health. The service components of ADAMHA were configured to create SAMHSA.

To achieve SAMHSA's mission - to improve the quality and availability of substance abuse prevention, addiction treatment and mental health services in the U.S. - we have developed a balanced, four-part strategy:

- Support and maintain State service systems through block and formula grants;
- Cultivate a system responsive to current and emerging needs through Targeted Capacity Expansion (TCE) grants;
- Improve service system performance and quality through Knowledge Development and

Application (KDA) grants; and

- Provide accountability through evaluation and data collection.

Consistent with your request, most of the examples in my remarks on the implementation of our four-part strategy focus on SAMHSA's substance abuse programs. I'm sure you will agree, the findings of the recent year-long GAO survey of our drug abuse treatment efforts provides a good place to start. Let me summarize. Clearly, at the individual, community and national health policy levels, Federal investments in prevention and treatment are both a cost-effective and beneficial response to substance abuse. Prevention *does* reduce substance abuse. Treatment *does* help people triumph over addiction and lead to recovery. And, SAMHSA's staff is to be commended for working in partnership with the States, communities and public and private sector organizations to achieve national goals and to develop model programs; to coordinate Federal policy related to providing prevention and treatment services; and to evaluate the process, outcomes, and community impact of prevention and treatment services. That is why SAMHSA was established by Congress and that is what SAMHSA is accomplishing.

NATIONAL STRATEGY TO REDUCE DRUG USE IS WORKING

As the data attest, our four-part strategy is reaping dividends. The encouraging findings from SAMHSA's 1998 National Household Survey on Drug Abuse (NHSDA), coupled with findings from NIDA's Monitoring the Future Survey, show that drug use among teens is no longer on the rise; in fact, it may be *declining*. The President's drug control strategy has set an aggressive target to reduce drug use to the lowest levels ever recorded by 2007. If we are to hit the mark, SAMHSA must continue a balanced deployment of resources into each one of our four program areas - Block Grant, TCE, KDA and evaluation. SAMHSA's achievements to date confirm the importance of federally supported drug abuse prevention and treatment programs; the achievements of our TCE and KDA program highlight the fact that our programs offer States and communities models of more effective and efficient ways to accomplish results.

For example, the National Treatment Improvement Evaluation Study (NTIES), a congressionally mandated, 5-year evaluation of substance abuse treatment programs, funded by SAMHSA's Center for Substance Abuse Treatment (CSAT), found a 50 percent reduction in drug use among clients *one* year after treatment. The clients included in this evaluation study were from vulnerable and underserved populations (minorities, pregnant and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system). They may well have been among the most difficult-to-treat people abusing substances. NTIES also reported up to an 80 percent reduction in criminal activity, decreases in homelessness (down 43 percent), and increases in employment (up almost 20 percent). High-risk sexual behaviors were lowered by 56 percent; health care visits for alcohol- or drug-related purposes also declined following substance abuse treatment.

SAMHSA's Services Research Outcomes Study (SROS), based on a nationally representative sample of treatment programs, found similar outcomes *five* years following treatment. SROS reported a 21 percent decrease in the use of any illicit drug, a 14 percent decrease in alcohol use, a 28 percent decrease in marijuana use, a 45 percent decrease in cocaine use, and a 14 percent decrease in heroin use.

The NTIES findings are corroborated by other studies, among them, a NIDA study of over 10,000 clients who received treatment in 96 programs in 11 large U. S. cities. In the study – the Drug Abuse Treatment Outcomes Study (DATOS) – NIDA found that, following treatment, patients dramatically reduced their drug use, reduced drug-related criminal activities and improved their physical and mental health. Treatments included the four most common types of programs – outpatient methadone, outpatient non-methadone, short-term inpatient and long-term residential care. According to DATOS, heroin use by clients enrolled in methadone treatment dropped 70 percent;clients enrolled in both long-term residential and outpatient drug-free treatment reported a 50 percent decrease in cocaine use at the 1-year follow up interview.

Substance abuse treatment is among the most cost effective of all medical treatments. Returns on every dollar invested in treatment range from $4 to over $11 saved in other medical and social costs. In just one year, the State of Minnesota saved $28.7 million in medical, hospital, psychiatric, driving under the influence (DUI) and justice costs, recovering over 67 percent of its investment in treatment. Washington State reported a 50 percent decrease in medical expenses for individuals who received substance abuse treatment compared to those not getting treatment – down from $9,000 per year to $4,500 per year. Oregon found that each dollar invested in substance abuse treatment produced savings of $5.60.

Our achievements in substance abuse prevention are also substantial. Just this year, SAMHSA's Center for Substance Abuse Prevention (CSAP) released findings from its landmark 48-community study with almost 80,000 participants that found statistically significant reductions in drug and alcohol abuse among males in communities with anti-drug partnerships funded by CSAP. Findings from our High-Risk Youth Demonstration Grants Program show ways to achieve significant reductions in alcohol, tobacco and illicit drug use among the youth. These results highlight that positive change can be achieved related to youth substance abuse. These changed include: enhanced ability to refuse drugs and resolve conflicts, reduced school failure and improved attendance; and improved communications between parents and their children. We have joined forces with Boys and Girls Clubs of America to use what we have learned to reach millions of young people and their families across the country with effective prevention programs.

Despite the Nation's recent successes in preventing and treating substance abuse, we are far from declaring victory. Unfortunately, the stigma of substance abuse and mental disorders persists. Lack of health insurance parity for substance abuse and mental health services, combined with limited government resources, prevent people in need from receiving treatment. The result, according to SAMHSA's National Household Survey on Drug Abuse, is that 3.6 million people in severe need of substance abuse treatment do not receive the help they need. These individuals all to often end up in other publicly funded, but far more expensive systems, including the welfare and criminal justice systems, where substance abuse and mental problems are not addressed

adequately, if at all.

The demographics of substance abuse are also changing. We often think of substance abuse as the province of adolescence and early adulthood, of boys and not girls. Well, girls have caught up to boys and trends in substance abuse across the age span may well change as the baby boomer generation ages. As the youth of the 1960s grow older, the number of older persons who abuse illicit drugs and alcohol may increase simply because the rates of substance abuse for this age group are higher than they were for previous generations. In fact, if we combine the aging of current drug users with the continuation of current rates of first-time drug use, we can project a 57 percent increase in the need for drug abuse treatment by 2020. To maintain a level demand for treatment, we would need an immediate 50 percent reduction in first-time drug use. Our current systems are not prepared for an aging group of drug users. At the same time treatment for teenagers, male or female, is far from its potential. These projections and unmet needs combined with the potential costs to society argue strongly for a prevention and treatment approach that balances the need to simply fund prevention and treatment services with the need to improve and target those services.

The Federal role is clear. The findings from Knowledge Development and Application (KDA) grants offer service providers and purchasers of prevention and treatments services, including Federal, State and local government access to improved, more efficient and effective prevention and treatment models. Targeted Capacity Expansion (TCE) grants offer a way to target prevention and treatment services to the areas of greatest need. Block Grants provide a way to help support States and to maintain their prevention and treatment delivery systems.

SUPPORTING STATE PREVENTION AND TREATMENT SYSTEMS

Among the Nation's most important tools available to increase the capacity to deliver quality services and to implement new findings are the Substance Abuse Prevention and Treatment (SAPT) and Mental Health Block Grants. To increase State flexibility, SAMHSA has

proposed to transform these Block Grants into Performance Partnerships. The proposal – developed in collaboration with the organizations representing State agencies responsible for substance abuse and mental health services, NASADAD and NASMHPD – would increase State flexibility by allowing States to set their own priorities for expenditures and management of Block Grant funds.

For example, we propose consolidating 12 required criteria for the Mental Health Services Block Grant plan into five. This will make it easier for the States to complete their plans, and reduce administrative expenditures, while still focusing on the important aspects of community-based mental health services for adults with serious mental illness and children with serious emotional disturbance.

For the SAPT Block Grant, we are proposing to increase flexibility by reducing the number of mandatory requirements and by creating conditional waiver authority for the Secretary of the Department of Health and Human Services for some provisions, such as tuberculosis services, the set aside for pregnant addicts and mandatory treatment for intravenous drug users. To maintain the focus on services for the particular populations specified in the statute, a State waiver would be conditioned on meeting criteria established by the Secretary in cooperation with the States and published in the Federal Register. Legislation to reauthorize SAMHSA and to implement these changes in the Block Grants has been adopted in the Senate and is pending action in the House.

Part of the 5 percent SAPT Block Grant set aside is used by SAMHSA for targeted technical assistance to help States improve service delivery systems and the quality of the services delivered. In 1999, technical assistance resulted in 66 percent of States making systems, program or practice improvements – 16 percent above SAMHSA's 1999 goal. The words of State Substance Abuse Authority Directors speak volumes about the value of SAMHSA's technical assistance efforts:

"First it increased collaboration across multiple systems for one of our counties. Also, the data integration technical assistance helped us demonstrate the efficiency of our system. This led to a budget increase by the legislature of $30 million dollars. This happened because we had good research that proves that what we are doing saves lots of acute care and psychiatric care. For every 2.5 million spent by us, the state saves 4.8 million in other health care costs."

"It has improved our ability to improve services to Medicaid populations and has bolstered our changes that are underway."

"The technical assistance has helped to get training which has helped us get results."

Technical assistance offered by SAMHSA is based on requests from the States. SAMHSA does not determine what States need. States specify the topics of interest and, sometimes, who should do the training. To ensure that States have access to requested training and services, SAMHSA draws on a nationwide network of top-notch trainers. From the kinds of technical assistance requested by the States, it is very clear that the States vary in their ability to collect and analyze data on cost, organization, human resources and, especially, outcomes data. So, SAMHSA has worked with the States to develop a core set of outcome indicators applicable to the SAPT Block Grant. OMB recently approved our proposed changes to the Block Grant uniform application to permit voluntary collection of treatment outcome data from States beginning with Fiscal Year 2000. States are being asked to collect and submit client outcome data in four areas or domains: criminal activity, employment status, living status, and alcohol and drug use.

In addition, through its Treatment Outcomes and Performance Pilot Studies (TOPPS I) program, CSAT supported a 14-State series of pilot studies to analyze performance and outcomes for specific components of selected State substance abuse treatment systems. Oklahoma, for

example, found that two-thirds of those with driving under the influence (DUI) convictions 18 months before treatment had no DUI convictions within 18 months following treatment; 62 percent of treatment clients in another study improved their economic status. Preliminary results from Maryland show that over 40 percent of clients successfully completed treatment, more than 70 percent were employed at discharge, and nearly 75 percent were reported to be substance use-free at discharge.

Through TOPPS II, a 19-State effort to develop a standardized approach to measure block grant client outcomes is underway. Participating States have developed a 31-item core data set to measure specific outcomes across the states, and data collection has begun on representative samples of over 19,000 clients. Common indicators, including number of clients served and functional outcomes in the areas of increased employment and decreased involvement with the criminal justice system, will both support SAMHSA and State efforts to increase their flexibility in the use of Block Grant funds and provide enhanced accountability for the expenditure of these funds.

CULTIVATING A SYSTEM RESPONSIVE TO CURRENT AND EMERGING NEEDS

While vital to the support and maintenance of State systems, Block Grant funds are based on a formula set by Congress that does not allow the flexibility to target funds based on need. Therefore the Block Grant funds are only part of a comprehensive Federal approach needed to help communities address emerging drug use and related public health problems, including HIV/AIDS and hepatitis C, at the earliest possible stages. SAMHSA's Targeted Capacity Expansion (TCE) program gives States and communities the tools needed to aggressively contain emerging problems before they intensify. Mayors, town and county officials, the Congressional Black and Hispanic Caucuses and Indian Tribal Governments have emphasized the need for Federal leadership to provide a rapid and strategic response to the demand for services that are regional or local in nature.

CSAT's TCE grants do just that. They target cities, counties, tribes and other entities that have identified a need and are rapidly able to put into place effective treatment services for emerging drug epidemics. For example, these grants may be used to respond to the outbreak of methamphetamine use that has spread across the West and Southwest, as well as dramatic heroin use increases reported in localized areas. Targeted Capacity Expansion grants already are providing treatment for women in three rural regions of Colorado, outpatient methadone treatment in Chicago, detoxification services in Philadelphia, and 147 additional treatment slots for heroin users in Orlando. One major requirement of this grant program is that services must be coordinated with State efforts to target populations, including substance-abusing women and their children, youth, the homeless, people with both substance abuse and mental disorders, and rural populations. We are also targeting improved substance abuse treatment services for African Americans and Hispanics with, or at risk for, HIV/AIDS.

Through CSAP's State Incentive Grants for Community-based Action program we are now working with Governors in 20 States and the Mayor of the District of Columbia to develop state/city-wide strategies and deliver science-based substance abuse prevention services. A full 85 percent of funds provided by this program are being directed to community prevention programs, resulting in the funding of approximately 1500 communities in the 21 jurisdictions. Three High-Risk Youth prevention programs developed by CSAP are identified as among the top 10 programs implemented by these communities. Others are implementing family strengthening approaches for substance abuse prevention developed by NIDA.

IMPROVING SERVICE SYSTEM PERFORMANCE AND QUALITY

We can multiply the Block Grant and TCE dividend in terms of people served and positive outcomes by applying the new knowledge learned from SAMHSA's Knowledge Development and Application (KDA) grant program. Investments in KDAs allow us to determine more effective and efficient ways to deliver substance abuse and mental health services. KDAs also play a key role in connecting the findings from research funded by the National Institutes on

Health and others, to the delivery of everyday health care services.

For example, CSAT has launched an initiative to determine the effectiveness of the MATRIX program, a model methamphetamine treatment program developed and proven to be efficacious for various populations by a NIDA grantee. CSAT is also investing in improving treatment services available for adolescents and adults dependent on marijuana. The Marijuana Treatment Project shows that brief treatment – two sessions – produces a significant reduction in smoking behavior and that extended treatment – nine sessions – produces significant levels of both abstinence and smoking reduction. Both brief and extended treatment interventions are more effective than no treatment. In a similar assessment of marijuana treatment for adolescents, preliminary pilot studies have demonstrated reductions in marijuana use with five interventions. In untreated adolescents, marijuana use typically accelerates until age 20, with out-patient treatment reducing or leveling the slope of increasing use.

Thanks to SAMHSA KDA activities, significant strides were made in learning how to provide better treatment for women and children through our Pregnant and Postpartum Women (PPW) and Residential Women and Children's (RWC) programs. Preliminary findings from CSAT's KDA-supported cross-site evaluation of the RWC/PPW program strongly support the value of residential substance abuse treatment for pregnant women in reducing adverse birth outcomes and infant mortality. The rate of low weight births among PPW clients was 5.7 percent, far lower than the 30 percent average rate for drug-exposed infants and below the national rate of 7.5 percent. Perhaps the most startling finding was that the percentage of reported infant deaths among PPW clients after treatment was 0.3 percent, far below the expected rate for substance-abusing women, and lower than the national average of 0.7 percent.

Because the effectiveness of current treatment models is not well established for adolescents, CSAT is currently working with NIAAA to identify effective treatment interventions for adolescents who abuse alcohol and for those who have become alcoholics. SAMHSA's Center for Substance Abuse Prevention is also working with NIAAA to examine the effects of

alcohol advertising on underage drinking and to develop effective interventions to prevent and reduce alcohol-related problems, including deaths, among colleges students.

SAMHSA is working with the Food and Drug Administration and NIDA to increase access to, and improve the quality and accountability of methadone and levomethadyl acetate hydrochloride (ORLAAM) treatment for people with heroin addiction. Improving access to and quality of treatment will be accomplished by moving from the current regulatory environment to a system that combines program accreditation, based on standards developed by CSAT, with statutory requirements.

Several mechanisms are used by CSAT to disseminate findings from research and KDAs. For example, the Practice/Research Collaborative program brings together researchers, providers and other community leaders to identify and prioritize the problems that need to be researched to meet community needs. Another component of this effort is our Addiction Technology Transfer Centers (ATTCs). To improve treatment services, ATTCs develop curricula, provide regionally-based training and consultants, sensitive to area needs. CSAT also continues to develop its highly successful Treatment Improvement Protocols (TIPs) publication series that provide best practice models to the treatment field.

The extraordinary progress during the past few years in understanding substance abuse prevention, addiction treatment and mental health services is clearly having an impact. However, just as Federal investments are needed to continue to improve services available for the prevention and treatment of cancer, HIV/AIDS, heart disease, diabetes and other chronic conditions, continued investments are needed to improve services available for the prevention and treatment of substance abuse and mental illnesses. Thus, Federal investments are needed to continue evaluation, to improve efficiency and effectiveness of prevention and treatment models, to help educate substance abuse and mental health professionals about the best practices available, and to ensure that prevention and treatment strategies are relevant and focused on the specific cultural needs of our increasingly diverse population. These and other service delivery issues are being

addressed at the request of States and others through SAMHSA's KDA grant program.

PROVIDING ACCOUNTABILITY

The fourth part of our strategy is used to inform the President, the Congress and the American people on our program performance. Our Government Performance and Results Act (GPRA) plan incorporates the four-part strategy that encompass all of SAMHSA's budget activities. We continue to invest considerable staff, time, and dollars to ensure that data are available to assess the results of our efforts and to help us improve our services in these four areas. In particular, a significant investment is being made to expand the National Household Survey on Drug Abuse. The expanded survey, already underway, will provide enhanced national estimates of substance abuse and, for the first time, comparable State-level estimates of substance abuse and national information on mental health. The analysis of trends over time from the expanded Household Survey, in combination with other data sources, will provide an invaluable tool to direct future investments, especially through the SAPT Block Grant; to measure outcomes of the National Drug Control Strategy; and to report our progress to Congress.

We are always working to ensure SAMHSA management and program resources are being optimized. Since SAMHSA was established, a number of changes have occurred in SAMHSA staff allocation that have improved efficiency and emphasized support for our programs and initiatives. The most significant of these occurred during Fiscal Year 1996. The House Appropriations Committee, in its report on the 1996 SAMHSA budget request (House Report 104-209), noted the following:

> ".....the Committee is concerned about the level of duplication of activities supported with program management resources. For instance, each of the three operating agencies as well as the Office of the Administrator retain budget, public relations and congressional affairs operations - functions which should more appropriately be centralized within the Office of the Administrator. Accordingly, the Committee directs SAMHSA to reexamine

its administrative structure and to streamline management of the agency to improve efficiency, reduce duplication of effort, and contain costs."

In response, SAMHSA undertook a significant restructuring effort. The majority of administrative functions that were spread across the Agency were consolidated within the Office of Program Services (OPS), a new SAMHA-level unit outside of the Office of the Administrator responsible for servicing all SAMHSA components. Duplication of effort was eliminated as a result. Staff dedicated to contracts management, grants management, administrative services and certain aspects of financial management were combined with those administrative services that already had been centralized in Fiscal Year 1993 (Human Resources and Information Resources Management). Economies achieved through consolidation permitted substantial FTE savings; a 25-30 percent staff reduction accrued from the resulting economies of scale; and the number of administrative offices was reduced from 20 to only 7. Through these administrative consolidations, 44 FTEs were saved which were then transferred back to the Centers for program purposes. The reorganization also reduced the size of the immediate Office of the Administrator to its present size of 7 staff members.

The FY 1997 House Appropriations Committee Report noted that:

"The Committee commends the agency for the difficult decisions it has taken to downsize and streamline its operations to improve productivity and efficiency with limited resources."

Beyond the centralization of administrative functions and transfer of 44 FTEs to the Centers for program purposes in 1996, there have been no real or relative staffing increases for any offices outside of the Centers. Neither have there been any formal changes in oversight practices or operational controls resulting in amendments to the delegations of authority accorded Center Directors. In fact, SAMHSA has a record of excellent internal controls and has not been cited as deficient in this regard in any of its audit findings or in reports of the Inspector General or

the General Accounting Office.

CONCLUSION

It is clear that each new generation of American youth presents us with new challenges. Each new scientific advance in substance abuse prevention, addiction treatment and mental health services provides new options. And these options need to be translated and applied to every-day, real-life practices in order to improve the quality and availability of substance abuse prevention, addiction treatment and mental health services. SAMHSA's Knowledge Development and Application program is the Federal tool specifically designed to make progress and improve services in our Nation's communities. Our Targeted Capacity Expansion program is working to cultivate a system responsive to current and emerging needs. Our Block Grants are the vehicles available to leverage adoption of best practices and to support and maintain the quality services provided by the States. In summary, SAMHSA's unique role in the Federal government results in benefits to the American people.

I'm optimistic and enthusiastic about what the future holds for our ability, with the Congress's help, to address some of the Nation's most costly and devastating problems. Again, Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear today. I'll be pleased to answer any questions you may have.

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Mr. MICA. Rather than start with questions, we'll first hear from Dr. Alan Leshner, Director of NIDA. Thank you and you're recognized, sir.

Dr. LESHNER. Thank you very much, Mr. Chairman, and members of the subcommittee. I'm very pleased to be here today to tell you about NIDA's diverse research portfolio and how research findings are being used to better understand and prevent and treat drug abuse and addiction. I provided a detailed analysis in my written testimony, but I'd like to make just a few points if I may here.

NIDA is one of the scientific institutes of the National Institutes of Health, the world's leading biomedical research institution. NIDA supports over 85 percent of the world's research on the health aspects of drug abuse and addiction. Our comprehensive portfolio addresses the most fundamental and essential questions ranging all the way from the causes of drug abuse and addiction to its prevention and treatment. We also work hard to ensure the rapid and effective dissemination of our research findings into practice.

Because of our dominant world role in science, NIDA is ever mindful that even our most basic research findings must be useful beyond just to the scientific community. For example, the fact that scientists can now use the most advanced brain imaging techniques to see the profound effects that drugs can have on the brains of awake, behaving, experiencing individuals may not immediately appear to be relevant, but I point out that it's precisely these kinds of abilities that are rapidly providing us with new insights into how to prevent and treat addiction. They are also helping us determine the factors that make individuals more or less vulnerable or susceptible to becoming drug addicts.

NIDA supported science is also significantly advancing drug abuse treatment in very direct ways. For example, NIDA researchers have developed a wide array of behavioral treatments and interventions, including cognitive behavioral, relapse prevention and new family therapies. They also developed the patch, gum, and spray for nicotine addiction and LAAM and methadone for heroin addiction. NIDA is also working to develop medications to treat cocaine addiction and to develop both behavioral and biological treatments for methamphetamine and other emerging drug problems. NIDA is working very closely with our sibling agency, SAMHSA, to bring buprenorphine, yet another effective treatment for heroin addiction to the clinical toolbox of physicians and others.

Moreover, NIDA research has shown not only that drug addiction treatment is effective, but also that it reduces the spread of HIV, reduces drug use by up to 60 percent, and diminishes the public health and safety consequences of addiction, including the increasing criminal behavior.

Research clearly shows that treating drug users while they are under criminal justice control dramatically reduces both their later drug use and their later recidivism to criminality by 50 to 70 percent. It is this combined set of scientific findings that is serving as the basis for the new trend that's gaining momentum throughout this country of blending criminal justice and public health approaches.

NIDA is also taking a proactive role to be sure that the science is used to improve the quality of drug addiction treatment throughout the United States. As is the case for other chronic disorders, effective treatments for addiction do exist. However, as is also the case for other disorders, we can do better. Moreover, few of the new treatments are being applied on a wide-scale basis in real-life treatment settings. In response, NIDA has expanded on a model pioneered by other NIH institutes, the National Cancer Institute, the National Heart, Lung, and Blood Institute, the National Institute of Allergy and Infectious Diseases, and we have established the National Drug Abuse Treatment Clinical Trials Network. We call it the CTN for short. The CTN will provide a much-needed, national research and dissemination infrastructure to both test new pharmacological and behavioral treatments and to systematically research how to correctly incorporate these interventions into real life settings.

We've already established the first six nodes and have brought 42 community treatment providers into this infrastructure. We'll bring another six nodes including another 40 treatment providers into the network this year.

Our ultimate goal is to include as many universities and community treatment providers in the network as possible and, of course, to be truly effective, the network must blanket the entire country.

The National Drug Abuse Treatment Clinical Trials Network epitomizes NIDA's role as a supporter and conveyor of reliable science-based information. However, to truly optimize its dissemination of new findings to frontline providers, we work closely with colleagues and many other Federal agencies, particularly SAMHSA. A prime example is SAMHSA's addiction technology transfer centers, which are working closely with the nodes of our Clinical Trial Network to help ensure that rigorously tested and effective treatment programs are disseminated to communities across the country.

To conclude my introductory remarks, because addiction is such a complex and pervasive health issue, we must include in our overall strategies a comprehensive public health approach, one that includes extensive research, education, prevention, and treatment. We're very pleased about the tremendous progress in drug addiction research and how these scientific advances are offering us the tools and practical solutions to reduce the devastating problems caused by drug abuse and addiction for all Americans.

Thank you very much. I'll be pleased to answer questions.

[The prepared statement of Dr. Leshner follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Statement by

Alan I. Leshner, Ph.D.

Director, National Institute on Drug Abuse

Before the

Committee on Government Reform

Subcommittee on Criminal Justice, Drug Policy, and Human Resources

"Oversight hearing on programs of the Substance Abuse and Mental Health Services Administration (SAMHSA) and SAMHSA coordination with the National Institute on Drug Abuse"

March 14, 2000
Washington, D.C.

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to participate in this hearing. I am pleased to have this opportunity to tell you about the research that the National Institute on Drug Abuse (NIDA) of the National Institutes of Health supports and how NIDA staff coordinate both formally and informally with our sister agency, the Substance Abuse and Mental Health Services Administration (SAMHSA) , to disseminate research findings which will help to lessen the burden of drug abuse and addiction on society.

I would like to start out by giving you a brief summary about NIDA's history and the role that Congress has identified for us. As the Nation's drug problem soared in the late 1960s and early 1970s, it became clear that a research agency specifically dedicated to understanding and finding solutions to the drug problem was needed. Toward this end, in 1974 Congress created NIDA as the Federal focal point for research, treatment, prevention and training services, and data collection on the nature and extent of drug abuse. Soon thereafter, it was placed within the newly established Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

NIDA and the Nation saw several major changes throughout the next several decades, including the emergence of the AIDS epidemic, which became and continues to be a high priority for NIDA. As NIDA's responsibilities continued to increase, from combating the AIDS problem to the formal establishment of NIDA's Medications Development Program in 1990, it became clear that NIDA's research program should

become a component of the world's premier biomedical research institute, the National Institutes of Health.

Thus, to strengthen both the research and service missions of the Federal Government, a comprehensive and important bipartisan legislation reorganized ADAMHA (the ADAMHA Reorganization Act [PL 102-321]) in 1992. The three research entities of ADAMHA –the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and NIDA were merged into the National Institutes of Health (NIH). The service-oriented arms of ADAMHA became the current Substance Abuse and Mental Health Services Administration.

Under the auspices of the NIH, NIDA is now the supporter of more than 85% of the world's research on the health aspects of drug abuse and addiction. We have a very comprehensive and diverse research portfolio which incorporates many fields of scientific inquiry and addresses the most fundamental and essential questions about drug abuse, ranging from the causes of drug abuse and addiction, to the course of the disease, and to its prevention and treatment.

NIDA's mission, then, is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. This charge has two critical components: The first is the strategic support and conduct of research across a broad range of disciplines, including biomedical, behavioral, health services research, and research training. The

second is to ensure the rapid and effective dissemination and use of the results of that research to significantly improve drug abuse and addiction prevention and treatment.

NIDA recognizes that simply supporting and conducting high quality science is not enough. For science to be truly useful it must be conveyed in a way that makes it useable. We believe that even the most basic research has relevance beyond the research community. For example, using neuroimaging techniques we can now look into the brains of awake and behaving individuals to see the profound effects that drugs can have on the brain. This advance is revolutionizing our understanding of addiction and its treatment. In the past couple of years, we have discovered many of the mechanisms by which these long-lasting brain changes can compromise an individual's cognitive and behavioral abilities. And, of course, understanding the mechanisms responsible for the impaired behaviors of addicts has tremendous implications for the treatment of addicted individuals.

Moreover, these brain images are also being used in our prevention efforts as we educate people about the harmful effects of drugs on the brain. As a final example, these basic neuroscience findings, coupled with advances in molecular genetics, are providing us with targets to develop new and improved addiction medications and allowing us to better determine who may be most susceptible to becoming a drug addict.

In another domain, NIDA-supported advances in science are significantly advancing drug treatments. For example, we have brought standardized notable

behavioral interventions, such as cognitive behavioral therapies and contingency management, to treatment providers; helped to develop and bring effective treatments for nicotine addiction (such as the nicotine patch and gum) directly to the citizens of this nation who can now purchase these treatments in their local supermarkets; and we have developed the most effective medications to date for heroin addiction, LAAM (levo-alpha-acetyl-methadol) and methadone. The breadth of NIDA's treatment program does not stop there. NIDA is also working to develop medications to treat cocaine addiction. In fact, NIDA's medications development program is taking the first promising anti-cocaine medication into multisite Phase III clinical trials. NIDA is also intensifying its efforts to develop treatments for methamphetamine and other emerging drug problems.

Because treatment researchers are finding that integrating behavioral and pharmacological treatment approaches in ways specific to an individual's needs is likely the best way to treat addictive disorders, NIDA has a strong behavioral therapies development program to complement its medications development program.

Research has taught us that we need to develop medications that will be readily used and accepted by the populations we are treating. This is one of the reasons why we are working to bring a new medication for heroin addiction, buprenorphine and buprenorphine combined with naloxone, to the Nation's forefront. This medication will expand access to previously inaccessible populations. Bringing this new medication to fruition is an example of the type of collaborative work we do with our colleagues from SAMHSA. As NIDA develops and tests the safety and efficacy of this new treatment,

NIDA is working with SAMHSA's Center for Substance Abuse Treatment and other federal agencies to improve access to this medication.

Ultimately, however, we know that our best treatment is prevention. NIDA has a comprehensive, multidisciplinary prevention research program that examines the multiple factors that contribute to drug abuse and how these factors interact. We have found that prevention interventions need to be directed at the specific needs of different groups of youths at risk for drug abuse, including members of different ethnic groups and those living in different socioeconomic situations. NIDA works with its own grantees and with SAMHSA to ensure that NIDA's science-based drug prevention principles and programs are effectively integrated into communities and social settings throughout the country.

We are also working with SAMHSA to demonstrate the effectiveness of other prevention and treatment-oriented activities. For example, the MATRIX program, a model methamphetamine treatment program developed and proven to be efficacious by a NIDA grantee, is now being tested by SAMHSA's knowledge development program in three states. SAMHSA is identifying and addressing service barriers to this program in different populations. Given the current popularity of methampehtamine among many young adults and the long lasting changes in the brain that this drug has, it is imperative that we develop effective accessible treatments for this menacing drug.

NIDA also works with SAMHSA to disseminate current research information to practitioners, policymakers and frontline workers. This is best exemplified by an

upcoming national conference that we will be co-sponsoring with SAMHSA on drug use, HIV and Hepatitis.

Curtailing the spread of infectious diseases such as hepatitis and AIDS is another major research area for NIDA. Our research shows that drug addiction treatment is effective in reducing the spread of HIV, reducing drug use by up to 60 percent and diminishing the public health and safety consequences of this destructive disease, including decreasing criminal behavior.

NIDA-funded scientists have demonstrated that comprehensive treatment of drug-addicted prison inmates, when coupled with treatment after release from prison, reduces almost by 70% the probability of their being rearrested and the likelihood they will return to drug use. This type of research clearly demonstrates how science is being implemented into practice. We are seeing a blending of public health and public safety approaches to drug problems in states and communities throughout the United States. There appears to be an increased understanding among the citizens of this Nation that if we don't treat criminals while they are under criminal justice supervision, they will not only return to drug use, but may pose a threat to the safety of the community. It makes good sense to treat drug addicted criminals; research demonstrates that we can no longer simply incarcerate them without treating them.

Given that research has repeatedly demonstrated that addiction is eminently treatable and its treatment results are comparable with those from other chronic disorders

such as diabetes or asthma, it is imperative that we not only ensure that we have the capacity to treat addicted individuals, but ensure that we are referring drug addicts to programs that have been shown scientifically to be effective. Good treatment is not only effective, but cost effective as well.

NIDA is taking enormous steps to improve the quality of drug addiction treatment in this country. As is the case for other chronic disorders, effective treatments for addiction exist. However, the efficacy of these new treatments has been demonstrated primarily in specialized treatment research settings, with somewhat restricted patient populations. As a consequence, few of these new treatments are being applied on a wide-scale basis in real life practice. In response, NIDA has expanded on a model pioneered by other NIH institutes and established the National Drug Abuse Treatment Clinical Trials Network (CTN).

Under NIDA's overall guidance, the CTN will provide a much-needed national research and dissemination infrastructure to more rapidly and systematically bring new science-based addiction treatments into real-life treatment settings. The network will both test new treatments and systematically research how to correctly incorporate new and improved interventions into community-based drug treatment. By meeting these two overall objectives, NIDA will not only be improving treatment capacity, but also improving the quality of drug abuse treatment. NIDA will use proven research methods to ensure that treatments are not only effective, but that they address the critical needs of the community-based treatment programs and are suitable for those settings. We have

already established the first six nodes of the CTN and have brought 42 local treatment providers into this infrastructure. We are about to begin implementing the first three treatment protocols, just months after making the first of the grant awards.

The CTN epitomizes NIDA's role as a supporter and conveyor of reliable science based information. Each node is in the process of establishing an information dissemination component so local experts affiliated with the CTN can share their research findings. We will also look to our colleagues in federal agencies, such as SAMHSA's Addiction Technology Transfer Centers and programs administered by the Department of Justice and the Department of Education, for example, to disseminate these findings, to ensure that only treatment programs that have been rigorously tested in a research environment are used.

By building this permanent research infrastructure NIDA will have a large population base to answer future research questions that go beyond the immediate treatment arena, such as the medical consequences of long-term drug use and the role that genetics plays in determining one's vulnerability to addiction. We anticipate that the CTN will be a valuable asset not only for improving the quality of our Nation's drug treatment, but also serve as a platform to study ways to reduce morbidity and mortality of other drug-abuse related diseases such as hepatitis and tuberculosis.

To conclude, I have presented you with an overview of the type of research that NIDA currently supports, while also providing you with a glimpse into our future

research plans. We are optimistic about where the science is taking us and how these scientific advances are offering us the tools and practical solutions to reduce the devastating problems of drug abuse and addiction.

I will be pleased to answer any questions you may have.

Mr. MICA. Thank you. Let me start with a few questions, if I may, for Dr. Chavez. One of the concerns that was raised as a result of the GAO report that we requested was the distribution of personnel. You testified in your opening statement about some changes reducing the administrative offices. Did you say 20 to 7?

Dr. CHAVEZ. Yes, sir.

Mr. MICA. And moving FTEs to centers. I wasn't quite sure what that was. Could you elaborate on the movement of those personnel?

Dr. CHAVEZ. In 1996, the House Appropriation Committee requested that we review our organization, and one of the things that they were looking at was the duplication. For example, we had many duplicative services in all three centers at SAMHSA. Their recommendation was that we centralize many of these administrative services. In addition, they also recommended that we look at some areas that needed to be strengthened.

Mr. MICA. Where did these 44 people come from and where did they go? 44 FTEs, are they just slots?

Dr. CHAVEZ. These were FTEs and these were slots.

Mr. MICA. Eventually, people moved from one point to another point. Where did they go?

Dr. CHAVEZ. They went to the three centers, to the Center for Mental Health Services, to the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention.

Mr. MICA. So we have the same number of people. They've just been moved to other responsibilities?

Dr. CHAVEZ. That is right. Some of those individuals—some of those positions were vacant, so those positions were also transferred to the centers.

Mr. MICA. One of the other things that caught my eye was the number of personnel in the administrator's office, which GAO reported at least 73, and I think you said there were 7. Can you account for this discrepancy? Where are the other folks working?

Dr. CHAVEZ. The reason that the Office of the Administrator appears to be large is that numerous essential operational and coordinating functions are grouped with the Office of the Administrator, the umbrella organization. For example, in my immediate office, there are seven individuals, a total of seven that are directly in that office, including Dr. Joseph Autry, who is the Deputy Administrator. There are five others that are detailed. One is detailed to the Department of Health and Human Services. Another person is detailed to HCFA. And the other to the Executive Secretary. In my office, I have a Deputy, an Assistant, and a Secretary. Dr. Autry has a Secretary and an Assistant. So in the immediate office there are seven individuals. Those other individuals which are listed are in various offices and provide agency-wide roles. For example, contract and review, which was one of the groups that the House Appropriation Committee recommended be centralized. They are responsible for managing legally required reviews for the centers. We also have program coordination and policy activities and offices that are responsible for coordinating many of these activities. Some of these offices are in statute. For example, we have an office for AIDS. We have an office for women. We have an office for alcohol. We also have legislative services as well as Equal Employment Opportunity, Civil Rights, and Executive Secretary functions.

Mr. MICA. There are 73 people total assigned to your staff, and then you have each of the different activities. Mental health has 113, substance abuse prevention 118, and Center for Substance Abuse Treatment 115. So most of what you have in these other activities would be a duplicate at your full administrative office. For example, you have 12 in communications, public communications. In mental health for that entire agency there are 13 substance abuse, and communications has 22. And 26—I'm sorry, 7 in substance abuse treatment. So you have duplicates in the Administrator's Office of which we have those activities, and each of the individual activities, one being just for citing—the numbers would be as I cited with public communications; is that correct?

Dr. CHAVEZ. Let me——

Mr. MICA. Those numbers are correct. I'm just looking at one function, which is communications or PR, and you have 12 in your office.

Mr. AUTRY. Mr. Chairman, may I respond to that, please. If you look at the fact that SAMHSA is an operating division within the Department of Health and Human Services, that means that we have functions that we have to carry out, including clearance of testimony, clearance of reports, doing special reports to the Congress, reports to the Secretary, et cetera. Those are functions that are carried out within the Office of the Administrator. The functions that are carried out in the centers are primarily those related to synthesizing knowledge information, disseminating that to the field around specific issues like substance abuse treatment, substance abuse prevention, mental health services, so there is not duplication in that area. Also, Dr. Chavez noted, we did centralize a number of the functions so that all of the peer review mechanisms are now centralized in OA. That did result in a savings of FTEs. Grants management contracts management, and a number of offices that run administrative services were also centralized in the OA as well as legislation and policy staff. So those are not duplicated in the Centers.

Mr. MICA. One of the major concerns, if they put the chart back up, on the block grant, the SAMHSA funding and staff allocations was—I'm sure you've seen it—State block grants, which accounts for 80 percent of the funds, which you give, that would be non-mental health or just in substance abuse prevention treatment? Can you put that chart up?

Again, what has raised some questions about the expenditure funds is—and 6 percent may be a good figure for overall for administering $3 billion at whatever total amount of funds you're administering, but with the bulk of the money, 80 percent of the money is given out in State block grants, 11 percent of the personnel are used. To give out the discretionary grants or other activities, 89 percent of the administrative funds are used to distribute to 20 percent, which has brought many to believe that we should block grant just about everything. Then we had people at the last hearing noting that there is overlap. They couldn't answer questions about research and scientific activity. I know some of your responsibility is evaluation, and that's an important activity, and also mandated by Congress. But there were questions as to why that hasn't been researched, being given to NIDA which has that re-

sponsibility, to bring down the cost of administration and put more of this money out into the treatment programs.

So we have some serious questions about the amount of money that is being expended for a very small portion of the budget. Did you want to respond?

Dr. CHAVEZ. Yes, sir. Thank you. Let me talk a little bit about the administrative costs and the excessive overhead that seems to be seen. SAMHSA's overhead costs are not excessive——

Mr. MICA. We've all agreed on that generally. But 11 percent of the personnel, according to the GAO, we didn't study it. We have no prejudice in this. All we're trying to do is look at the facts. They say 11 percent of your personnel are used to distribute 80 percent of the fund. The 89 percent are in the expenditure of 20 percent of the funds, and some of those activities are indeed NIDA, who has the lion's share of activity, I would imagine.

Dr. CHAVEZ. You are correct. NIDA is the premier research institute.

Mr. MICA. Should we turn the rest of that over to NIDA, the activities you now have in R&D?

Dr. CHAVEZ. Yes, I would like to answer the block grant question if that's OK with you.

The question that has been raised is that perhaps we're either shortchanging the block grants staffing, whether it's appropriate and reasonable. The block grants differ from all of our SAMHSA programs in that the States decide on which project will be funded and then they manage these directly.

What we have done at SAMHSA is to ensure that the staffing for the block grants is in proportion to what we believe is critical—in relation to the work that needs to be done. Now, the staff members who are assigned direct responsibilities are also supported by other staff members to carry out the necessary functions. For example, we do a lot of technical assistance which is, by the way, requested by the States. We do site visits and we do audits. Joe, I don't know if you want to add anything else to that.

Mr. AUTRY. Mr. Chairman, if I may add a couple of comments. One of the things about block grants is that they are, by definition, moneys that go through the States with very little strings attached to them, if you will. And so there is not the degree of review of application, nor the degree of oversight in terms of what specific activities that they are funding that is necessary in a discretionary grant program. As Dr. Chavez indicated, the review of the applications regarding TA, making sure we do appropriate audit procedures are the main function of the block grant staff. It's not as labor intensive as our discretionary grant program. Most of our discretionary grant programs are what we call cooperative agreements, which means there's a significant Federal oversight role in developing both individual project and cross-project, or cross-program evaluation, to determine how effective and efficient those activities are as they are delivered in the real world.

Dr. Chavez is quite correct that our program is quite different from Dr. Leshner's, and as he noted, his institute does, in point of fact, conduct research. They do clinical trials work, they look at behavioral therapies, medications interventions, et cetera. Once you put that out into the community, and I can tell you as a practi-

tioner, many times what you develop in the laboratory or very controlled setting differs significantly on what really works in the real world. And we're very pleased to have an ongoing dialog with Dr. Leshner to continue to get his input as we try to improve the effectiveness and efficiency out in the real world.

The acknowledge development activities that we support are in service of the block grant and in service of targeted capacity expansion trying to find more effective ways to intervene, better ways of doing assessments, and more efficient ways of using what we know and constantly trying to improve our knowledge, including feeding interventions back to NIDA that need additional research. So it is more labor intensive than the discretionary grant program.

Mr. MICA. Well, first of all, Dr. Chavez, I never or anyone from this panel, accused you of shortchanging in the administration and overhead for the block grant program. It appears to be fairly cost effective to administer in the scheme of things. That's not the problem. The problem is on the other side of the equation. I could be a better advocate for your department than both of you are because there are many things that Congress has mandated. Part of your costs are the evaluation system, which we require to be set up, and accountability. And that's an important mandate. From the testimony we heard from folks, that sounds like we went a little bit overboard, and we need to go back and grant a little bit more flexibility.

There was one witness who said she spends 4 hours preparing forms. Almost 1 day a week preparing forms and reporting and 4 days for treatment. That's how bad it's gotten in the reporting area. We're here straightening out many of the things and States overreact. The other thing we heard was also duplication. When you're down at the lower end of the pecking order, the States have requirements and Feds have requirements, and this poor little person who is trying to treat folks at the end of the feeding chain, and sometimes smaller operations, are burdened with overhead and spending time on completing forms rather than treating people.

The other thing that we are concerned about technical assistance, and we do need to provide that. Sometimes, only the larger body can provide that. In this case, hopefully, the Federal Government and agency can adequately provide technical assistance on a broader base. You didn't say, I think, publications. We had testimony that noted some of what you do, as far as even publications and bringing information together and disseminating, is extremely valuable.

Our problem is we also heard testimony and have evidence that show many of the discretionary grants are given to treatment programs that already are getting State money or indirect Federal money through State money, so they are going through sometimes three levels of evaluation or scrutiny or reporting. And it seems like we've created a very expensive overhead for some of these KDA activities. So we are wondering why we can't shift more money to get out to the treatment programs and less money for administering discretionary programs.

I'm sure there are some unique programs that only the bureaucrats and only the people in Washington can decide that are valuable for national interest, but when you spend $129 million, and

if my plan works, to spend only $29 million and give $2 million additional dollars to States for those activities—she doesn't like that. OK. We'll redo the figures. In any event, we're trying to find a way to have less administrative overhead yet more money into the programs, eliminate these extra requirements. And the final thing is if there's overlap with Dr. Leshner, if we could shift to NIDA with some interagency agreement. For them to conduct this, then the problem we have is even when we get into some of these testing areas. I don't want to take all the time.

I want to yield, and then we can come back. We get into some of these testing areas, and I find that there are further delays in testing and evaluations. I just read out a report that now we may be looking at 2003 before the earliest standard for new drug tests, and technologies-acceptable standards can be implemented. So we have research. We have testing. We have evaluation. We have different important functions in trying to sort out how we can make them all fine-tuned and efficiently delivered.

Dr. Leshner, finally, could you see us combining and working in some interagency agreement and shifting all of the research activities to your agency?

Dr. LESHNER. Actually, sir, I don't think we have literal overlap in what our two agencies do. We conduct research and applied research and SAMHSA, and we overlap, at most, just a hair at the edges of what we do and in an attempt to provide a somewhat seamless transition.

Mr. MICA. They may not overlap, but I just say there are administrative costs. Is there any efficiency of you doing the whole enchilada and having some type of cooperative agreement?

Dr. LESHNER. Not that I'm aware of, sir.

Mr. MICA. Maybe we can ask GAO to look at that question, specifically. Sometimes, it's hard for agencies to come up with consolidation recommendations and dichotomy of scales.

Mrs. Mink.

Mrs. MINK. Thank you, Mr. Chairman.

Dr. Leshner, your primary research mission, as I understand it, is to analyze how drugs impact on behavior, on human development, and create a wide variety of mental and physical disorders. Is that basically the type of research that you do in NIDA?

Dr. LESHNER. That's a portion of the research that we support because we represent 85 percent of the world's research. Our research portfolio ranges, actually, all the way from the very most molecular levels of analysis of understanding how drugs of abuse function and produce addiction through prevention research, treatment research, and research on the organization and financing of services for substance abuse. And so we say we do everything from the molecule to managed care, or everything from the most molecular level all the way out to understanding social systems and how those social systems affect and respond to the drug abuse and addiction problem.

Mrs. MINK. The primary function of SAMHSA is to distribute block grant moneys for treatment of drug addicted individuals, and that's how they distribute their block grants. Is it at all feasible to consider a suggestion that NIDA then determine whether the treatment programs that are funded by the Federal Government are

working and to what extent they could be improved, or to what extent they could be translated in other venues?

Dr. LESHNER. We do, in fact, study the treatment system, both public and private and its effectiveness, and again have determined it to be highly effective. However, we don't have any authority over individual programs or the way in which States administer the treatment programs.

Mrs. MINK. I don't mean to suggest you would have any authority but to study whether they are effective or not.

Dr. LESHNER. We do, in fact, not tied to any particular funding stream, but, of course, we do analyze the nature of this treatment system in this country and the way in which it's functioning.

Mrs. MINK. Is that why they distribute it then to the various State agencies?

Dr. LESHNER. I believe it is. Just as one example, we recently produced the first science-based guide to drug addiction treatment, which has now gone out to over 250,000 communities in this country, and we've had over 55,000 copies downloaded from our Website. Every State is using this guide as a part of its own activities, and it's a compilation of research and what we've learned from research, so I do believe that the information is, in fact, available to the States. The States are participating actively in our Clinical Trial Network. In fact, the State director from Oregon is a member of the CTN oversight board. So that there is a close relationship between us.

Mrs. MINK. So the work that you've just described as part of NIDA and the work that is now assigned and taken over by SAMHSA, you say there's only a fine line of duplication of effort?

Dr. LESHNER. My own view is that there is virtually no duplication. There is, however, an attempt to have a seamless connection between what we do and what SAMHSA does. An example of that I mentioned in my testimony is the Association of the Addiction Technology Transfer Centers that SAMHSA supports with our clinical trial network. Another example would be, just last week I was in Oregon meeting with our northwest node, and present in the room were the people from the Center for Substance Abuse Treatments Practice Research Consortium, so we do, in fact, try to mesh activities as much as we can in order to have that translation. My own view is we have virtually no overlap.

Mrs. MINK. I know that it's not particularly appropriate for one agency to criticize or make comment about another agency's function, but since we are here today to try to understand SAMHSA, and if there are any possible ways in which their application of the law can be improved, would you be able to comment, with respect to this one area that the chairman has criticized with the KDA, if there is any room for improvement as to how the funds should be allocated there or commissioned out by contracts and so forth. Is there anything that you could clarify for us?

Dr. LESHNER. I don't know enough about the administration of it to make any comments like that. I can say that the KDAs, with which I'm most familiar, use science and use the science base that we've provided as a foundation for what they do, but I really am not qualified to comment on the administrative ends of it.

Mrs. MINK. Are you able to comment on whether SAMHSA has need for the delineation of this program for research and for evaluation and for dissemination of information?

Dr. LESHNER. I find SAMHSA's programs extremely useful in terms of helping to get dissemination and translation into actual practice of what we do. I apologize for going on, but just give you one example, NIDA research produced something called the matrix model as a treatment approach for methamphetamine addiction. The subject must be well known to you and SAMHSA's Center for Substance Abuse Treatment has now done a multisite KDA demonstration of that program in a variety of places around the country, and I believe that again is an example of the relationship that can exist.

Mrs. MINK. Thank you. Your responses to my question, I think, are very illuminating. While we could probably get the same response from SAMHSA, Mr. Chairman, sometimes it's much more compelling if you have another agency corroborating what I believe the primary witness, Dr. Chavez, has already testified to. Frankly, Mr. Chairman, administrative costs are always a disturbing factor when you think of the tremendous need out there for additional funds and only 50 percent of the people that should get treatment do. I think it's relevant to say that the Federal Government does not have the entire responsibility for drug abuse treatment. We share only a limited participation in this area. The main function ought to be State and local governments, but in looking at my own situation in my State, I find that the Federal Government is supporting more than 50 percent of what we are spending in my State, and I think that's willfully lacking in terms of our own State performance.

So while I would like to see many more dollars going out there to my State for treatment, I do think that the burdens that have been placed upon this agency for evaluation and research and dissemination of information and so forth require this 50-person allocation for administration of these block grants. But I think it's worthy to look at it and to study it, but I see really no basis for criticism of the agency's use of these 50 bodies.

There's one column in this column which is mental health, which is not part of our inquiry, so we're only taking the three, and there are 50 bodies that go across the line block grant. But I don't think that's only for analyzing who gets the grants. It's to make sure that the use of the funds as appropriate and in accordance with the law, and I think that you and the majority members in particular are always honing in to make sure that the funds are properly spent, yet you don't want one-size-fits-all, and you don't want the Feds dictating how the funds are going to be used.

So you're kind of in a tough spot, Mr. Chairman, in trying to meet all of these criteria. But I think in this instance, I personally am satisfied that the agency is doing well, and while I would like to have more money and greater freedom in my district for how the funds are to be used, I don't see any particular discrepancy in the administrative costs allocation insofar as the testimony that's been presented so far. Thank you, Mr. Chairman.

Mr. MICA. Thank you. I'll respond in my questions when I get time after Mr. Tierney.

Mr. TIERNEY. Thank you. Dr. Leshner, let me go a little bit astray here on this. You said about 95 percent of your work was drug abuse and treatment research. How much of that is allocated to alcohol abuse?

Dr. LESHNER. Another NIH Institute, the National Institute on Alcohol Abuse and Alcoholism [NIAAA], has primary responsibility for alcohol research, because if you have a grant from NIDA, you may also be studying alcohol in the course of it, since most drug addicts are, in fact, polydrug users, we estimate, and this is an estimate that we support, about $40 million a year, that includes alcohol.

Mr. TIERNEY. Most of it goes under another NIH——

Dr. LESHNER. NIAAA.

Mr. TIERNEY. You also indicated NIDA was instrumental in coming up with a patch, gum and spray for nicotine treatment, that your research actually resulted in the development of those.

Dr. LESHNER. Yes.

Mr. TIERNEY. NIDA is not the one advertising or selling those. I am curious to know how they got in the hands of private manufacturers and what the deal was underlying that?

Dr. LESHNER. We have our own research laboratories in the hospital on the grounds of the Johns Hopkins Bayview campus in Baltimore, and one of our researchers, Jack Henningfield, did the pioneering work on the addicting qualities of nicotine and on techniques for administering nicotine-like substances through other vehicles, which goes into the public domain, where private companies are, of course, free to pick up the technology.

Mr. TIERNEY. No proprietary rights on that at all?

Dr. LESHNER. We don't on the nicotine patch. However, now, as you may know, we are forming what are called CRADAs, cooperative research and development agreements, with pharmaceutical companies for the development of antiopium and anticocaine medications. We have a number of those and what we have there is a share in the developing costs, because the Federal Government believes it's so important to develop these medications. We don't actually get money back as a result of it, but we do, in fact, facilitate treatment, and it keeps the costs down tremendously.

Mr. TIERNEY. Why is it that you don't get anything back, and didn't in particular with Mr. Henningfield's work?

Dr. LESHNER. In the case of Dr. Henningfield's work, it was, of course, the work that produced our understanding that nicotine is an addicting substance, and he has since gone on to great and famous things. But the technology itself was developed as a part of the scientific investigation and was not at the time developed predominantly to be a marketable product. Therefore, when it was published, it went into the public domain and just like many other technologies that you now have for the application of medicines, the various parts of your body, have been in the public domain, that particular technology was also. The approach of trying to produce sustained nicotine levels as a treatment approach was the scientific question that Dr. Henningfield was investigating at the time.

Mr. TIERNEY. You also made some comments or your remarks that few of the new treatments that are being developed are yet to be widely used. Am I correct in quoting you there?

Dr. LESHNER. Yes, sir, you are.

Mr. TIERNEY. Can you tell me what we're doing about that and how we're going to improve that situation?

Dr. LESHNER. There are a variety of things happening. First of all, it's important to recognize that many of these treatments are treatment components. They are not comprehensive programs. They are pieces that you might incorporate into a comprehensive program and they have only been developed within the course of the last 10 years.

However, having said that, we are about to mount the first three trials in our Clinical Trial Network just 4 months since we made the first awards. What will happen is we'll test them in real life settings, and then if they work, people will use them. In addition to that, what we're doing, and again, to use that methamphetamine matrix example or the addiction technology transfer centers example, SAMHSA's programs take the results of the scientific research, and then help disseminate them to community-based providers.

So we have both a relatively permanent research infrastructure, our Clinical Trials Network. That's one vehicle. SAMHSA's addiction technology transfer centers and their KDAs programs that provide another mechanism to help facilitate dissemination of scientific findings. Both of these activities are really quite new, and my own view is that they are being pretty successful at getting the information out but there are many thousands of treatment programs in this country, and it's very hard, of course, to change behavior.

Mr. TIERNEY. Thank you.

Dr. Autry and Dr. Chavez, let me ask you, the chairman made a comment about block granting everything in your program, which I don't think is necessarily going to be the appropriate way to proceed, but I'd like your comments on that. Would it at all help or hinder your efforts to address the situation for which you're formed?

Dr. CHAVEZ. Mr. Congressman, in 1980–1981, that was considered by the Congress—in 1980 and 1981 as well as in 1986. At that time, in 1980 and 1981, the Congress made a decision that, in addition to block grants, we also needed to have a national presence through demonstration programs. Then in 1996, the same issue was addressed, and at that time, the Congress made a decision that we really needed to ensure that the knowledge or the science that is being developed by NIDA is translated and carried out into community programs, and basically that is what our knowledge, development and application program is about.

What I believe, and I think many of us out in the field and throughout the community believe, is that in order for us to really begin to close the treatment gap and to continue to reduce drug use among youth, we need a balanced approach. As the Congresswoman said earlier in one of her comments, one size does not fit all. Our approach has been with—the block grant that the States perform a very, very critical job, and they, too, are limited, as we all are, in terms of their resources. And in some States the demand

is so great that it cannot be met for treatment services. That is one component of a balanced approach.

The other component of a balanced approach is KDA and TCE, which is our knowledge development and application. Within that, we take a lot of the research and we build on what NIDA has done and give it life in communities. We're asking "Does it work?," especially in diverse communities. The other area that is also part of that umbrella is what we call our targeted capacity expansion. The targeted capacity expansion was created because the Congress of Mayors, Indian tribes, the Black Caucus, the Hispanic Caucus, and many groups throughout the communities came to us and said that they needed our help in ensuring that we were targeting services specifically to their community.

We have looked at the drug problem as a national problem. However, it's a regional problem as well and as that map that we have over on that side clearly indicates, if you look at methamphetamine as one example, we have the same information for heroin and many of the other drugs. Methamphetamine, in this particular instance is, as you can see, a very regional problem. What we have done there is that we have issued announcements to communities and to mayors and to counties and to Indian tribes. Let them assume the responsibility in terms of identifying what the problem is in their community and then we will provide short-term dollars to help them resolve these problems.

Now, having said that one size does not fit all, and I do not believe because of the nature of its formula, and some of the other issues, that the block grant alone is going to be able to succeed in terms of solving some of the issues that we're having to deal with today.

Joe, do you want to add anything?

Mr. AUTRY. I would just like to add a couple of comments. One, as Mrs. Mink noted earlier, there really are insufficient funds to fund the block grant, and insufficient funds at the State level to entirely close the treatment gap using just a block grant mechanism. On the other hand, the block grant provides the necessary infrastructure to support treatment systems within the States and without that, you would be even further behind in closing the treatment gap.

Looking at the regional distribution of drug use in this country, knowing that there are communities who do not receive sufficient funds through State coiffeurs, and knowing that many times we need to have additional funds come in and sometimes people are reluctant to use the same old mechanisms to provide funds, we try to tailor programs that meet those emerging needs. We try to tailor programs that address distribution of drug use, emergence of HIV-AIDS infection and the needs of special populations who are not met many times through the block State funding.

So if we don't have a balanced approach, we don't provide Federal leadership, work in conjunction with our State colleagues, we're not going to be able to have the effective programs that we need to address substance abuse in this country.

Mr. TIERNEY. With respect to the amount of money you disseminate through block grants, if you weren't constrained by the formula, would your agency think of allocating those funds in a dif-

ferent direction? Are there other areas of need or other priorities that you would address instead of spreading them out by the same formula?

Mr. AUTRY. Two comments to that. One is, the formula is, in point of fact, a vehicle created by Congress. I think it's already taken into account a lot of those varying competition needs——

Mr. TIERNEY. My question is, do you think it's effectively doing that or not?

Mr. AUTRY. I think the block grant is a highly effective mechanism in providing the necessary treatment and prevention infrastructure resources in the State, and I'm pleased to say we work with our colleagues at NASMPHD and NASADAD to continue to provide oversight to that to develop common core outcome and performance measures. We look forward to continuing to do that.

Mr. TIERNEY. Thank you all. Thank you, Mr. Chairman.

Mr. MICA. Let me just followup on a couple of things. You said you tailor programs to assist where there is a problem. This chart identifies the methamphetamine problem. We just did hearings in California. I saw the red part, at least the California coast, I should say the Pacific coast, and what's going on there. There's a meth epidemic. It's beyond anything. I've only been chairman for 14 months, and I had no idea that it was that severe. I have a chart here that shows the percentage of State money for treatment services by funding source that was provided to us by GAO, and it shows State and Federal funding.

Actually, California gets about 25 percent of its funds, if we include this other Federal, we might get up to 39 percent. One of the lowest in Federal funds and highest in State or other funds. It would seem to me that a State that would have an epidemic problem should be getting more funds.

Next to it is Florida, which has an epidemic heroin problem. Is there anything that's done to make certain that more Federal resources get to where we have these epidemic problems?

Dr. CHAVEZ. Thank you, sir. That's a great question or a great comment. First of all, California—in terms of block grant distribution—California, if I remember correctly, gets more dollars than any other State in their grant block distribution. The question that you have raised is an excellent one, because that's exactly what is at the heart of our treatment capacity expansion.

This is what I said earlier—when communities, when mayors, when county officials, when Indian tribes, when the Black Caucus, and when the Hispanic Caucus have said that some of these dollars are not reaching our communities. We have, in some of our communities, epidemics, and these epidemics range from HIV-AIDS and substance abuse to methamphetamine, to heroin, to drug overdose by young people, et cetera.

The idea, in terms of the creation of the targeted capacity expansion, was to give local communities the opportunity to sit with their political subdivisions and define the problem—in ways that were truly getting to the heart of that problem. Then they would submit an application to SAMHSA which, like all of our applications, is reviewed, as required by statute, by peers.

Mr. MICA. The local communities we talked to, almost every one of them, are first submitting to the State, and then they are sub-

mitting again to SAMHSA under your formula. My question would be if we do the chart from last year, and I was out Monday in that area, they are hanging on by their own teeth, only because they put together patchwork programs with the State agencies.

I'd like to see what we've done last year to increase these percentages in some of the target areas. If that's our purpose, they are telling me they aren't getting the assistance. They are already applying to the State, and then we have the State investing over 400 hours preparing its application for block grants possibly. They were complaining to us that this application process is extensive, burdensome, time-consuming. It needs to be shortened, streamlined. New York was here and testified. They say they have even higher standards than you, I think, had set up, and you run them through a lot of unnecessary hoops. Why can't some of this be done electronically. We have new technology today, and they said SAMHSA is still in the dark ages.

From what I see out there, when you go see an epidemic, and you tell me you set it up so communities can apply to you, and these people in Washington decide whether they get it, the States and locals are already ahead of you and not getting the money and complaining about two and three levels of approval and preparation.

Mr. AUTRY. Mr. Chairman, let me respond to that. Let me start first by congratulating California. The reason that we're only 25 percent of the treatment dollars there is because they've chosen to make a significant investment of State funds in the treatment system. Last year California received $217 million in block grant funds for substance abuse treatment and prevention, and they received an additional $30 million in discretionary grants from us, and it's because of the very nature of the emerging problems, the severity of the problems, the prevalence of the problems, that they were as successful in competing for those discretionary funds.

Applying to the Federal Government does not require duplicate methods or duplicate applications with the States. We do require that communities are applying——

Mr. MICA. A local community program has already received State approval. They don't need additional approval, then, for funding from you or additional evaluation.

Mr. AUTRY. They do need to be peer reviewed. That's the requirement under our statute and regulations that any discretionary grant program must have peer review. What we are doing is we are experimenting with the ways to simplify both the application process, the duration of time from application to review and funding; and second, we're experimenting with new ways of doing reviews to expedite the reviews. And that's an ongoing commitment on our part to try and expedite how rapidly we can get dollars out to the field.

I might also add that many times in the KDA program, we use the existing service dollars there to continue to fund the services at the same time that we're putting in, looking at new interventions, looking at more effective and efficient interventions. So we build on the service dollars that are there and add dollars on top of that rather than supplanting the service dollars.

Mr. MICA. As I understand the process, discretionary KDA grants awarded by SAMHSA go directly to cities and communities. Why isn't this process closely coordinated with the States?

Mr. AUTRY. Mr. Chairman, it is indeed closely coordinated with the States. We have an agreement with the States that when a community, a city or sub-State region submits an application, it must be reviewed and signed off by the State.

The reason we do that is twofold: one, we want to make maximum effective use of all the dollars that are at the State level. Second, we want to build in State awareness of this program, so No. 1, they can learn from the effectiveness of the interventions used; and No. 2, there will be sustainability as the States can pick up the funds once our discretionary money has ended.

Mr. MICA. Now, I can't recall exactly the testimony, and we could get staff to submit this question, but in KDA review process, they said that the States are not adequately represented? We have some testimony on one of those. Some of the review process we had criticism that there wasn't adequate dollars in the review. We'll get that to you and maybe you can respond.

Let's go a minute to SAMHSA's contracts in the Washington, DC area, which is table 4 of the GAO report. And that raised some questions, particularly with Mrs. Mink and, some of the minority members from other areas that don't have any of these contracts. These are all in Mrs. Morella's and Mr. Wolf's district. But 27 of 29 contracts awarded by SAMHSA for over $1 million, those contracts in that range total $64 million awarded to the Washington, DC area. Why can't more of these services be contracted across the country? It looks like it started into a little cottage industry here for big contracts with the Beltway folks. What's the story? All the knowledge is in Washington. We know that.

Dr. CHAVEZ. The contract process that we have at SAMHSA is open and it's a competitive process.

Mr. MICA. It doesn't sound like it's that competitive. There were two others. Did either go to Florida or Hawaii?

Dr. CHAVEZ. They adhere strictly to the Federal Acquisition Regulation. They don't favor any contractor over another. They are all peer reviewed by panels. They are comprised of experts from throughout the United States and all of this is required by law. Can I maybe—I think——

Mr. MICA. Let me tell you, I could probably give a better answer than that. Congress has imposed a lot of requirements on this agency for evaluation and for reporting, and we do buildup cottage industries that do those activities. And they are located right next to the seat of powers. We need to go back and look at what we've done. I also heard that we created some inflexible overreporting. But again, it raises eyebrows when you have those kinds of funding being spent in one locale.

Mr. AUTRY. Two comments. I certainly agree with you that cottage industries tend to grow up at the seat of the money, and this is an issue that's faced not only by HHS, but all the other Federal agencies as well. There are a couple of things I think that we try to do differently than perhaps some other Federal agencies. One is we work with our State colleagues to identify not only what needs they may have for training or for TA, but also to find people out-

side of the Washington area, be it in there State or adjacent States, who can work with them to meet those training and TA needs.

So we try to spread the money around, even with the prime contractor maybe here in Washington. Similarly, we work with our colleagues at NASADAD. The contract money they have does not all get spent for what's done here. That actually goes out and helps fund the States to do data collection and whatever elements we may be needing for that, but we agree with you, we would like to see a higher distribution of the moneys throughout the United States.

Mr. MICA. I have another question relating to target populations and activities. One of the reasons to have Federal programs is to be able to address the broader picture and then target our resources. In some instances, they are not the largest portion of funds being expended. Tell me about our national programs. There was testimony here how important and effective it is to reach the corrections population, both people entering into the criminal justice system and hopefully giving them an opportunity to find another path and then within the prisons we find that we have tremendous recidivism with drug abusers, users, popping them into prison and then out of prison. Could you give me a dollar amount, or is there a program amount? Do we have a target publication that says we are doing this? Are prisons eligible to apply for these funds, and do you have programs in that area?

Could you respond, Dr. Chavez?

Mr. AUTRY. If you don't mind, Mr. Chairman I would like to respond to that. You referenced a 1991 report that HHS, ONDCP and Justice had done. We had a symposium—assembly, rather, just this last fall in which those same three groups came back together to talk about what the current State of knowledge is, what the current State of need is, and what we can do together to work on this. We have an extensive history of providing both TA and training to the criminal justice system, and we work on both sides of the black box, if you will, those that can be diverted from entering into the criminal justice system or into incarceration, and those who are coming out——

Mr. MICA. What programs specifically? How many dollars of all of our drug treatment dollars are going to these? In Florida, my former district representative now works with the correction system, working with me in Congress and going to the Florida corrections system. But he is now working with them just as an aside, and if I go to him at this point and say we spent millions at the Federal level, and we know that there's a good program to divert these people, so I don't have to incarcerate them in Florida prisons at $60,000 or whatever it costs, and I've talked to Dr. Autry, and he said that SAMHSA says this is a good program, what is it and which one have we spent money on and what do I tell him?

Mr. AUTRY. A couple of things. One, we just agreed with the Department of Justice and ONDCP to start a new $10 million program covering some of the issues you're concerned about. I can get you, for the record, additional moneys that are already there. I would also point out that a recent report by the Department of Justice pointed out that only 40 percent of their prisons have treatment programs for substance addiction.

Mr. MICA. Are prisons eligible to apply for funds for treatment?

Mr. AUTRY. Those who are incarcerated get their funds through the Department of Justice. Those who are not incarcerated work jointly, and many times fund those programs themselves.

Mr. MICA. I've been joined by a gentleman from Maryland, Mr. Cummings. Let me recognize him at this point.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I want to thank our witnesses for being with us today.

Dr. Chavez, in your testimony you said that the drug use among teens is no longer on the rise. It may just be declining. When will you know whether it's, in fact, declining and is this decline in drug use for all drugs or is this just marijuana?

Dr. CHAVEZ. Mr. Congressman, it's good to see you. Thank you.

Mr. CUMMINGS. Good to see you also.

Dr. CHAVEZ. We've seen a slight improvement in terms of that decline, but as I said in my testimony, I do not want us to be overly optimistic. And what I mean by that, sometimes when we see these declines, we have a tendency to become very relaxed, until we see the next epidemic. What we are seeing is that—we're seeing drug use, especially the increases in the drug use that we have seen in the past have been among those 12- and 13-year-olds, which is an age group that we have become very concerned about, and as an age group where we have targeted many of our efforts. The other area that is of great concern, as I mentioned earlier, is the regional nature of the drug.

For example, in some areas, we have seen an increase in the use of heroin, whereas in other areas we've seen an increase in the use of methamphetamine, and that is one of the reasons that we are really trying to target many of our programs.

Now, in August of this year, we will have the data on our household survey, and we are hoping that with the expansion of the Household survey—this is the year it was expanded—we are going to have information that will be of help to all of us. It gives us specific State-by-State data so that we will have a better picture in terms of what is happening in some States. Why that becomes more and more important is because of our KDA and our treatment capacity expansion in that we'll be able to focus those dollars more where we see in some of those States, that it's more of a problem than it may be in other States.

Mr. CUMMINGS. Let me ask you, is there a particular type of child or are there certain characteristics—when you think about a young child, 12, 13-year-old, that's pretty young, and I know that children use drugs even earlier than that. I live in a neighborhood where I think that happens, in Baltimore. From what you've seen, are there any particular characteristics or type of settings? In other words, home life or neighborhood or how they are doing in school, parental supervision, activities, being involved in activities or lack thereof? Is there a typical young person that if you looked at a certain set of characteristics, you say based upon what we know, this child is, I hate to use those words, "at risk?" They just bother me, but you get what I'm saying. You understand?

Mr. AUTRY. Let me speak to that. One of the things I think you know as well as the rest of us is that substance abuse is really an equal opportunity disease. It doesn't strike any particular ethnic

group, doesn't strike any particular geographic group or strike any particular socioeconomic group. It's across the board. There are, however, both resiliency and risk factors that do predict when someone is likely or less likely to abuse substances. Children who grow up with high family bonds is a case in point. Good role models with respect for their parents are less likely to use drugs than those who don't.

Children who grow up with families where there's an emphasis on communication, emphasis on education, are less likely to grow up using drugs than those who do not get that. Kids who are engaged in activities such as good school bonding and the performance in school is important to them are less likely to engage in drug use than those who do not. Children who are engaged in post-school activities or entering programs are less likely to grow up to use drugs than those who do not. I think as we look at prevention, you've seen a shift in recent years from talking so much about risk factors to talking more about resiliency factors and the things we need to promote good mental health, good physical health and decrease substance abuse.

Mr. CUMMINGS. In Baltimore, we have a situation, where, because of budget circumstances, we have had to cut back on recreation, and unfortunately, I mean, we're approaching the drug problem from a criminal standpoint. But I'm of the opinion that you need to do both because I think the recreation keeps children busy, and a lot of times recreation centers have become almost substitutes, and important substitutes for children whose mothers and fathers may be working or may be part of a single head of household family where the one person just can't be there all the time, particularly the summertime when you're out on vacation and things of that nature. That's why I was just wondering about that. Did you have something that you wanted to add?

Dr. CHAVEZ. Yes, Mr. Cummings. What you've described is what we're really looking in terms of drug problems—drug issues as public health issues that involve many, many components. We know from the research, we know what works. We know what are some of the things that are very, very critical, and as Dr. Autry indicated, one of the strongest things that we have found in terms of the research that has been done is that the family bonding becomes very critical at a very early age. Unfortunately, what we see happening in terms of the need for prevention services and treatment services is that there are not enough services to provide for the need that is out there. We have a great need. What we are finding in many communities is that parents can't find treatment for their young people, for their adolescents.

Many times what happens is that they do commit a crime and they become part of the juvenile or criminal justice system. Then there will be some treatment which may have been unneccessary if we had more interventions, early interventions, prevention and treatment programs targeted specifically to many of these communities. But again, it's the parent, it's the family, the school, it's the community. It's not one.

It's the responsibility of all of us, including the clergy, to be part of developing systems within communities that work for those communities.

Mr. CUMMINGS. Yesterday, when I was at the Post Office, I ran into a fellow who was a former drug addict. He's a recovering addict. One of the things he said to me was very interesting. You know, he said, "Cummings, I wish people would come to my barbershop. I haven't used drugs in 15 years." He said, "But every time they show people on television and they talk about drug treatment, they always show people who look like they're down and out. I'm doing fine." He said, "I can show you thousands, literally, there's a whole community out there who are former drug users who, because of treatment, are now doing fine, raising their families, supporting, contributing to our taxes."

That leads me to the question that was one of the things that was on my mind at our last SAMHSA hearing. This is a continuation. And I asked a question of how do we make sure and what does SAMHSA do, and what can we do to assure that the treatment that is being rendered, moving on to sort of another subject now, is effective treatment.

I'm one of these people that run around the Congress with a flag that says treatment and prevention and begging my colleagues to look at treatment. But the thing that we get over and over again, and I hear, and in many instances this is a legitimate argument, I hear the argument, well, is the treatment effective? How do we measure it? Are people just setting up shop and going through some motions? To be very frank with you, there are people who are recovering addicts like the fellow I talked to yesterday who told me, and I've heard this in my community over and over again.

There are some shops that are not effectively addressing the drug problem. They set it up, and I think that does a disservice, not only to the good programs, but to the addict because the addict goes through this process, he or she thinks she's supposed to be getting well. It's not legit. When I say "legit," I mean it's not being effective.

I think it's going to be very important for States and for this Congress to try to hold programs to some kind of standard, because as I see it, and I've just been watching, I just don't think we're going to be able to get those treatment dollars unless we really can show that these programs are being effective, that we need some kind of mechanism that makes sense. I think we could probably have a whole lot more of the Congress saying hey, we've got to give treatment if they know that's real and it's going to be effective. So I leave you with that. I ask you, do you have any comments?

Mr. AUTRY. First of all, let me applaud you for your advocacy. Second, we have over there one of the charts that shows, as Dr. Leshner referenced earlier, that treatment does, in point of fact, work. It reduces criminal activity, reduces illicit drug use and alcohol use. It improves housing situations, and most importantly perhaps in the Congress's perspective, it also increases employability. We rely very heavily on the research that NIDA has done in order to look at more effective and efficient treatments. We put these out into treatment services. We're working with our colleagues in the States to define appropriate performance and outcome measures that we use, not only across our discretionary grant programs, but also across the block grant programs that they will be funding, that they do fund in the States. So we're very concerned about the per-

formance and outcomes measures, and it's as—one of our highest priorities is to continue to improve the effectiveness and efficiency in treatment.

Alan, you want to add anything to that?

Dr. LESHNER. I think the point is well made. I think the problem is, sir, is that just as in any treatment enterprise, there are people who deliver well and people who don't deliver well. We have the problem that we have no mechanisms by which to evaluate every single program and to be able to ensure what they provide, but I would say the overall quality of drug abuse treatment in this country is extraordinarily high, and comparisons that have been done on the effectiveness of drug addiction treatment compared to other medical illnesses that are similar in nature, drug addiction treatment is as effective as the treatment for hypertension, as the treatment for asthma, the treatment for other chronic, often relapsing disorders. The problem is people don't know it.

Mr. CUMMINGS. Last question, Mr. Chairman. At the last hearing, we had representatives from three States. I can't remember which States they were, but I know they earned reputations nationally as having good treatment, or very good treatment, and when I say very good, I mean effective. And one of the things that they all had in common is that they had a standard by which they were able to measure, which is very interesting. And I asked them, I said, "Well, does every State have these standards?" They said, "Well, no, I don't think so."

I know you share Mr. Mica's concerns and Mrs. Mink's concerns, and we want all of our tax dollars to be spent efficiently and effectively. I'm just wondering, do States come to SAMHSA and say, look, what kind of standards can we use or does SAMHSA go to States and say, look, this is something you might take into consideration in measuring these programs because I'm telling you, I mean this, it just irks me. It would really upset me. We are setting up shops that are not being effective, but then it bothers me if we don't have any standards to even determine what effective is. Those are search questions under one question, but I'm finished after this.

Mr. AUTRY. Let me try and focus on what I think is the most important one, that is, how effective are these treatment programs and what do we do to make sure we're using the most effective interventions we have, whether it be prevention or treatment, but treatment in particular? We worked with the States through our TOPS 1 and TOPS 2 program to look at and define outcome measures, what sort of performance we expect from a treatment provider, what sort of performance we expect from a treatment system.

We've done this now in 19 States. And we're working with NASADAD to try and collect data across all the States that measure outcome measures in the four domains I mentioned earlier: criminal activity, decreased drug and alcohol use, housing situation, and employability. Those are the elements that say is somebody doing well or not. And working with the States, we are trying to implement these across all the States. Their instrument is vulnerable in terms of the States to provide that information at the present time.

But that's an ongoing commitment on our part and the part of NASADAD to continue to work to upgrade the data infrastructure so that all States can provide that kind of accountability data. Currently we are doing this on a voluntary basis. In the future we will be doing this on a mandatory basis. Again, building on what we've done with NASADAD and the States to this point in time rather than mandating something on high sum.

Mr. CUMMINGS. How soon do you think it will be mandatory?

Mr. AUTRY. We have high hopes this will be 2001.

Mr. CUMMINGS. So what authority do you have to make it mandatory?

Mr. AUTRY. We recently have an all radioing from our own counsel, Office of General Counsel, and also from the GAO that we do have the authority to do that. We will work on that this year, and if we can't do it for 2001, we hope to move to mandatory by 2002, which will be a year from this October 1.

Mr. CUMMINGS. What would be the holdup?

Mr. AUTRY. The holdup is going to be the States' ability to provide the information because of the variability and lack of infrastructure support. We're currently in discussions with the Office of Management and Budget because we have had some disagreement within OMB as to whether or not we have the authority. We hope to resolve that very shortly in the next month or two.

Mr. CUMMINGS. Do you anticipate the possibility, not probability, that you may need authority there in the Congress?

Mr. AUTRY. As Dr. Chavez referenced earlier, we have been approved in the Senate for reauthorization, we are certainly looking for approval in the House. If that does indeed happen, I think we will have all the authority we need, sir.

Mr. CUMMINGS. Thank you.

Mr. MICA. Thank you. Just a couple of wrap-up questions here. In surveys of Department of Health and Human Services, employees over the past 3 years, the reported morale of SAMHSA employees has not been among the lowest ratings for HHS for the entire agency. You made some comments, Dr. Chavez, at the beginning about morale. Did you say that it's improving? Where are we with the problem of morale in the agency? All the errors I've gotten said it ranks among the lowest of any agency.

Dr. CHAVEZ. We have taken several steps as we outlined in the report that we submitted to you to try to lift morale. One of the big issues that we have faced that we had mentioned to you earlier has been that even though there seems to be a sense that maybe our administrative costs have been very high in our program management fund, we have reduced our staffing in so many areas, and this has had a tremendous impact on staffing because of the increased workload. We have increased our workload tremendously in the past 5 years. There are more specific things that we are involved in that I would like Dr. Autry to respond to, because this is something that he's been working with very carefully.

Mr. AUTRY. Thank you, Dr. Chavez. We're very concerned about staff morale, and one of the key things that we've noted is that morale relates to two key elements. One is the workload that people have received, and that has been increased, as you saw, from the decrease in staff going back to 1993. We've also absorbed a number

of programs, high-risk programs, most notably, and school violence programs that came to us from Congress. We've done that within the existing staff levels. So that has increased the workload. We also find that when ideas that staff have developed are put forward are either not supported in the administration or not supported in the Congress, that also leads to low morale.

Quite frankly, I don't know of a harder working, more dedicated staff across any Federal agency than we have in SAMHSA, and they really believe in what they do and they put their heart and soul into doing it. We have established a quality-of-worklife committee that's made up of both management and employees to look at things that we can do to improve morale. We're in the process of implementing a transit subsidy program that would help in that regard. We're looking at redistributing workload across the agency. We've also started a process of management called appreciative inquiry, which is where you take the elements within the agency that are working well, and you look at the lessons that you can learn for what made that work well and apply it in areas where things might not be working quite so well.

We've also started doing cross-center and also cross-agency collaboration on projects to make sure that all staff are involved as we go forward in planning and budgeting implementation. We also have had a series of focus groups, some with management employees mixed with some employees by themselves have honest and frank discussion of the difficulties that they've encountered that, perhaps, have contributed to low morale.

We do fully expect to see that there will be an increase in morale, and it certainly is a commitment on our part as we go forward to try to have SAMHSA to be the kind of place that not only you want to work at because of the important work we do, but because of the atmosphere we create as we work with one another.

Mr. MICA. The centers you talked about earlier, did you have 22 regional centers and combined them into 7? Is that it?

Mr. AUTRY. Those were administrative offices, some within the Office of the Administrator, and some within the centers. They were collapsed into seven.

Mr. MICA. What about regional operations?

Mr. AUTRY. We don't have regional operations at the present time. There are many days, quite frankly, we wish we did have.

Mr. MICA. All of that is located here?

Mr. AUTRY. Correct.

Mr. MICA. I just wondered if anything had been sent out to regional centers. But that's OK.

Mr. AUTRY. I'll make one comment on that we have worked closely with the regional offices and HRSA, the Health Resources and Services Administration, to make sure that the regional offices are informed of the activities that we do. We find them an invaluable resource looking at treatment needs across the region and State, and they were very instrumental to us in our national treatment system regional meetings and national prevention system regional meetings.

Mr. MICA. Dr. Chavez, it took 18 months to develop guidelines for urinalysis in 1987 to 1988. It's my understanding that SAMHSA has now contemplated what will turn into a 10-year re-

view process for hair analysis or other methodologies. I'm told now it's put off to 2003. What's the problem?

Dr. CHAVEZ. I would like to have Dr. Autry respond to that because he's the expert on the hair analysis. I think he's testified before you in the past.

Mr. AUTRY. Mr. Chairman, it's a pleasure to revisit this subject with you. One of the things that we put in place going back now about 2½ years ago is that we developed a matrix of all of the standards that any drug testing methodology must meet in order to be certified for use in the Federal program. We have worked with industry, worked with laboratories, worked with medical review officers to assess the current state of the science of all the different testing technologies and methodologies to identify the gaps that exist in terms of meeting those standards and have laid out protocols that are necessary to fill in those gaps. All of our meetings have been open to the public, involved both industry as well as Feds, and laboratory people. You can find summaries of all the meetings that we've had in the current state of the science www.health.org/workpl.htm.

Mr. MICA. My understanding that some agencies like the Federal Reserve already use hair testing and have settled on that.

Mr. AUTRY. A number of companies do. One of the largest manufacturers of hair testing in this country is a company called Psychometrics. They estimate they have about 2,000 employers of various sizes who do use this. That is actually a small proportion of those individuals that are subject to testing. We make available to whoever wants the latest scientific evidence about the effectiveness of that. One of our big concerns is that there is not an appropriate quality assurance or quality review mechanism in place to assess the accuracy of the ongoing testing.

Mr. MICA. Finally, for the record, and I'd like for it to appear at the end of the record, request the agency to provide us with detail relating to their programs which were briefly outlined dealing with our corrections and criminal population and the proposal, more details relating to the $10 million proposal that we've heard a little bit about today. Additionally, I'd like them to list the top 20 programs in the country for treatment and we can use the successes treatment 1 year drug free, or 2 years drug free, and we can categorize those into sort of tough cases or average drug treatment cases because I know some were repetitive, tough every instance and I always hear you can't compare one with the other; first, second-time offender or drug abuser versus someone who's been repetitive. I would just like those to appear at the end of the record of this hearing. That would be helpful also as a guideline to offer. We will leave the record open for at least 3 weeks to accomplish getting those responses.

We have additional questions for the witnesses. Our intent is not to call you in here and just give you grief. Our intent is to try to assess what's going on. We requested the GAO report. They came back with information. We have a responsibility to conduct oversight. When I have members of the package like Mr. Cummings who has 60,000, at least he told me in that range, people addicted and has a community, we'll be going there in a week or so, 2 weeks. We're going next week to Honolulu, can't wait for 18 hours

of flight, Sunday, Monday, to do that for Mrs. Mink, but our purpose is not to give the agency a hard time. It's to see how we can improve the expenditure of funds.

When you go to California as I did last week at the request of members and you see what's going on, I wish some others could have seen it, the methamphetamine problem was just beyond anything, so much child abuse, 40 percent of murders, hundreds of children literally abandoned by their families. It does such devastation to these folks. We need to even rededicate ourselves more to finding workable cost effective solutions to this problem. So if it takes having hearings every day, or twice a week or whatever, wherever we have to go we're going to get this done. When we get complaints about how things are operating and some of those things have been imposed by Congress, we need to see that corrective measures are taken. We will do our best to work in that regard.

I appreciate the witnesses coming forward today. We look forward to working with you.

Mrs. Mink.

Mrs. MINK. I just want to make a comment. I am a little bit troubled with the emphasis on the need to evaluate the effectiveness of any specific treatment methodology because I think we know that in all kinds of diseases, that because you don't have 100 percent cure rate doesn't necessarily mean that the particular treatment is not a suitable one. It may not be suitable for the specific individual because of the individual's own unique propensities or other kinds of mental pressures. So I do want to say that while it's important to evaluate the outcomes and to determine which ones have the best outcomes, I don't think, however, that necessarily leads to a conclusion that the treatment that has the lower outcomes is necessarily not proven to be satisfactory for a variety of clientele.

Mr. MICA. Thank you. That's why I asked for this sort of the tougher-than-average cases. This is for my own information. We have thousands of treatment programs out there, and I'm interested in what are successful models. We heard some. We have Washington, I think New York and several other States, and I think Mr. Cummings rightfully pointed out that there are some commonalities to have standards of certain things that we can point to where programs are successful and maybe we can replicate this, maybe we can't. Maybe we should go home.

Mr. CUMMINGS. Mr. Chairman, my ranking member and I, we agree on most things, and I think we agree on this. I guess my concern, Mrs. Mink, in my community and the way this even came up for me was just listening to recovering addicts whose really saw what was effective for them. And I know that everybody may be different, but they actually said, "Cummings, if it was up to us, we'd close down that program, that program, that program, and then we would keep these open." And these are people who have nothing to gain. They want to make sure that programs are effective because they feel, and a lot of them are very angry because they saw what they went through and then they look at what other people go through. The other thing that they said was a lot of these

people who go through the programs and that they consider shams, then come back and they are trying to help them get off of drugs.

So they see it in every which way. I agree with you. I think we have to be very careful because you can evaluate to the degree that you destroy. You can take something apart so much that you destroy it. But on the other hand, I think we hold people to standards constantly, and I think we have to have at least some general standards to look at and say, OK, are we having some effectiveness, are we accomplishing something here?

And I guess the reason why I'm so concerned about this is I think it goes to the credibility of the entire process. I think it's easier to make the case for more Federal dollars if we do have some standards, and we're able to do some measuring. That way—you know what they say, Mrs. Mink. People will on come back and say, oh, treatment doesn't work. At least we'll be able to say we've got some standards, those standards are being met and we are being effective. So when we see tragic stories like the chairman just mentioned, we can say there is something we can do about that. It worked in Nevada, it worked in Idaho and damn it, it will work here. That's what I was concerned about.

Mr. MICA. I thank the gentleman. I thank the ranking member. Being no further business to come before the subcommittee on criminal justice drug policy and human resources this meeting is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 2, 2000

The Honorable John L. Mica
Chairman, Subcommittee of Criminal Justice,
Drug Policy, and Human Resources
United States House of Representatives
Washington, D.C. 20505-0907

Dear Chairman Mica:

The purpose of this letter is to underscore the critical role the Substance Abuse and Mental Health Services Administration (SAMHSA) plays in support of the *National Drug Control Strategy*. As the key Federal agency involved in funding and strengthening the provision of substance abuse prevention and treatment services in this country, SAMHSA deserves our fullest support. Through the **Substance Abuse Prevention and Treatment (SAPT) Block Grant** funds, SAMHSA provides the prevention and treatment fields and State and local governments the program support they need to develop programs to address the drug problems they face and to demonstrate that treatment and prevention are effective.

In addition to providing the States with substance abuse services funding through the **SAPT Block Grant**, SAMHSA offers several innovative and relevant programs to strengthen service provision. For example, SAMHSA's **Targeted Capacity Expansion** program makes funds available to cities, towns, counties, and tribal units to address emerging or existing treatment shortfalls. Through hundreds of grants, SAMHSA works to improve the effectiveness and the efficiency of the substance abuse prevention and treatment systems. In addition, its **State Incentive Grant (SIG)** program provides Governors the funding and "leverage" they need to strengthen and better coordinate prevention services within their States.

Finally, SAMHSA's support and direct contribution to various priorities of the Office of National Drug Control Policy (ONDCP) is significant. SAMHSA representatives chair key interagency committees involved in developing and reviewing *Performance Measures of Effectiveness* for the *National Drug Control Strategy*. SAMHSA has worked with ONDCP to improve both the definition and the measurement of the treatment gap, and SAMHSA has been a key partner in our demand reduction efforts with Mexico.

We appreciate your personal leadership and support of the *National Drug Control Strategy's* goal of reducing drug abuse, drug availability, and their negative consequences.

Respectfully,

Barry R. McCaffrey
Director

Jeb Bush
Governor

Kathleen A. Kearney
Secretary

February 15, 2000

The Honorable John L. Mica
Florida 7th Congressional District
Rayburn Building
Washington, D.C. 20515

Dear Congressman Mica:

This is to follow-up your personal request for information that we discussed at Florida's Drug Summit last Friday. Attached is the listing of direct grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Substance Abuse Prevention (CSAP) and Centers for Substance Abuse Treatment (CSAT) to organizations in Florida. Out of a total of 19 recipients, 5 have been awarded to universities, 11 have been awarded to community-based organizations, and 3 have been awarded to our department. The Governor's office, in collaboration with our office last year, was awarded a $9 million state incentive grant for preventing substance abuse. Of the total 22 state grants awarded, 19 are received by organizations that receive either block grant or state funds for providing substance abuse services.

The state's block grant award for this fiscal year is $81.3 million, or 52 percent of our $156.4 million budget. Our services are completely privatized through contracts with over 130 community-based organizations. In FY 1999, we provided prevention, intervention and treatment services to over 152,000 Floridians. Additionally, we estimate that our community-wide prevention activities touched an additional 32,750 Floridians. I am also enclosing a briefing on our substance abuse activities statewide.

As the Director of Substance Abuse for the Department of Children and Families, the agency responsible for administering the Substance Abuse Prevention and Treatment Block Grant (SAPT), there are a few points I would like to make for your consideration:

- I believe there is a role for direct support for a portion of SAMHSA's portfolio to community organizations. With estimates of only 23 percent of need being met for children and 16 percent of need being met for adults here in Florida, these additional resources help. However, it is critical that these grants be coordinated with the state office to avoid duplication of services. The state incentive grants program (CSAP) and the TOPS outcome study programs (CSAT) administered by SAMHSA, are good examples of programs with strong state involvement. These grants provide a venue for applying research in community-based programs that can be transferred throughout the state to improve service outcomes across all providers. This is research that the state lacks the resources and infrastructure to administer. The funding for programs such as these, with a few exceptions, tend not to be picked up by the states upon expiration of these grants.

- SAMHSA can do a better job of involving state agencies following the awarding of these direct grants to recipients by requiring grantees to coordinate more closely with the state substance abuse office and other community organizations. In, Florida, one of our goals is to bridge the gap between community-based practice and research in order to improve the effectiveness of substance abuse services. These grants should play an important role in reaching that objective.

- Lastly, we support the reauthorization of SAMHSA this year. It is important for the substance abuse and mental health community to have a federal agency that is providing leadership in this area.

Thanks for the opportunity to offer our input on this issue. Please do not hesitate to call me if I can be of further assistance. I can be reached by phone at (850) 921-8461.

Sincerely,

Phil Emenhaser for

Kenneth A. DeCerchio, MSW, CAP
Director of Substance Abuse

cc: Kathleen Kearney, Secretary
Todd Parrish, Director of Legislative Affairs
Karen Hogan, Florida Washington Office

DISCRETIONARY FUND AWARDED BY SAMHSA
TO FLORIDA IN FY 1999

	Grant Number	Contact	Amount	State Contractor/ Non State Contractor
GFA # TI 99-001 "Grants for Evaluation of Treatment Models For Adolescents"				
University of Miami Miami, Florida	TI 11871-01	Howard Liddle, Ed.D	$ 422,222.00	Non State Contractor
Total			**$ 422,222.00**	
GFA# TI 99-006 "Bridging the Gap: Developing Community Based Practice Research Collaboratives"				
University of South Florida Tampa, Florida	TI 1226-01	Roger Peters	$ 248,000.00	Non State Contractor
Total			**$ 248,000.00**	
GFA # SP 99-01 "Community-Initiated Prevention Interventions"				
Center for Drug Free Living Orlando, Florida	SP 08623-01	Dick Jacobs	$ 399,898.00	State Contractor
University of Miami Miami, Florida	SP 08984-01	Peter C. Mundy	$ 168,906.00	Non State Contractor
Total			**$ 568,804.00**	
GFA # SP 99-02 "Cooperative Agreements for Parenting and Family Strengthening Prevention Interventions: A Dissemination Of Innovations Study"				
Center for Drug Free Living Orlando, Florida	SP 08844-01	Dick Jacobs	$ 96,123.00	State Contractor
Family Resources, Inc. St. Petersburg, Florida	SP 08747-01	Pat Gerard	$ 96,123.00	Non State Contractor
House Next Door Deland, Florida	SP 08859-01	Ella Bryan	$ 96,122.00	State Contractor

DISCRETIONARY FUND AWARDED BY SAMHSA
TO FLORIDA IN FY 1999

	Grant Number	Contact	Amount	State Contractor/ Non State Contractor
Florida Department of Children & Families Miami, Florida			$ 475,000.00	State Agency
Orange County Health Family Services Orlando, Florida			$ 475,000.00	County Government
Total			**$ 1,425,000.00**	
"Targeted Capacity Expansion Grants" (HIV/AIDS Grants)				
Operations PAR, Inc. Pinellas Park, Florida			$ 405,819.00	State Contractor
River Region Human Services, Inc. Jacksonville, Florida			$ 505,047.00	State Contractor
Think Life, Inc. Ft. Lauderdale, Florida			$ 353,521.00	State Contractor
Total			**$ 1,264,387.00**	
"State Incentive Grants: Center for Substance Abuse Prevention				
Florida Department of Children & Families Substance Abuse Program Tallahassee, Florida	SP 08200	John Forsyth	$ 2,999,514.00	State Agency
Total			**$ 2,999,514.00**	
TOTAL DISCRETIONARY GRANT FUNDS			**$ 8,096,133.00**	
99-2000 SAPT BLOCK GRANT AWARD			**$ 80,256,078.00**	
TOTAL FEDERAL GRANT FUNDS AWARDED TO FLORIDA			**$ 88,352,211.00**	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

MAR 0 7 2000

The Honorable John L. Mica
Chairman, Subcommittee on
Criminal Justice, Drug Policy and Human Resources
Committee on Government Reform
House of Representatives
Washington, D.C. 20515

Dear Mr. Mica:

This is in response to your letters of February 2 and March 2 regarding the protection of human subjects of research. I would like to address each of the concerns stated in the February 2 letter. I apologize for the delay in responding. However, the National Institutes of Health (NIH) shares your commitment to ensuring the safety of research participants in clinical trials and appreciates the opportunity to address your concerns.

1. **What actions have been taken by HHS and NIH to implement protections and promote efficiencies in response to problems and risks associated with human research, including IRB reforms?**

The NIH has in place a comprehensive system for protection of research participants that is designed to prevent physical injury, psychological injury, and harm to the dignity of research subjects. The current system is composed of multiple levels of protection. First, the "informed consent" process requires that potential participants be given an explanation of the purposes of the research, the expected duration of the subjects' participation, a description of the procedures to be followed, and information regarding the potential risks of the research and any potential benefits. Often a volunteer ombudsman is present to ensure that participation is informed and voluntary.

Second, all research protocols funded by the NIH, or by one of the 16 other agencies that are signatories to the Common Rule (45 C.F.R. 46, Subpart A), must be reviewed by an Institutional Review Board (IRB). Each institution must constitute an IRB to review all protocols prospectively and, on a continuing basis, balance the potential risks to the individual participants against potential benefits of the research. The IRB system is designed to be a system of local review, by individuals who are in the best position to know the science as well as the prevailing values and ethics of the community and the likely subject population.

Third, Data Safety and Monitoring Boards (DSMBs) are often employed to assess data and safety as a study progresses. A study can be stopped prematurely because of a toxic effect, or because a strong positive effect has been seen and it would be unethical to continue withholding from some subjects an intervention that has demonstrated benefit.

Fourth, it is the role of the Office for Protection from Research Risks (OPRR) to make sure that the IRB process works at grantee institutions within the OPRR's jurisdiction. The OPRR provides extensive guidance and education to IRBs and institutions to ensure compliance with all regulatory requirements regarding human subjects protections. Since 1990, the OPRR has undertaken more than 125 site visits to various institutions to review their compliance and provide technical assistance with their oversight processes. In addition, the OPRR investigates allegations of noncompliance with the regulations. These investigations have resulted in several instances in which research at an institution has been suspended until corrective actions have been taken. The result of these suspensions has been increased vigilance by all institutions regarding the importance of ensuring the protection of human subjects in research.

Although we believe that the current system minimizes the potential for harm while promoting the pursuit of new knowledge, we are constantly seeking to find the best balance between these issues, and to improve human subjects protections. To this end, we have been working hard at a number of new initiatives. Some of these initiatives are as follows:

1) To enhance the effectiveness of the OPRR in carrying out its oversight responsibilities, the Secretary of Health and Human Services determined in July 1999 that the OPRR should be relocated in the Office of the Secretary. Doing so will place the OPRR in a position to more effectively exercise a leadership role in the research community on issues relating to the protection of human subjects. Locating the OPRR at the departmental level also will permit the OPRR to forge alliances with components within the DHHS and with other Federal agencies that support human research.

2) The NIH will conduct ten "not-for-cause" site visits each year to grantee institutions to monitor compliance with NIH policies.

3) The NIH initiative addressing regulatory burden includes human subjects protections. The thrust of this initiative is to identify ways to streamline the process without negatively affecting the protections that are afforded to subjects.

4) In June 1999, the NIH issued guidance on reporting of adverse events to promote the efficient and meaningful dissemination of information among investigators, IRBs, and DSMBs.

5) On June 11, 1998, upon receiving the DHHS Office of the Inspector General's (OIG) report on its review of IRBs, the OPRR announced its plan to significantly increase its educational efforts. In 1999, the OPRR hired an Associate Director for Education who is developing new and more "user-friendly" educational materials and resources, in addition to traveling extensively to meet with IRB and institutional representatives. In addition, the OPRR has streamlined the process of obtaining the assurances required by the regulations from institutions funded by the

DHHS. This streamlined process will make the assurance process more efficient and will enable the OPRR to devote more resources to technical site visits and other educational activities.

In the specific area of gene transfer research, NIH's oversight consists of three interrelated components: the *NIH Guidelines for Research Involving Recombinant DNA Molecules (NIH Guidelines)*; the Recombinant DNA Advisory Committee (RAC); and ensuring public access to information about gene transfer research. The *NIH Guidelines* set forth standards and principles for the conduct of human gene transfer trials and requirements for the submission of protocols and adverse event reports to the NIH. They apply to investigators conducting gene transfer research that is either funded by the NIH or carried out at an institution that receives NIH support for recombinant DNA research of any type. Institutions, principally through Institutional Biosafety Committees (IBCs), are responsible for ensuring that all recombinant DNA research conducted at or sponsored by that institution is conducted in accord with the *NIH Guidelines*. The RAC recommends changes in the *NIH Guidelines* in light of advances in the knowledge about the science and safety of gene transfer research. It conducts public review and discussion of the scientific, safety, and ethical issues of novel gene transfer protocols. It explores in-depth complex scientific and ethical issues raised by the continuing progress of the research by convening Gene Therapy Policy Conferences, which can also yield important consensus recommendations that guide the field. The NIH makes information on gene transfer trials publicly available. Every gene transfer protocol is available to the public. Updates on new protocols and adverse events are presented at each quarterly RAC meeting and posted on NIH's Web site. The NIH is in the process of developing an interactive database to enable users to search for specific variables, analyze aggregate data, and identify emerging trends.

The *NIH Guidelines* require investigators to report all serious adverse events to the NIH immediately. When warranted, the NIH Office of Biotechnology Activities (OBA) notifies the NIH RAC, OPRR, IBCs, and all principal investigators engaged in related clinical research. The NIH can also collect additional data prior to a comprehensive and public review of the adverse event by the RAC and ad hoc experts. Adverse event reporting enables the NIH to mobilize the RAC and the scientific community, when necessary, to review the causes and implications of the events, to recognize trends that may have significant implications for the safety of patients enrolled in similar human gene transfer studies, and to foster broad public awareness of issues and developments in human gene transfer research.

The NIH recently became aware of widespread noncompliance with NIH requirements for reporting serious adverse events. The following steps are being taken to enhance compliance with the reporting requirements.

- The NIH has directed institutions conducting human gene transfer research to review their institutional policies and procedures for ensuring compliance with the *NIH Guidelines* and to report back to the NIH if compliance problems are found. IRBs, IBCs, and principal investigators at these institutions were also notified of this effort. The NIH is contacting investigators directly to further ensure compliance with the adverse event reporting requirements.

- The NIH is now notified when sponsors report serious adverse events to the FDA. This new procedure enhances the NIH's ability to monitor serious adverse events, but it does not diminish the responsibility of investigators to fulfill their reporting requirements to the NIH.

- The NIH will be making site visits to NIH-funded institutions to identify any problems with compliance with *NIH Guidelines* and other NIH policies including financial conflicts of interest.

- A working group has been organized by the NIH Director to evaluate NIH's role in oversight. The group will develop and consider several options, including whether the RAC authority to approve and disapprove protocols should be restored.

- The RAC is reassessing the scope and timing of the NIH reporting requirements and considering whether the requirements should be harmonized with FDA requirements. Currently, FDA and NIH requirements for reporting adverse events are different. The NIH requires all serious adverse events to be reported immediately; the FDA requires immediate reporting of adverse events considered to be related and unexpected. Unrelated or expected adverse events are to be reported annually to the FDA.

In addition to these efforts, the NIH and the FDA today announced two new initiatives that reflect the commitment of the Administration to patient safety and public access to gene transfer research information—the Gene Therapy Clinical Trial Monitoring Plan and the Gene Transfer Safety Symposia. As you know, on February 8, 2000, President Clinton directed the Secretary of Health and Human Services to accelerate DHHS review of patient protections in gene transfer research.

- *Clinical Monitoring Plan.* FDA's clinical trials monitoring plan addresses emerging evidence that the monitoring by study sponsors of several recent gene therapy trials has been less than adequate. The FDA will now require that sponsors of prospective gene therapy trials routinely submit their monitoring plans to the FDA. The FDA will review these monitoring plans and seek modifications as warranted to improve the quality of monitoring. The FDA will also perform surveillance and "for cause" inspections of clinical trials to assess whether the plans are being followed and whether monitoring has been adequate to identify and correct critical problems.

- *Gene Transfer Safety Symposia.* These NIH-FDA symposia will enhance patient safety by providing critical forums for the sharing and analysis of medical and scientific data from gene transfer research. The symposia, which are expected to take place about four times a year, will bring together leading experts in gene transfer research and give them an opportunity to publicly discuss medical and scientific data germane to their specialties.

2. **What changes are needed in the roles, responsibilities, competencies and resources of HHS components to maximize protections for participants involved in human subjects research?**

DHHS components have many different roles that enable them to act to protect participants in human subjects research. For example, staff interact with potential applicants through the review and award process, the ongoing monitoring of projects, and special roles such as those of the OPRR staff. These different activities provide many opportunities for staff to exercise their oversight of human subjects research and the protection of participants. If program staff lack specific competencies, they may bring consultants into this process. We do not believe there are any gaps in the defined roles, responsibilities, or competencies available.

The National Bioethics Advisory Commission is currently reviewing the policies and procedures of human subjects protection in the 17 agencies that have signed on to the Common Rule. I anticipate that the product of this review will inform the agencies of any future changes that are needed to maximize subject protection.

3. **What changes are needed in laws, rules and regulations to ensure clear lines of authority and responsibility for the protection of human subjects?**

The lines of authority and responsibility are clear. Responsibility for the protection of human subjects resides at the local level with oversight at the Federal level to ensure that institutions are abiding by appropriate laws and regulations. The Common Rule applies to each signatory agency, although there is some variation in interpretation and implementation across agencies. Agency representatives participate in the human subjects subcommittee of the President's National Science and Technology Council, which meets regularly to promote uniform interpretation of the Common Rule and more efficient systems for protection of human subjects.

4. **Please provide monthly summaries for the past twelve months of all reported adverse events associated with human subjects research. What improvements are planned or underway that will result in a comprehensive system of adverse event reporting, and the sharing of human subjects research information and results with researchers and the public?**

Attached are three documents. The first is a summary of Institutional Incident Reports (IRPTs) reported to the OPRR by institutions for the period 1997 through 1999. The second is a

summary of incident reports. These reports relate to all areas of clinical research. In the specific area of human gene transfer research, as discussed earlier, the NIH is working assiduously to strengthen compliance with serious adverse event reporting requirements. The serious adverse events that are submitted to the NIH are reviewed publicly through quarterly meetings of the RAC. These data management reports are also posted on the Web site of the Office of Biotechnology Activities (http://www4.od.nih.gov/oba/documents.htm). The first phase of the interactive database under development is expected to be operational later this year. It will facilitate information dissemination and allow users to search for specific variables, analyze aggregate data, and identify emerging trends. Summary information about reports of serious adverse events in gene transfer research in 1999 and 2000 is attached (attachment 3). We will continue to explore ways to improve our gathering and disseminating of information related to adverse events and human subjects research. To assist us in this process, the OPRR will be consulting with thoughtful leaders in this area, including the Institute of Medicine, the Agency for Healthcare Research and Quality, and the National Forum for Health Care Quality Measurement and Reporting.

The NIH appreciates your interest in our efforts to ensure the safety of participants in NIH-supported or conducted clinical research. We welcome your interest and continued support of our efforts.

A similar letter is being sent to Mr. Kucinich.

Sincerely,

Ruth L. Kirschstein, M.D.
Acting Director

Enclosures

Summary of Incident Reports
Received by OPRR in 1999

Month	UP/AE	NC	SUSP	OTHER	TOTAL
January	4	4	3	0	11
February	1	0	2	0	3
March	1	3	3	1	8
April	1	7	5	1	14
May	3	5	3	0	11
June	6	6	6	0	18
July	5	7	3	2	17
August	6	11	4	0	21
September	9	6	3	1	19
October	7	8	4	0	19
November	11	5	5	0	21
December	7	6	2	0	15
1999 Total	61	68	43	5	177

UP/AE = Unanticpated problem/adverse event report
NC = Noncompliance report
SUSP = Suspension or termination of research
OTHER = Other miscellaneous reports

Number of institutions from which OPRR received reports in 1999: 87

NOTE 1: Some adverse event reports received from an institution report more than 1 event
NOTE 2: Many suspensions/terminations of research result from noncompliance or adverse events

Attachment 1

Prepared by OPRR 2/24/00

Summary of IRPTs by Institution 1997-1999

	1997					1998					1999					1997-1999				
Institution	UP/AE	NC	SUSP	OTHER	ALL-IRP	UP/AE	NC	SUSP	OTHER	ALL-IRP	UP/AE	NC	SUSP	OTHER	ALL-IRP	UP/AE	NC	SUSP	OTHER	ALL-IRP
ALBANY MEDICAL COLLEGE							1					4				0	5	0	0	
ALLEGHENY U HLTH SCI			1													0	0	1	0	
ALTON OCHSNER MEDICAL FOUNDATION	1					1					1					3	0	0	0	
AMERICAN INSTITUTE OF RSCH						1										1	0	0	0	
BAYSTATE HEALTH SYSTEM												1				0	1	0	0	
BOWMAN GRAY SCHOOL OF MED						1										1	0	0	0	
BRIGHAM & WOMEN'S HOSPITAL												1				0	1	0	0	
BROOKHAVEN NATIONAL LAB						1										1	0	0	0	
CALIFORNIA FRANCHISE TAX BD						1										1	0	0	0	
CALIFORNIA HEALTH & WELFARE AGENCY												1				0	1	0	0	
CENTERS FOR DISEASE CONTROL & PREVEN	1	1				2					1					4	1	0	0	
CHILDREN'S HOSP OF ORANGE COUNTY		1														0	1	0	0	
CHILDREN'S HOSPITAL & MED CTR - SEATTLE												1				0	1	0	0	
CHILDREN'S HOSPITAL - BOSTON						2						1				2	1	0	0	
CHILDREN'S HOSPITAL - LOS ANGELES											1	1				1	1	0	0	
CHILDREN'S HOSPITAL - OAKLAND													1			0	0	1	0	
CHILDREN'S HOSPITAL - PHILADELPHIA											1					1	0	0	0	
CHILDREN'S HOSPITAL - PITTSBURGH												2				0	2	0	0	
CHILDREN'S NATIONAL MED CTR													1			0	0	1	0	
CHRISTIANA CARE HLTH SERVICES						1										1	0	0	0	
CLARIAN HEALTH PARTNERS, INC		1														0	1	0	0	
CLEVELAND CLINIC FOUNDATION						1							1			1	0	1	0	
COLORADO STATE U						3							1			3	0	1	0	
COLORADO U																0	0	0	0	
COLUMBIA RIVER ONCOLOGY PROGRAM						1										1	0	0	0	
COOK COUNTY HOSP HEKTOEN INST																0	0	0	0	
COOL COUNTY HOSP	1															1	0	0	0	
COOPER HOSPITAL U MED CTR	1															1	0	0	0	
COTTAGE HEALTH SYSTEM														1		0	0	0	1	
DANA FARBER CANCER INSTITUTE						1										1	0	0	0	
DUKE U												1				0	1	0	0	
DUKE U MED CTR												1				0	1	0	0	
EAST TENNESSEE STATE U											7		2			7	0	2	0	
EMORY U												1				0	1	0	0	
EMORY U ROBT W WOODRUFF HLTH SCI CTR											2			1		2	0	0	1	
FAMILY HEALTH INTERNATIONA		1														0	1	0	0	
FORDHAM U		1														0	1	0	0	
FRED HUTCHINSON CANCER RSCH CENTER								1								0	0	1	0	
FRIENDS RESEARCH INSTITUTE, INC.												2				0	2	0	0	
GENCELL	3					2										5	0	0	0	
GEORGE WASHINGTON U						1										1	0	0	0	
GEORGIA DEPT HUMAN RESOURCES						1										1	0	0	0	
HARBOR-UCLA MED CTR												2				0	2	0	0	
HARVARD SCHOOL OF PUBLIC HEALTH												1				0	1	0	0	
HEALTH PARTNERS RESEARCH FOUNDATION												1				0	1	0	0	
HUNTSVILLE HOSPITAL	1															1	0	0	0	
INDIANA U	1															1	0	0	0	
INDIANA U PURDUE U												1				0	1	0	0	

Prepared by OPRR 2/24/00

Attachment 2

	1997					1998					1999					1997-1999				
Institution	UP/AE	NC	SUSP	OTHER	ALL OTHR	UP/AE	NC	SUSP	OTHER	ALL OTHR	UP/AE	NC	SUSP	OTHER	ALL OTHR	UP/AE	NC	SUSP	OTHER	ALL OTHR
JOHN WAYNE CANCER INSTITUTE					0	1				1					0	1	0	0	0	1
JOHNS HOPKINS U					0	1				1					0	1	0	0	0	1
JOHNS HOPKINS U SCHOOL OF MEDICINE					0	1				1		1			1	1	1	0	0	2
KANSAS STATE U					0					0		1			1	0	1	0	0	1
LDS HOSPITAL					0	1				1					0	1	0	0	0	1
LOUISIANA STATE U MED CTR - NEW ORLEANS					0					0			1		1	0	0	1	0	2
MAGEE - WOMENS HOSPITAL					0		1			1					0	0	1	0	0	1
MASSACHUSETTS GENERAL HOSPITA	1				1					0	1				1	2	0	0	0	2
MAYO FOUNDATION	1				1					0					0	1	0	0	0	1
MEDICAL CITY DALLAS HOSP					0					0		1			1	0	1	0	0	1
MEDICAL COLLEGE OF GEORGIA	1	1			2					0					0	1	1	0	0	2
MEDICAL COLLEGE OF OHIO					0					0		1			1	0	1	0	0	1
MEMORIAL SLOAN-KETTERING CAN CTR					0					0		1			1	0	1	0	0	1
MERCY HEALTHCARE ARIZONIA	6				6	11				11					0	17	0	0	0	17
MICHIGAN TECHNOLOGICAL UNIV		1			1					0					0	0	1	0	0	1
MT. SINAI SCHOOL OF MEDICINE					0					0			1		1	0	0	1	0	2
NATL INSTITUTE HEALTHCARE RSCH		1			1					0					0	0	1	0	0	1
NEWTON-WELLESLEY HOSPITAL					0					0	1				1	1	0	0	0	1
NIH EXTRAMURAL PROGRAM					0	1				1	1				2	2	0	0	0	2
NIH INTRAMURAL RESEARCH PROGRAM		1			1					0					0	0	1	0	0	1
NIH NIAAA	1				1					0					0	1	0	0	0	1
NIOSH - NATL INST OCC SAFETY & HLTH	1				1					0					0	1	0	0	0	1
NORTHWESTERN U	1				1					0					0	1	0	0	0	1
PEDIATRIC ONCOLOGY GROUP					0	1				1					0	1	0	0	0	1
PENN STATE U HERSHEY MED CTR					0					0			1		1	0	0	1	0	2
RESEARCH FOUNDATION MENTAL HYGIENE	2				2	3				3	2				2	7	0	0	0	7
RHODE ISLAND HOSPITAL					0					0					0	0	0	0	0	0
ROSWELL PARK MEM CANCER INST					0	2	1			3	1				1	3	1	0	0	4
SANTA CLARA VALLEY MED CTR	1				1					0					0	1	0	0	0	1
SCOTT & WHITE					0	1				1					0	1	0	0	0	1
SCOTT & WHITE MEMORIAL HOSP					0					0		1			1	0	1	0	0	1
SCRIPPS CLINIC AND RESEARCH FND					0					0		1			1	0	1	0	0	1
SOUTH JERSEY HOSPITAL					0	1				1					0	1	0	0	0	1
ST. FRANCIS HOSPITAL					0	2				2					0	2	0	0	0	2
ST. JOHN'S HEALTH CTR					0					0		3	1		4	0	3	1	0	4
ST. JOSEPH'S HOSPITAL & MED CTR	1				1	1	1			2			1		1	2	1	1	0	4
ST. JOSEPH'S HOSPITAL & MED CTR - TAMPA					0	1				1					0	1	0	0	0	1
ST. LOUIS U					0		2			2		1			1	0	3	0	0	3
ST. LUKE'S EPISCOPAL HOSP					0					0			1		1	0	0	1	0	1
STANFORD U					0					0	2			1	3	2	0	0	1	3
SUN HEALTH RESEARCH INSTITUTE					0					0	2				2	2	0	0	0	2
SUNY ALBANY					0					0		1			1	0	1	0	0	1
SUNY BUFFALO					0	1				1	24		1		25	25	0	1	0	26
SWEDISH MED CTR	4				4			1		1					0	4	0	1	0	5
TEXAS TECH U HEALTH SCI CTR					0					0			1		1	0	0	1	0	1
THE MIRIAM HOSPITAL					0					0	1				1	1	0	0	0	1
THOMAS JEFFERSON U					0	2				2		1			1	2	1	0	0	3
TRIPLER ARMY MED CTR					0			1		1		1			1	0	1	1	0	2
U ALABAMA BIRMINGHAM					0	1				1		1			1	1	1	0	0	2
U ARIZONA					0					0			2		2	0	0	2	0	2

Prepared by OPRR 2/24/00

Institution	1997					1998					1999					1997-1999				
	UP/AE	NC	SUSP	OTHER	ALL SR	UP/AE	NC	SUSP	OTHER	ALL SR	UP/AE	NC	SUSP	OTHER	ALL SR	UP/AE	NC	SUSP	OTHER	ALL SR
U ARIZONA HLTH SCI CTR	1							1								1	0	1	0	
U ARKANSAS MED CTR											1	1	1			1	1	1	0	
U BUFFALO	22					14										36	0	0	0	
U CALIFORNIA SAN DIEGO												1				0	1	0	0	
U CALIFORNIA IRVINE	3											2				3	2	0	0	
U CALIFORNIA LOS ANGELES	3			1								1	1			3	1	1	1	
U CALIFORNIA SAN FRANCISCO	1					3										4	0	0	0	
U CINCINNATI MED CTR						1										1	0	0	0	
U COLORADO HEALTH SCIENCES CTR												1				0	1	0	0	
U FLORIDA	1					5						2	1			6	2	1	0	
U HAWAII	1															1	0	0	0	
U ILLINOIS CHICAGO		1														0	1	0	0	
U IOWA												1				0	1	0	0	
U KANSAS MED CTR											1					1	0	0	0	
U LOUISVILLE	4											1				4	1	0	0	
U MARYLAND BALTIMORE	1					1						2				2	2	0	0	
U MED DENT NEW JERSEY						1										1	0	0	0	
U MED DENT NEW JERSEY MED SCHOOL						1							1			1	0	1	0	
U MINNESOTA						1	1					2		1		1	3	0	1	
U MISSOURI COLUMBIA							1									0	1	0	0	
U NEBRASKA						1					1					2	0	0	0	
U NEW MEXICO HLTH SCI CTR	4					1										5	0	0	0	
U NORTH CAROLINA CHAPEL HILL	1															1	0	0	0	
U OKLAHOMA HLTH SCI CTR	1															1	0	0	0	
U PENNSYLVANIA						1					2					3	0	0	0	
U PITTSBURGH											3					3	0	0	0	
U PUERTO RICO												1				0	1	0	0	
U SOUTHERN CALIFORNIA												2				0	2	0	0	
U TEXAS HLTH SCI CTR HOUSTON	1											1	1			1	1	1	0	
U TEXAS MED BRANCH GALVESTON	1					1	1					4				2	5	0	0	
U TORONTO						1										1	0	0	0	
U UTAH						1						1				1	1	0	0	
U VERMONT	2											1				2	1	0	0	
U VIRGINIA											1	2				1	2	0	0	
U WASHINGTON	1					1								1		2	0	0	1	
U WISCONSIN MADISON		1				1										1	1	0	0	
USN NATL NAVAL MED CTR			2					8				2	18			0	2	28	0	
USUHS							1									0	1	0	0	
VA HOSPITAL EDWARD HINES, JR.												1				0	1	0	0	
VA MED CTR ALBUQUERQUE	2					1										3	0	0	0	
VA MED CTR MINNEAPOLIS												1				0	1	0	0	
VA PALO ALTO HEALTHCARE SYSTEM											1					1	0	0	0	
VA PITTSBURGH HEALTHCARE SYSTEM											3					3	0	0	0	
VIRGINIA COMMONWEALTH U - MCV						1										1	0	0	0	
WALTER REED ARMY MED CTR		1										1				0	2	0	0	
WASHINGTON U SCHOOL OF MEDICINE						1							2			1	0	2	0	
WEST VIRGINIA U	2					2	1						1			4	1	1	0	
WOMEN & INFANTS HOSP													1			0	0	1	0	
TOTALS	61	12	3	1	87	92	11	12	0	115	61	68	43	5	177	234	91	58	6	389

SERIOUS ADVERSE EVENTS IN HUMAN GENE TRANSFER RESEARCH REPORTED TO NIH IN 1999

		Sub-Total	Total
Reported by Investigators in the Period Jan 1, 1999 – Dec 31, 1999			103
By Vector Class:	Retrovirus	35	
	Adenovirus	40	
	DNA –Liposome	17	
	Naked DNA	11	
		103	
	Unexpected, Possibly Associated with Product	9	
	Not Associated with Product	94	
		103	103
Reported on Adenovirus Trials, in Response to the NIH Request dated October 1, 1999			970
	Unexpected, Possibly Associated with Product	86	
	Not Associated with Product	884	
		970	970
TOTAL SERIOUS ADVERSE EVENTS REPORTED FOR 1999		1073	1073

Attachment 3

SERIOUS ADVERSE EVENTS IN HUMAN GENE TRANSFER RESEARCH REPORTED TO NIH IN 2000

		Sub-Total	Total
Reported by Investigators in the Period Jan. 1, 2000 – Mar. 1, 2000			464
By Vector Class:	Retrovirus	2	
	Adenovirus	25	
	DNA –Liposome	7	
	Naked DNA	2	
	Canary Poxvirus	1	
	Unspecified	6	
		43	
	Unexpected, Possibly Associated with Product	43	
	Not Associated with Product	421	
TOTAL SERIOUS ADVERSE EVENTS REPORTED TO DATE (3/1/00)		464	464