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TO: Mr. John P. Hart

"A Business And Industrial Policy For San Diego: An Economic Policy Paper", by, Mr. Peter Navarro, Candidate for Mayor, City of San Diego, April,1992.

PHOTOCOPY PRESERVATION

OUTLINE FOR SUBSTANCE ABUSE TREATMENT BRIEFING

I. Successful Approaches to Treatment

A. Household Addicts -- estimates indicate that there are at least 1.4 million treatable drug addicts in the country, many of whom do not receive any type of treatment.

Perspectives on Treatment -- Treatment in the US is a funny thing. We expect more from drug addicts than we do other addicts. If someone tries to quit smoking or drinking, we can appreciate if they "cut back" or "fall of the wagon". We understand that -- like controlling your blood pressure -- it takes time and effort, and you improve as you progress. Not so with drugs. Our society views drug addicts as criminals, and we can't understand why they can't cure themselves in a thirty-day program. And despite the fact that treatment is proven to reduce the criminality and drug use of addicts, we have difficulty accepting anything less than abstinence.

Effective Treatments -- Must be lengthy. At least three months, maybe a year. We know that the longer an addict stays in treatment, the more likely he/she is to stay off drugs. Intensive and highly-structured treatment helps. Like the e.g. of acupuncture that gives addicts a concrete form of treatment. Also, educational and employment opportunities help. Give addict a "turning point". Unfortunately, we always expect addicts to become typical middle class society members -- but most of them never were. We must have realistic criteria of success.

Methadone Maintenance -- When other forms of treatment don't work methadone may. While it has the potential to simply substitute one addiction for the next, it has been around since 1964 and is the most evaluated treatment. According to a recent study, over 85% of those who stay on for two years quit heroin for good. NB: Methadone treatment was recently the subject of a critical 60 minutes story. From time to time, methadone programs have come under fire for not being properly administered.

B. Criminal Addicts -- estimates indicate that there are some 1.4 million drug users in our criminal justice system. More than half of the federal inmate population consists of drug offenders -- and this number is expected to jump to 90% by 1995. More than 3/4's of all state inmates are drug abusers. Still, very few prisoner receive effective drug treatment.

Effective Prison Treatments -- inmates are separated from the general population; attended by well-trained staff; treatment last at least six months, preferably just prior to release; prerelease planning and aftercare essential. These elements can be included in expanded boot camp efforts.

Drug Courts -- faced with rising caseloads, over capacity prisons, and not wanting to use valuable prison space for minor drug offenders, some criminal courts have found ways to put drug offenders in treatment (Miami Drug Court). Other courts require intense education, drug testing, and AA/NA classes (Oakland). Treatment is not

necessary for every offender, and this method helps ferret out who truly needs residential treatment. More importantly, in drug courts the defendants can't be passive recipients of punishment, they must be active participants in their own rehabilitation.

II. Meeting the treatment demand

A. Treatment shortfall -- no matter whose numbers you use, there ar a paucity of treatment slots in the country. At best, the shortfall is about 800,000; at worst, it's more than 3 million. Moreover, the demand for treatment cannot simply be met by increasing funds; it would be a waste of money due to the lack of infrastructure to absorb the funds. A major expansion would have to be phased in to maximize effectiveness. (Treatment facilities are a patchwork of state, local, private and federal programs and efforts.)

B. Prioritizing -- Certain critical populations are obvious targets of priority: pregnant women, at risk youth, correctional inmates and persons under criminal justice supervision (probation and parole), and individuals at risk for HIV.

Pregnant Women -- Some 554,400 to 739,200 drug-exposed babies are born each year (1 in 10 new births). Daily health costs for a drug-exposed baby is $5,500, and aggregate first-year costs estimates range form a minimum of $51 million to as high as $1 billion.

At-Risk Youth -- According to NIDA, individuals with less than 12 years of education have an incidence of drug use 67% higher than the general public, which often translates into criminal activity. We must target high school dropouts.

C. Accountability -- Drug treatment is not a single entity, but many (e.g., methadone, therapeutic communities, outpatient, 28 day chemical dependency, etc.). The Federal Government has failed in establishing standard guidelines, providing technical assistance, and in engaging in long-term, strategic planning that keeps treatment research and methods current to the problem. Some of these concern should be addressed by the 1992 ADAMHA Reorganization Act.

- **President Clinton's Budget ($12.366 billion) is no different than former President Bush's ($12.037). Its overall increase is less than inflation, and it effectively retains the 70/30 supply/demand ratio.**

- NO -- if drug treatment is incorporated as a basic service in a national health care plan, we will have done more to increase treatment availability than ever before. Also, the new ONDCP director will be reviewing our national drug strategy and recommending appropriate changes in policy and funding levels.

- **The President has gutted ONDCP and demoted the "War on Drugs" as a priority.**

- NO -- the President's organization will help revitalize the office. First, he has reformed the office from being a political dumping ground to a more focused policy and planning office. While ONDCP was meant to give coherence to drug policy, it has not succeed in its mission. Second, the new ONDCP director will be elevated to the Cabinet level; the previous Administration demoted the ONDCP director from his cabinet status.

SUBSTANCE ABUSE TREATMENT -- TALKING POINTS

Affirmative

- Perhaps the best way to increase drug treatment is to include it as one of the basic services to be offered by a national health plan. The Task Force is now examining the interplay between substance abuse treatment and health care reform.

- President Clinton pledged to increase drug treatment, and his economic package includes a $1.5 billion investment over the next four years to do so.

- President Clinton expressed his support for court-mandated drug testing programs to augment drug treatment for released offenders, and his nominee for the position of Attorney General is a recognized innovator in this area. Janet Reno helped launch the Miami Drug Court, a program where drug offenders are offered a strictly regimented drug treatment program as an alternative to prison. Some 60% of the programs successful participants remain "arrest free".

- While drug use among the general population, and among certain adolescent students, is down, hard-core drug use is on the rise. These hard-core users are responsible for much of the drug-related crime. We must demanding that they get treatment.

- The President's plan to put 100,000 new police officers on the street and dramatically increase community policing will help to identify these hard-core users and get them into treatment.

- Another trend: Drug prices have continued to fall while quality/purity has gone up.

Defensive

- **Drug Treatment is "soft on crime".**

- Next to prison, drug treatment is the most effective way to reduce an addicts criminality -- and treatment is infinitely less expensive. More and better drug treatment is good health policy, good drug policy, good crime policy, and good urban policy. Former OMB Director Richard Darman estimated drugs, in the aggregate, put as a $300 billion drain on the economy.

- **President Clinton is going to slash drug interdiction and enforcement to fund increased drug treatment.**

- The President is committed to increased drug treatment availability, but his overall funding levels will be based on programs that work. For too long our drug policy has been politicized and polarized by the argument over arbitrary funding ratios (supply/demand ratio). The treatment and law enforcement communities have come to realize that they both have a role to play in fighting illegal drugs -- and that good and bad programs exists in both sectors.

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SUBSTANCE ABUSE TREATMENT -- FACT SHEET

Major Clinton Promises

- Provide "treatment on demand".
- Support court-mandated drug testing programs to augment drug treatment for released offenders.
- Reaching children with drug and alcohol programs through school-based efforts.
- Targeting pregnant addicts for treatment.

Drug Treatment Spending

- **Total FY93 Anti-Drug Budget = $12.037 billion**. (Approximately 70% for supply reduction and 30% for demand reduction.)
- Total national spending on drug treatment -- including private sector -- is about $8 billion. Total Federal spending is $2.2 billion.
- President's proposed spending increase (for treatment and prevention): $1.5 billion over four years.

"Treatment Shortfall"

- The National Institute on Drug Abuse (NIDA) estimates that 6.5 million people abuse drugs.
- A 1990 Institute of Medicine (IOM) study estimated that 5.5 million people need drug treatment -- with 2.5 million clearly in need of treatment (1.1 million in the criminal justice system) and 3 million probably in need of treatment.
- In 1992, the Office of National Drug Control Policy (ONDCP) estimated that there are 2.77 million drug users who can benefit from drug treatment.
- Assuming an annual treatment capacity of 1.7 to 2 million, the treatment shortfall can be estimated to be about 800,000 to 1 million -- for treatable addicts. This is a conservative estimate; some believe the shortfall to be three times as high.
- Alternatively, a 1990 National Academy of Sciences study, "Treating Drug Problems," estimated that a $1.3 billion increase over current levels -- and a one-time capital investment of $1 billion -- would be required to implement a comprehensive drug treatment system.

Major Clinton Options

- Include substance abuse treatment among the basic services offered by a national health insurance plan. This is the best way to dramatically -- and cost effectively -- expand drug treatment.

- If inclusion in the health plan is a long-term prospect, the proposed four-year, $1.5 billion increase should be targeted to juveniles and pregnant users, and then to the criminal justice system on the next priority.

- While some drug treatment advocates have called for dramatic increases in federal drug treatment spending, this is not necessarily a viable option. An equally dramatic capital investment would be required for the treatment infrastructure to be able to absorb such an increase.

Office of National Drug Control Policy (ONDCP)

- ONDCP was established by Congress in the 1988 Anti-Drug Abuse Act. It was created to bring coherence to drug abuse policy. Currently more than three dozen federal agencies are involved in some aspect of drug control -- and some 75 committees and subcommittees in Congress share jurisdiction over drug issues.

- ONDCP has the responsibility of compiling an annual national drug strategy and budget, which has been past due since February 1, 1993.

- ONDCP was a Democratic creation. Reagan vetoed the original bill, but Democrats attached it to major drug legislation.

- The first ONDCP Director ("Drug Czar"), William Bennett was in the cabinet. But the second Czar, Bob Martinez, was demoted from the cabinet and physically moved from the Old Executive Office Building to nearby commercial offices.

- The President has proposed cutting ONDCP from 146 employees to 25 employees. Formerly, some 50% of ONDCP's employees were political appointees with little or no drug policy experience.

- As a result of ONDCP's reorganization, its budget has been cut from $118.5 million to $91.8 million.

- ONDCP never succeeded in bringing coherence to federal drug policy. Hopefully, a more "nimble" policy and planning shop will be able to do so.

- ONDCP's authorization expires on November 18, 1993. Additional changes to the office will be considered at that time.

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U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

Drugs & Crime Data

November 1992

Fact Sheet: Drug Data Summary

As part of ongoing research, the Drugs & Crime Data Center & Clearinghouse has prepared this fact sheet to summarize current drug-related law enforcement, court, and corrections statistics as well as drug use and cost information.

Law Enforcement

Drug enforcement operations

The Bureau of Justice Statistics (BJS) 1990 Law Enforcement Management and Administrative Statistics (LEMAS) survey of State and local law enforcement agencies found that 77% of the Nation's local police and sheriffs' departments and 69% of State police departments had primary responsibility for drug law enforcement in their jurisdictions.

Among those agencies with primary drug enforcement responsibilities, many operate special drug enforcement units or participate in multiagency drug enforcement task forces.

Special drug unit operation and multiagency task force participation of agencies with primary drug enforcement responsibility:

Type of agency	Operation of special drug unit	Participation in multiagency task force
State police departments	85%	91%
All local agencies	28	55
Police departments	25	51
Sheriffs' departments	39	68

Arrests

In 1991, the Federal Bureau of Investigation (FBI) reported an estimated 1,010,000 State and local arrests for drug law violations in the United States. The highest number of arrests during the past decade for drug offenses occurred in 1989.

Estimated arrests for drug offenses:

Year	Total arrests	Sale/ Manufacturing	Possession	Percent of all arrests
1982	676,000	137,904	538,096	5.6%
1983	661,400	146,169	515,231	5.7
1984	708,400	155,848	552,552	6.1
1985	811,400	192,302	619,098	6.8
1986	824,100	206,849	617,251	6.6
1987	937,400	241,849	695,551	7.4
1988	1,155,200	316,525	838,675	8.4
1989	1,361,700	441,191	920,509	9.5
1990	1,089,500	344,282	745,218	7.7
1991	1,010,000	337,340	672,660	7.1

In 1982, drug arrests were 5.6% of the total of all arrests reported to the FBI; by 1991, drug arrests had risen to 7.1% of all arrests.

Drug seizures

Many Federal agencies are involved in removal of illicit drugs from the market. The Federal-Wide Drug Seizure System (FDSS) reflects the combined drug seizure efforts of the Drug Enforcement Administration (DEA), the FBI, and the U.S. Customs Service within the jurisdiction of the United States, as well as maritime seizures by the U.S. Coast Guard. FDSS eliminates duplicate reporting of a seizure involving more than one Federal agency. The following statistics indicate the total amount of drugs seized in fiscal years 1990 and 1991 by the Federal agencies participating in FDSS:

Drug	Pounds seized fiscal 1990	Pounds seized fiscal 1991
Heroin	1,794	3,041
Cocaine	235,214	239,048
Marijuana	483,248	491,764
Hashish	17,062	178,211

Order Code IB87013

CRS Issue Brief

Major Planning Issue

Drug Control

Updated October 29, 1992

by
Harry Hogan
Government Division

Congressional Research Service • The Library of Congress

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Drug Control

SUMMARY

How to prevent the nonmedical use of dependency-producing drugs has been a public policy concern for at least a century. A large part of the responsibility for controlling such substances has been assumed by the Federal Government. Historically based on a decision to restrict availability through a system of close regulation, including selective prohibition, the current Federal anti-drug strategy relies on activities and programs in the following major areas: (1) regulation and other "enforcement" efforts; (2) support for international control and for control efforts of individual drug-producing and drug-transiting countries; (3) education and other prevention activities; (4) treatment and rehabilitation for drug-dependent persons; and (5) research on drugs, drug dependency, and prevention and treatment methods.

Although the basic policy of restriction has been criticized, it seems to enjoy general national support. A renewed discussion of the merits of legalization or "decriminalization" has not yet been reflected, to any significant degree, in congressional concerns over drug matters. Instead, today's policy questions are more likely to focus on the degree of priority assigned to the problem, the level of resources devoted, the emphasis given to each of the major components of the anti-drug strategy, and the effectiveness of policy implementation (including overall coordination and direction).

Included among anti-drug enactments of the 101st Congress was an omnibus crime and drug control bill (S. 3266, P.L. 101-647) passed at the close of the second session. This 1990 measure followed the passage of similar omnibus bills in 1984, 1986, and 1988, of which the latter two included authorizations for large increases in anti-drug appropriations. A number of significant drug-related provisions were dropped from the final version of the 1990 statute, and these proposals again became focal points in the 102d Congress. On July 11, 1991, the Senate passed the Violent Crime Control Act (S. 1241), a 49-title bill with many drug-related provisions, and the House passed a related proposal (H.R. 3371) on Oct. 22, 1991. A conference agreement was approved by the House before the end of the first session, but three failed cloture motions in the Senate kept it from enactment.

ISSUE DEFINITION

The nonmedical use of narcotics and other dangerous drugs has been a national problem since the latter part of the nineteenth century. A large part of the responsibility for controlling such substances has been assumed by the Federal Government. Currently embracing a broad spectrum of approaches, the Federal commitment to anti-drug efforts has expanded rapidly in recent years. At the most general level, the major issue is whether the policy of preventing the abuse of drugs through restrictive and even prohibitory controls is the best possible. Assuming that it is, the second-level policy questions are is the drug problem accorded an appropriate position in the list of national priorities? Are we pursuing the most effective strategies for carrying the policy out? Are these strategies being properly implemented? If not, how can they be improved? Do the strategies conflict with other national or public interests?

BACKGROUND AND ANALYSIS

General Background

How to prevent the nontherapeutic use of dependency-producing drugs has been a public policy issue in the United States for over a century. Interest in the question has been especially strong in the past 25 years. During this period, an apparently sharp increase in heroin use in many inner cities has been augmented by the growing abuse of other drugs -- including cocaine and, more recently, cocaine base ("crack" and "rock").

Current estimates of retail dollar value of the three principal illicit drugs consumed annually in the United States (cocaine, marihuana, and heroin) range from $50 billion to $150 billion. Although various indicators point to a significant decline in drug abuse within some population groups during the past decade, there is also evidence of a significant increase in chronic use -- especially of cocaine and "crack" -- among other groups. Additionally, there are indications that heroin imports and use are again on the rise.

Statistics concerning the drug problem are controversial. Even the extent of abuse, past and present, is disputed -- and, concomitantly, any attempt to depict the long-range trends of abuse. However, most authorities agree that there was a surge in drug use generally in the 1960s with an apparent moderation of heroin dependency in the early 1970s; the two decades were distinguished by spread of the problem to population groups not previously associated with it. Many analysts believe the recent data indicate a "two-tier drug problem" in the United States, characterized by a decline in use among a substantial segment of the middle class, but by an escalation among some lower socioeconomic groups.

On the Federal level, both the Executive and the Congress have reacted to public concern with new initiatives -- legislative and administrative -- as well as with the expansion of existing programs. Many approaches have been taken: "demand reduction" programs for treatment, prevention, and related research; "supply reduction" efforts such as regulation of commerce in the drugs in question, investigation and

prosecution of drug traffickers, drug interdiction, and the development of international accords.

It was during the 1960s and early 1970s that the more traditional Federal emphasis on supply reduction was challenged in Congress, and the trend of legislation in that period reflected a greater concern for reduction in demand through provision of treatment and rehabilitation services to users, along with educational and other activities to prevent or reduce drug use. The Community Mental Health Centers Act of 1963, administered by the Public Health Service, became the vehicle for establishing (in 1968) a specialized grant program for treatment of drug dependence and for prevention efforts. Subsequently, other prevention grant programs, emphasizing school-based education, were added to the mandate of the Department of Education.

Currently, three dozen or more Federal agencies are involved in some aspect of drug control. In Congress, approximately 75 committees or subcommittees have an interest in the issue. Budget totals in particular provide a measure of the level and trend of the growing Federal commitment in this area: spending for all such efforts rose from $82 million in FY1969 to $10.8 billion in FY1991. Appropriations for FY1992 were close to $12 billion, and the Administration requested $12.7 billion for FY1993.

National Drug Control Strategy

The present Federal strategy for preventing abuse of dangerous drugs is multifaceted, based on domestic laws to closely regulate the commerce in such drugs -- in some instances effectively banning them. Those laws are complemented by a system of international production controls and by a complex of multilateral and bilateral agreements, covering not only production but also general domestic regulation and other aspects of government efforts to prevent illicit commerce. Efforts to reduce the supply of drugs are supplemented by a demand reduction strategy of support for treatment and prevention programs through grants-in-aid; a program of research, both extra- and intra-mural, related to the abuse of drugs and methods of curbing it; and enforcement and promotion of certain "user accountability" measures. The latter are designed to discourage drug use by subjecting the user to certain civil sanctions in addition to possible criminal charges.

Most of the above elements, with the exception of the "user accountability" features, have been followed to some degree for a number of decades. In the early 1970s, the notion of a comprehensive "strategy" was formalized by statute, and the first official "Federal Strategy for Drug Abuse and Drug Traffic Prevention" was coordinated by a group known as the Strategy Council on Drug Abuse. Similar documents continued to be issued periodically under various names, and the concept of such a unified strategy was included as a requirement in the Anti-Drug Abuse Act of 1988, specifically as a responsibility of the newly created Office of National Drug Control Policy (ONDCP).

The first of the strategies prepared by ONDCP was released in September 1989, followed by an amplifying second document in January 1990. The third and fourth of the series were submitted in February 1991 and 1992 respectively. The statute provides that the strategy:

"(A) include comprehensive, research-based, long-range goals for reducing drug abuse in the United States;

(B) include short-term, measurable objectives that the Director determines may be realistically achieved in the 2-year period beginning on the date of the submission of the strategy;

(C) describe the balance between resources devoted to supply reduction and demand reduction; and

(D) review State and local drug control activities to ensure that the United States pursues well-coordinated and effective drug control at all levels of government."

Conceptually, the 1989-92 strategies are characterized by a continuing commitment to the principle of attacking both supply of and demand for drugs. Increased support for demand reduction through treatment and prevention is a major feature. The strategies have proposed no significant resource increases for interdiction, a fact interpreted by some analysts as signaling a deemphasis of that aspect. Many recommendations in the reports could be interpreted as implying that "street level" enforcement is more important in the long run than large-scale seizures and "busts."

User Accountability. In the 1989-92 strategies, a striking difference from past drug strategies is the degree of emphasis on the theme that society needs to apply greater pressure to the casual drug user. Making the point that continuing legal, institutional, and social pressures are also a form of "demand reduction," the strategies now see the user as the base on which the illegal drug industry rests and spreads. Although stressing that drug use is but one manifestation of more general dislocations in society, they nevertheless hold that a number of things can be done to deter use and change attitudes. Recommended are such "accountability" measures as State laws providing civil penalties for simple possession, publication of the names of persons convicted of possession, greater use of forfeiture laws to seize property (such as motor vehicles) of persons arrested for possession, and more punitive treatment of drugs users in public schools and colleges. In general, the reports affirm the value of the user accountability provisions of the Anti-Drug Abuse Act of 1988 and call upon States to adopt similar policies.

Andean Initiative. An emphasis of U.S. anti-drug policy for the past decade has been a mix of efforts aimed at curbing the importation of the drug cocaine and its variants into the United States. One feature of the Bush Administration's strategy is a plan to provide enhanced law enforcement, economic, and military assistance to the three Latin American countries (Bolivia, Colombia, and Peru) accounting for the production of most of the cocaine on the world market. As outlined in the two strategy reports and further amplified by President Bush at the Feb. 15, 1990 "anti-drug summit" in Cartagena, Colombia, the proposal called for expenditures of some $2 billion over 5 years for a variety of activities designed to suppress coca production and disrupt processing and trafficking operations. (See CRS Issue Brief 88093: *Drug Control: International Policy and Options.*)

Broad Policy Questions

The following outline indicates a range of possible answers to these general questions: Is the basic policy of restriction the right one? Are we pursuing the right set of strategies to carry out the policy? Are they properly implemented? How could they be improved?

1. The basic policy is wrong. We should legalize drugs because:
   a. The black market would collapse and along with it the accompanying potential for corruption of the society, and
   b. Experience demonstrates that we can't stop the illicit traffic in any case.

2. Both policy and implementation are about right.

3. Continue basic policy of regulation and selective prohibition, but:
   a. Substantially increase resources committed --
      (1) all around.
      (2) selectively.
   b. Reduce commitment.
      (1) We're spending too much, and we're uncertain about the effectiveness of what we're doing.
      (2) Rely on demand-reduction efforts to make the problem more manageable.
      (3) Rely on time to solve the problem. America (as well as other countries) has experienced drug epidemics before, and they eventually subsided; they have a natural life cycle that must run its course, followed by a period of reaction.
   c. Change the emphasis.
      (1) Current policy puts too much emphasis on supply reduction. Concentrate on demand reduction ("it's the user who keeps the market going") through more education and other prevention efforts; more and better treatment of those already dependent on drugs; more emphasis on deterrence by random testing for drug use in the workplace and in schools, followed by appropriate action; more determined enforcement of "simple" possession statutes by the police; imposition of higher penalties by the courts; or various other sanctions designed to "recreate a stigma." (Demand-reduction advocates do not necessarily agree on the relative effectiveness or advisability of these courses.)
      (2) Current policy puts too much (or not enough) emphasis on solving the problem "at the source." Overseas efforts to reduce the production of poppies, coca, and cannabis are unrealistic and doomed to fail (or, alternatively, offer the major hope, justifying an even greater commitment to the International Narcotics Control program under the Foreign Assistance Act and to related efforts).
      (3) Concentrate on interdiction; it's more efficient to seize drugs before they enter the country or at the border than after they have been moved into the interior.
      (4) The breakup of trafficking organizations is, in the long run, the best way to disrupt the flow of drugs; and it is the result of vigorous investigation and prosecution activities.

Advocates of legalization have not succeeded, to any significant degree, in influencing Congress on anti-drug strategy. Instead, today's broad policy questions are more likely to concern the degree of priority assigned to the problem, the level of resources devoted, the emphasis given each of the major components of the strategy, and the effectiveness of implementation.

The question as to whether anti-drug strategies conflict with other national or public interests or legal requirements could be asked in connection with (1) the use of sanctions or other forms of pressure on foreign countries where the United States has other major interests that might thereby be compromised; (2) practices, such as random employee testing, that might threaten a constitutional right; (3) selective law enforcement approaches based on "profiles," again perhaps conflicting with constitutional principles; and (4) the expenditure of large sums of money at a time when the Federal Government is burdened with a massive budget deficit.

Additional policy questions are posed in connection with almost every aspect of the Federal drug control program. In the case of prevention efforts, for example, the overriding concern is whether they are effective. Particularly with respect to curricula-based efforts in the schools, critics contend they have often proved counterproductive, e.g., by stimulating an interest that ends in experimentation. Advocates, however, view the schools as an obvious place to begin, a primary source of information and behavioral guidance for many adolescents.

Questions also continue to be raised about long-run results of treatment and rehabilitation regimens, as well as about the relative effectiveness of various treatment modalities. Although support for the general concept of providing treatment remains high, doubts have caused some policymakers to challenge calls for greater commitment.

Some support alternative avenues to demand reduction, e.g., testing workers and students for drug use and other proposals often called "user accountability" measures. Those who favor such policies, which are allied to calls for a return to stricter enforcement of simple possession laws, believe it is necessary to make life more uncomfortable for the users -- to make them fear the legal consequences of their behavior and also, partly through those consequences, to re-stigmatize that behavior within the culture. This approach is more likely to be emphasized by those who view the drug problem as a manifestation of deeper societal displacements of recent times.

As suggested above, major questions have also been raised in recent years as to the efficacy of interdiction and overseas control measures in reducing supply. While a 1987 study commissioned by the Customs Service has been interpreted to show that it is more cost-effective to remove illegal drugs before they enter the country, other analyses conclude that it may be impossible to police U.S. borders to the extent required to produce a significant impact on drug smuggling. Although a policy of "stamping out drugs at the source" still has strong adherents in Congress, critics question whether such efforts can ever be sufficiently successful to reduce drug flow into the United States, the premier market in the world. Finally, those who question the wisdom of emphasizing overseas and interdiction strategies ask why we should assume that success in blocking the entry of foreign drug products would not drive drug users to domestically produced synthetic drugs.

Perhaps the most central of all drug policy questions, since it bears strongly on the selection of strategies for solution, concerns causality. What phenomenon has created criminal drug empires, with all their potential for political and social subversion? Why do people use drugs?

Hypotheses range widely. On one level, analysts offer such reasons as peer pressure, escape from unhappiness, quest for excitement, and imitation of what is perceived as the glamorous life; on another, they point to more general conditions that may have made the society vulnerable to such motivations.

Of the broad "root cause" theories, one that has been influential for many years sees poverty, discrimination, and lack of economic opportunity as the principal reasons for drug abuse and many other forms of anti-social behavior. In contrast, another creates a case that economic affluence is precisely the condition most conducive to the development of pleasure-seeking societies. Yet another points to the ascendancy of radical skepticism and philosophical relativism, which challenge traditional beliefs and authority in all aspects of intellectual and social life. A variant of the latter cites in particular the long, gradual disintegration in the West of the basic communities that in the past imposed limitations on unacceptable behavior. According to this perspective, family, church, neighborhood, guild -- all have seen their one-time strength diminished, and the consequent increase in freedom for the individual has created a variety of new social problems, including the misuse of intoxicating and mood-altering substances. Another view stresses that it is human nature, even animal nature, to seek intoxication.

Whatever broad cultural or biological theory is accepted, only a minority of individuals subject to the same negative influences become drug users. Many people continue to respect socially or legally imposed limitations on behavior or succeed in imposing their own. If there exists a "natural" urge toward intoxication, most people choose to forego it or to use intoxicating substances only in moderation. What factors make the difference? This is one of the most important questions asked by researchers and policymakers.

Finally, as in the case of all efforts to modify human behavior, there is the problem of how to measure the effectiveness of efforts to control drug abuse. Of the various approaches outlined, what actually works? Available data seldom provide clear answers. Indeed, a further policy issue of particular current interest concerns the reliability of official statistical indicators of the U.S. drug problem. Although those indicators have been showing favorable trends in the past several years, some policymakers remain unconvinced and charge that the Administration is "painting a rosy picture." Others, however, argue that government statistics have frequently *over*stated the magnitude of the problem.

Recent Congressional Context

The original Bush Administration budget for FY1990 requested an estimated $6.4 billion in antidrug budget authority. Supplemental requests, as reflected in the 1989 National Drug Control Strategy, yielded an amended total of $7.9 billion, nearly 40% higher than the FY1989 appropriations. Congress added another $900 million (under the "Byrd amendment") to the Department of Transportation appropriations bill,

providing a final amount of $9.5 billion. Appropriations are estimated to total nearly $12 billion for FY1992, and the Administration has requested $12.7 billion for FY1993.

In other actions of the 101st Congress, two major non-appropriations bills were enacted: H.R. 3614, amending the Drug-Free Schools and Communities Act, and H.R. 3611, authorizing $125 million for FY1990 in new military and law enforcement assistance to Bolivia, Colombia, and Peru. Also, a major omnibus crime and drug control bill was enacted (P.L. 101-647). Although significant features were dropped from the final version -- concerning the death penalty, *habeas corpus* in capital cases, the exclusionary rule, and "semiautomatic assault weapons" -- it contained a number of provisions relating to drug law enforcement, regulation, money laundering, treatment, and prevention (including certain "user accountability" measures).

In the 102d Congress, attention was focussed on new omnibus proposals incorporating some of the elements omitted from the Crime Control Act of 1990. Both the Senate and the House passed versions of a crime, drug, and gun control bill (H.R. 3371) during the first session, but the Senate has three times failed to approve cloture so that a vote could be taken on the conference agreement.

Other major aspects of the drug issue were reflected in enactments for foreign assistance (H.R. 6187) and for reauthorizing and modifying the principal treatment and prevention programs (P.L. 102-321, S. 1306).

For additional information, see CRS Issue Briefs 88093, *Drug Control: International Policy and Options*; 88009, *Alcohol, Drug Abuse, and Mental Health Block Grant and Related Programs*; 87139, *Drug Testing in the Workplace: An Overview of Employee and Employer Interests*; and 87174, *Drug Testing in the Workplace: Federal Programs*.

LEGISLATION

P.L. 102-132, H.R. 3259

Authorizes appropriations for drug abuse education and prevention programs relating to youth gangs and to runaway and homeless youth. Introduced Aug. 2, 1991; referred to Committee on Education and Labor. Reported (H.Rept. 102-122), amended, Sept. 26. Passed House, amended, Sept. 30. Passed Senate Oct. 2. Signed into law Oct. 18, 1991.

P.L. 102-140, H.R. 2608

Justice Department Appropriations Act, FY1992. Contains a provision to make permanent the current 75%/25% Federal-State formula used for distribution of funds under the Byrne block grant program. Conference report (H.Rept. 102-233) passed House and Senate Oct. 3. Signed into law Oct. 28, 1991.

P.L. 102-143, H.R. 2942

Department of Transportation and Related Agencies Appropriations Act, 1992. Among other things, requires alcohol and drug testing of safety-sensitive rail, air, trucking and mass transit workers. Passed House, amended, July 24, 1991. Passed

Senate, amended, Sept. 17. Signed into law Oct. 28, 1991. (Related bills: H.R. 3361, S. 676-678.)

P.L. 102-190, H.R. 2100

National Defense Authorization Act, FY1992 and 1993. In addition to other drug control funding authorizations, provides for additional Department of Defense support ($40 million total) for counter-drug activities of Federal, State, local, and foreign law enforcement agencies. Makes clear that the DOD lead role in detection and monitoring of aerial and maritime importation of illegal drugs into the U.S. is to be carried out in support of such agencies. Conference report (H.Rept. 102-311) passed House Nov. 18. Passed Senate Nov. 22. Signed into law Dec. 5, 1991.

P.L. 102-302, H.R. 5132

Dire Emergency Supplemental Appropriations, FY1992. As passed by Senate, but not by conference committee, includes appropriation of an additional $250 million for the "Weed and Seed" program coordinated by the Justice Department, as well as funding of other programs and activities responding to recent events in Los Angeles and Chicago. Reported as an original measure (H.Rept. 102-518) by the House Committee on Appropriations May 12, 1992. Passed House May 14. Referred to Senate Committee on Appropriations May 19. Reported (without written report), amended, May 19. Passed Senate, amended, May 21. House disagreed to Senate amendments and agreed to a conference, June 3, 1992. Conference report agreed to by House and Senate June 18. Signed into law June 22, 1992. (Related bill: S. 2728.)

P.L. 102-321, S. 1306

Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992. Reconstitutes ADAMHA as the Alcohol, Drug Abuse and Mental Health Services Administration (ADAMHSA), with the present agency's research functions transferred to the National Institutes of Health. Makes a number of changes in the ADAMHS block grant program, which would be administered by the new agency, most notably a revision of the formula by which funds are apportioned among the States (intended to "redress the imbalance between urban and rural interest"). Introduced June 17, 1991; referred to Committee on Labor and Human Resources. Reported (S.Rept. 102-131), amended, July 30. Passed Senate, amended, Aug. 2, 1991. Passed House, with contents of H.R. 3698 substituted, Mar. 24, 1992. Senate disagreed to House amendments Mar. 25. House disagreed to conference report (H.Rept. 102-522) May 19 and recommitted it, with instructions, May 28. Conference report (H.Rept. 102-546) passed Senate June 9. Passed House July 1. Signed into law July 10, 1992. (Related bills: H.R. 3698, S. 597.)

P.L. 102-393, H.R. 5488

Makes appropriations for the Treasury Department and other agencies for FY1993. Conference agreement contains a provision to establish a Department of the Treasury Forfeiture Fund. Conference report (H.Rept. 102-919) agreed to in House and Senate Oct. 1, 1992. Signed into law Oct. 6, 1992. [Related bill: S. 3230 (S.Rept. 102-398).]

P.L. 102-484, H.R. 5006

National Defense Authorization Act for FY1993. Under Title X, *Subtitle E -- Counter-Drug Activities*, extends authorization for DOD support to other agencies for counter-drug activities; requires the Secretary of Defense to establish requirements for detection and surveillance systems to be used by the Department; requires the

identification and evaluation of existing and proposed counter-drug surveillance and detection systems and -- based on such evaluation -- preparation of a plan for development, acquisition, and use of improved systems by the armed forces, with a report to be submitted within 6 months of enactment. Reported by House Committee on Armed Services (H.Rept. 102-527) May 19, 1992. Passed House, amended, June 5, 1992. Referred to Senate Committee on Armed Services, June 6. [S. 3114 (Nunn) reported by Armed Services Committee (S.Rept. 102-352) July 31.] Passed Senate, with language of S. 3114, Sept. 19. Conference report (H.Rept. 102-966) agreed to in House Oct. 3. Agreed to in Senate Oct. 5, 1992. Signed into law Oct. 23, 1992.

P.L. 102-XXX, H.R. 5334

Housing and Community Development Act of 1992. Under Title XV (Annunzio-Wylie Anti-Money Laundering Act), requires the Federal depository institution regulatory agencies to take additional enforcement actions against depository institutions engaging in money laundering, and for other purposes. Introduced June 5, 1992; referred to Committee on Banking, Finance, and Urban Affairs. Reported (H.Rept. 102-760), amended, July 30. Passed House, amended, Aug. 11. Passed Senate, with language of S. 3031, Sept. 10. Conference report (H.Rept. 102-1017) agreed to in House Oct. 5. Agreed to in Senate Oct. 8, 1992. Signed into law Oct. 28, 1992 (no public law number assigned yet). [Related bills: H.R. 26, H.R. 6048, S. 305, S. 2733 (S.Rept. 102-282).]

H.R. 11 (Rostenkowski)

Revenue Act of 1992. Contains provisions to establish an interagency council to provide assistance in implementing new authority relating to the establishment of enterprise zones in designated areas, include the Attorney General and the Director of the Office of National Drug Control Policy, and authorize enterprise zone assistance provided under the act to be used for carrying out certain specified anti-crime and anti-drug activities and programs. Introduced Jan. 3, 1991; referred to Committee on Ways and Means. Reported (H.Rept. 102-631), amended, June 30, 1992. Passed House, amended, July 2. Referred to Senate Committee on Finance July 21, 1992. Passed Senate, amended, Sept. 29. Conference report (H.Rept. 102-1034) agreed to in House Oct. 6. Cloture voted in Senate Oct. 8. Agreed to in Senate and cleared for White House Oct. 8, 1992.

H.R. 33 (Dingell)

Drug Testing Quality Act. Establishes standards for certification of laboratories engaged in drug testing. Introduced Jan. 3, 1991; referred to Committee on Energy and Commerce. Reported (H.Rept. 102-302), amended, Nov. 12. (Related bill: H.R. 2422.)

H.R. 463 (Rangel)

Amends Title XIX of the Social Security Act to permit States to elect the option of covering substance abuse treatment services under Medicaid. Introduced Jan. 7, 1991; referred to Committee on Energy and Commerce. (Related bills: H.R. 2489, S. 29, S. 1677.)

H.R. 464 (Rangel)

Establishes a National Commission to Study the Causes of the Demand for Drugs in the United States. Introduced Jan. 7, 1991; referred to Committee on Government Operations. Incorporated into H.R. 3371.

H.R. 548 (Schumer)

Provides for a schedule of implementation of the requirement that treatment for drug dependency be made available to all eligible Federal prisoners desiring it. Introduced Jan. 16, 1991; referred to Committee on Judiciary. Provisions incorporated into H.R. 3371.

H.R. 1264 (Snowe)

Women's Mental Health and Substance Abuse Act. Establishes an Office on Women's Mental Health within the Alcohol, Drug Abuse, and Mental Health Administration. Introduced Mar. 5, 1991; referred to Committee on Energy and Commerce. Similar provisions incorporated into H.R. 2507 as passed by House.

H.R. 1355 (Schulze, Rangel, Coughlin)

Provides for certain Federal monetary awards, payable to persons who provide information leading to the arrest and conviction of individuals for the unlawful sale, or possession for sale, of a controlled substance or controlled substance analog, provides for incentive awards to States payable from certain funds proceeding from forfeitures under Federal drug laws. Introduced Mar. 7, 1991; referred to Committee on Judiciary.

H.R. 1551 (Clement)

Amends the Controlled Substances Act to increase penalties for the distribution of controlled substances at truck stops and rest areas. Introduced Mar. 21, 1991; referred to Committees on Energy and Commerce and on Judiciary. Similar provisions included in H.R. 3371 as passed by House and agreed to by conference committee.

H.R. 1657 (Wise)

Amends title I of the Omnibus Crime Control and Safe Streets Act of 1968 to prevent reprogramming of moneys available for discretionary grants and to limit the amount of the special discretionary fund that may be expended in connection with Federal entities. Introduced Mar. 22, 1991; referred to Committee on Judiciary. Provisions incorporated into H.R. 3371.

H.R. 2116 (Solomon)

Suspends Federal education benefits to individuals convicted of drug offenses. Introduced Apr. 25, 1991; referred to Committee on Education and Labor.

H.R. 2117 (Solomon)

Requires that courts, upon a criminal conviction under the Controlled Substances Act, notify the employer of the convicted person. Introduced Apr. 25, 1991; referred to Committee on Judiciary.

H.R. 2118 (Solomon)

Amends the Anti-Drug Abuse Act of 1988 to eliminate the discretion of the court in connection with the denial of certain Federal benefits upon conviction of certain drug offenses. Introduced Apr. 25, 1991; referred to Committee on Judiciary.

H.R. 2119, H.R. 2120 (Solomon)

Respectively, requires random drug testing of Federal employees and universal testing of prospective Federal employees. Introduced Apr. 25; 1991; referred to Committee on Post Office and Civil Service, with H.R. 2120 also referred to Judiciary and to House Administration. (Related bills: H.R. 2420, H.R. 2421.) [Note: Related

provisions have been offered as House floor amendments to various FY1991 and FY1992 authorization bills (e.g., H.R. 1455, which passed House on May 1, 1991, and H.R. 1988, which passed on May 2). For more detailed information and discussion, see CRS Issue Brief 87174, *Drug Testing in the Workplace: Federal Programs.*]

H.R. 2310 (Rangel)

Requires the Secretary of the Treasury to collect and maintain information concerning U.S. currency confiscated by law enforcement agencies in connection with drug seizures or drug-related money laundering. Introduced May 13, 1991; referred to Committee on Banking, Finance and Urban Affairs.

H.R. 2774 (Conyers)

Provides that one-half of the Justice Assets Forfeiture fund be available for funding community-based crime control programs for drug education, prevention, and demand reduction. Introduced June 26, 1991; referred to Committee on Judiciary.

H.R. 2810 (Michel, Coughlin, Rangel)

Contains provisions designed to expand the Nation's capacity to treat drug dependence and promote drug-free and drug-safe schools; requires statewide drug abuse prevention and treatment plans; and ensures that new Federal grant funds provided for treatment services do not displace State funds. Introduced June 27, 1991; referred jointly to Committees on Energy and Commerce and on Education and Labor.

H.R. 2956 (Mazzoli)

Amends title I of the Safe Streets Act to reduce the amount of non-Federal funds required to be provided for a grant under subpart 1 of Part E. Introduced July 18, 1991; referred to Committee on Judiciary. (Related bills: H.R. 1707, H.R. 2608.)

H.R. 3371 (Brooks, Schumer)

Violent Crime Prevention Act of 1991. As passed, contains 25 titles, with drug control provisions including those to (1) establish a new grant program of emergency assistance to State and local areas suffering a high level of drug-related problems, (2) provide for the possibility of the death penalty for trafficking in very large amounts of drugs (even where no death has resulted), (3) authorize grants and other measures for rural drug enforcement, (4) provide for new penalties for failure, by the operator of any aircraft that has crossed the U.S. border, to respond to an official order to land, (5) provide for penalty enhancement for drug trafficking in a Federal prison, (6) double penalties for drug distribution near or around truck stops or safety rest areas, (7) establish a National Commission to Examine the Root Causes of Drug Abuse in the U.S., (8) extend the special anti-drug trafficking penalties covering schools and playgrounds to include public housing, and (9) authorize grants to States for drug testing of arrestees and condition receipt of other Federal funds by States on implementation of drug testing of prisoners. Also, many provisions of a general nature have drug control implications. (For further detail, see CRS Report 91-737 GOV, *Crime, Drug, and Gun Control: Comparison of Major Omnibus Bills Pending in the 102d Congress.*) Introduced Sept. 23, 1991; referred to Committees on the Judiciary and on Ways and Means. Reported by Judiciary (H.Rept. 102-242, Part I), amended, Oct. 7. Reported by Ways and Means (H.Rept. 102-242, Part II), amended, Oct. 9. Passed House, amended, Oct. 22. Passed Senate with contents of S. 1241 substituted, Nov. 21. Conference report (H.Rept. 102-405) agreed to by House Nov. 27. Cloture motion on

conference report failed in Senate Nov. 27, 1991; second cloture motion failed Mar. 19, 1992.

H.R. 3562 (Guarini)

Amends the Tariff Act of 1930 to authorize the use of certain unobligated moneys in the Customs Forfeiture Fund for use in drug treatment for individuals under criminal justice supervision and for trauma care. Introduced Oct. 15, 1991; referred to Committee on Ways and Means. Reported (H.Rept. 102-633, Part I) June 30. Failed of passage in House, amended, July 8, 1992.

H.R. 3603 (Downey)/S. 4 (Moynihan)

Contains provisions designed to promote family preservation and the prevention of foster care with emphasis on families where abuse of alcohol or drugs is present and to improve the quality and delivery of child welfare, foster care, and adoption services. Introduced Oct. 22, 1991; referred to Committee on Ways and Means. Reported (H.Rept. 102-684, Part I), amended, July 22, 1992, and referred to Committee on Education and Labor. Reported to House (H.Rept. 102-684, Part II), amended, July 31. Passed House, amended, Aug. 6. Referred to Senate Committee on Finance Aug. 11, 1992. S. 4 introduced Jan. 14, 1991; referred to Committee on Finance. (Related bill: H.R. 5600.)

H.R. 3698 (Waxman)

Community Mental Health and Substance Abuse Service Improvement Act of 1991. Reauthorizes programs and activities of the Alcohol, Drug Abuse, and Mental Health Administration. Introduced Nov. 1, 1991; referred to Committee on Energy and Commerce. Reported (H.Rept. 102-464) Mar. 24, 1992. Contents substituted for those of S. 1306, which was subsequently passed, Mar. 24. (Related bill: S. 1306.)

H.R. 4396 (Bliley)

Provides for stricter penalties for committing a crime of violence in the District of Columbia or for distributing drugs in the vicinity of schools in the District; revises standards for bail and pretrial detention in the District. Introduced Mar. 5, 1992; referred jointly to Committees on District of Columbia and on Judiciary.

H.R. 4754 (Gallegly)

Provides for 2,000 additional border patrol agents from military personnel displaced by defense cutbacks. Introduced Apr. 2, 1992; referred to Committee on Judiciary.

H.R. 4776 (Schumer)

Amends the Contract Services for Drug Dependent Federal Offenders Act to provide for additional appropriation authorizations. Introduced Apr. 7, 1992; referred to Committee on Judiciary. Reported (H.Rept. 102-824) Aug. 10. Passed House Aug. 11, 1992.

H.R. 5051 (Stark)

Allows information on prescriptions of drugs that are controlled substances in schedules II, III, and IV to be electronically transmitted to and collected by central repositories of designated State agencies. Introduced Apr. 30, 1992; referred to Committee on Energy and Commerce.

H.R. 5194 (Martinez)

Amends the Juvenile Justice and Delinquency Prevention Act of 1974 to authorize appropriations for FY1993-1996. Includes provisions establishing a new grant program for achieving gang-free schools and communities and for community-based gang intervention. Introduced May 18, 1992; referred to Committee on Education and Labor. Reported (H.Rept. 102-756), amended, July 29. Passed House, amended, Aug. 3. Referred to Senate Committee on Judiciary Aug. 6, 1992.

H.R. 5313 (English)

Omnibus bill "to eliminate the scourge of illegal drugs and fight drug abuse." Introduced June 3, 1992; referred jointly to Committees on Foreign Affairs; Ways and Means; Banking, Finance, and Urban Affairs; Judiciary; Armed Services; Intelligence; Education and Labor; Energy and Commerce; Government Operations; Public Works and Transportation; Merchant Marine and Fisheries; and Science, Space, and Technology.

H.R. 5512 (Rangel, Coughlin)/S. 3066 (D'Amato)

Amends the Controlled Substances Act and the Controlled Substances Import and Export Act with respect to the drug fentanyl, including making certain penalties comparable to heroin violations penalties. H.R. 5512 introduced June 30, 1992; referred jointly to Committees on Energy and Commerce and on Judiciary. S. 3066 introduced July 24; referred to Committee on Judiciary.

H.R. 6187

International Narcotics Control Act of 1992. Consolidates and revises authorities and requirements pertaining to international narcotics control assistance (including the process certifying antidrug efforts of foreign aid recipients and of reporting to Congress on such efforts), with revisions generally designed to provide greater flexibility for the executive branch; exempts narcotics-related military assistance for FY1993 and FY1994 from prohibition on assistance for law enforcement agencies; requires increased reporting on money laundering and precursor chemicals countries; and provides for Export-Import Bank financing of sales of defense articles or services for antinarcotics purposes. Authorizes $147.8 million for FY1993. Essentially similar to H.R. 6018, which was based on Title III of H.R. 2508 (which passed House June 20). Introduced Oct. 6, 1992; referred to Committee on Foreign Affairs, Committee discharged, and bill called up by House by unanimous consent. Passed House by voice vote Oct. 6. Passed Senate and cleared for White House Oct. 7, 1992. [Related bills: H.R. 2508 (H.Rept. 102-96), S. 1435.]

H.Con.Res. 334 (Kolbe)

Expresses the sense of the Congress that the President should take prompt diplomatic action to ensure that joint efforts by the United States and Mexico to combat illegal drug trafficking continue at the current level of cooperation. Introduced June 18, 1992; referred to Committee on Foreign Affairs.

S. 275 (Dole)/H.R. 661 (Crane)

Provides for the implementation of a tariff preference regime affecting certain articles from Andean countries. S. 275 introduced Jan. 29, 1991; referred to Committee on Finance. H.R. 661 introduced Jan. 28, 1991; referred to Committee on Ways and Means. Reported (H.Rept. 102-337), amended, Nov. 19. Similar provisions incorporated into H.R. 1724, which was enacted as P.L. 102-182, Dec. 4, 1991.

S. 676 (Hollings, Danforth)

Provides for testing for the use, in violation of law or Federal regulation, of alcohol or controlled substances by persons who operate aircraft, trains, and commercial motor vehicles. Introduced Mar. 14, 1991; referred to Committee on Commerce, Science, and Transportation. Reported (S.Rept. 102-54), amended, May 2. Passed Senate, amended, May 20. In House, referred jointly to Committees on Public Works and Transportation and to Energy and Commerce, May 21. (Related bills: S. 677, S. 678, H.R. 3361.)

S. 1241 (Biden)

Violent Crime Control Act of 1991. Omnibus, 49-title bill. Contains numerous provisions related to drug control. (For detailed summary, see CRS Report 91-581 GOV, *Crime, Drug, and Gun Control: Summary of S. 1241*; also, 91-737 GOV, *Crime, Drug, and Gun Control: Comparison of Major Omnibus Bills*.) Introduced (as replacement for S. 618) June 6, 1991; placed on the calendar. Passed Senate, amended, July 11. Contents substituted for those of H.R. 3371, and the latter passed by Senate Nov. 21, 1991. (Related bills: S. 618, S. 635/H.R. 1400, S. 1313, S. 1335, S. 1575.)

S. 1250 (Simon)

Illegal Drug Profits Act. Requires Federal and State criminal courts to report to the Internal Revenue Service any individual posting cash bail in excess of $10,000 for criminal offenses involving controlled substances or money laundering. Introduced June 6, 1991; referred to Committee on Judiciary. Incorporated into S. 1241 as passed by Senate and H. R. 3371 as agreed to by conference.

S. 1303 (Mitchell, DeConcini)

Provides for new authority designed to curb violent and drug crimes committed by "outlaw gangs"; establishes new penalties aimed at such groups. Introduced June 17, 1991; referred to Committee on the Judiciary. (Related bill: S. 1337.)

S. 2008 (Hatch, Boren)

Quality Assurance in the Private Sector Drug Testing Act. Establishes Federal standards to ensure quality assurance in private sector drug testing programs. Introduced Nov. 21, 1991; referred to Committee on Labor and Human Resources.

S. 2305 (Thurmond)

Crime Control Act of 1992. Omnibus, 15-title bill. Contains provisions selected from both House- and Senate-passed versions of H.R. 3371, the conference agreement on which was approved during the first session by the House only. Subjects covered include: (1) habeas corpus petitions, (2) procedures for imposing the death penalty under Federal law, (3) Exclusionary Rule modification, (4) State and local law enforcement grants, (5) compensation for victims of crime, (6) use of firearms in committing Federal crimes of violence or drug trafficking crimes, (7) terrorism, (8) control of illegal drugs and precursor chemicals, and (8) sexual violence and child abuse. Provisions without counterparts in the earlier bills relate to the possibility of imposing the death penalty for aggravated murders in the District of Columbia and to additional funding for Federal prison construction. Introduced Mar. 3, 1992; referred to Committee on Judiciary. Contents proposed as an amendment (No. 1795) to S. 652 May 6. (Related bills: H.R. 1400, H.R. 3371, S. 635, and S. 1241.)

S. 2408 (DeConcini)

Limits plea agreements and cooperative agreements that promise reduced sentences or other benefits in exchange for cooperation by drug kingpins and others charged with extremely serious drug offenses. Introduced Mar. 13, 1992; referred to Committee on Judiciary. (Related bill: S. 2356.)

S. 2726 (Biden, Thurmond)

Weed and Seed Implementation Act. Authorizes appropriations for an expanded Weed and Seed Program, coordinated by the Justice Department, for FY1993 and succeeding years. Introduced May 14, 1992; referred to Committee on Judiciary. (Related bills: H.R. 11, H.R. 5678, S. 3026.)

S. 3086 (Lautenberg)

Juvenile Mentoring Act. Encourages development of mentoring programs that link children in high-crime areas with law enforcement officers and other responsible adults. Introduced July 28, 1992; referred to Committee on Judiciary.

S. 3097 (Gorton)/ H.R. 5717 (Schumer)

Chemical Control Amendments Act of 1992. Amends the Controlled Substances Act to further control the diversion of certain chemicals used in the illicit production of controlled substances and to provide greater flexibility in the regulatory controls placed on legitimate commerce in those chemicals. Both bills introduced July 29, 1992 and referred to respective Committees on Judiciary. Similar provisions incorporated into S. 1241 and H.R. 3371. (Related bill: S. 1406.)

OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

February 22, 1993

The Honorable Leon Panetta
Director, Office of Management and Budget
Executive Office of the President
Washington, D.C. 20500

Dear Mr. Panetta:

In my capacity as Acting Director of the Office of National Drug Control Policy (ONDCP), with the statutory responsibility of recommending the program mix and funding levels that should be provided for drug control efforts, I am writing to you concerning the FY 1994 funding levels for drug control programs.

OMB passed back FY 1994 funding levels to Departments and agencies last week. The effect of these levels on funding for drug control -- according to the information provided to us by OMB (and I would note that in prior years ONDCP and OMB worked closely together to develop drug control program funding levels, whereas this year there was no interaction) -- appears to produce a drug budget that is indistinguishable from the Bush Administration's priorities. I am enclosing two tables that show the FY 1994 funding levels.

I understand that the appeals process is currently underway, and I would request that in considering appeals you entertain revisions to the funding levels provided for drug control programs. These funding levels, as currently recommended by OMB, raise several concerns:

1. Total funding for drug control programs appears to increase by 3 percent, or less than inflation.

2. The split between supply reduction programs and demand reduction programs would be essentially identical to that of the previous Administration -- i.e., two-thirds for supply reduction and one-third for demand reduction.

3. Funding for interdiction and source country efforts would increase by 3 percent.

4. Funding for domestic law enforcement, including aid to State and local law enforcement, would increase by 2 percent.

5. Funding for demand reduction activities would increase by 4 percent, or less than 1 percent above inflation. Although there is apparently $150 million provided for an unspecified treatment initiative, no new funds are provided for prevention activities in the Department of Education or the Department of Health and Human Services.

Although the Administration has not yet formally promulgated a National Drug Control Strategy, the levels I have noted above, if they are accurate, would appear to be inconsistent with positions identified this fall by the current Administration, although they would seem to be in accord with the priorities of the previous Administration. I would thus request that in considering Department and agency appeals OMB take these concerns into account. We would be more than happy to work with OMB in developing the funding levels for drug control programs.

Sincerely yours,

Bruce Carnes
Acting Director

Enclosures

cc: Ricia McMahon
Jose Cerda

NATIONAL DRUG CONTROL BUDGET SUMMARY

Agency Funding Levels

($ Millions)

	FY 1992 Actual	FY 1993 Enacted	FY 1994 Est. OMB Passback	93–94 % Change
Action	**$10.0**	**$10.4**	**$10.4**	**0%**
Agency for International Development	**258.8**	**139.9**	**89.9**	**–36%**
Department of Agriculture				
Agricultural Research Service	6.5	6.5	6.5	0%
U.S. Forest Service	9.4	9.6	9.9	4%
Total, Agriculture	**15.9**	**16.0**	**16.4**	**2%**
Department of Defense	**1236.1**	**1140.6**	**1204.0**	**6%**
Department of Education	**715.2**	**701.0**	**701.0**	**0%**
Dept. of Health and Human Services				
Administration for Children and Families	111.0	118.5	88.6	–25%
Substance Abuse and Mental Health Administration & NIDA	1609.9	1706.9	1856.9	9%
Centers for Disease Control	28.6	31.2	31.2	0%
Food and Drug Administration	6.7	6.8	6.7	–1%
Health Care Financing Administration	201.8	231.8	231.8	0%
Indian Health Service	35.2	44.9	44.9	0%
Total, HHS	**1993.3**	**2140.2**	**2260.2**	**6%**
Dept. of Housing and Urban Dev.	**165.0**	**175.0**	**175.0**	**0%**
Department of the Interior				
Bureau of Indian Affairs	22.7	23.9	27.7	16%
Bureau of Land Management	8.9	10.0	10.0	0%
Fish & Wildlife Service	1.0	1.1	1.1	–2%
National Park Service	11.1	9.1	9.1	0%
Office of Territorial and International Affairs	1.5	1.4	1.4	1%
Total, Interior	**45.2**	**45.6**	**49.4**	**8%**
The Judiciary	**359.9**	**406.9**	**491.5**	**21%**
Department of Justice				
Assets Forfeiture Fund	412.0	498.3	437.9	–12%
U.S. Attorneys	206.7	200.9	225.3	12%
Bureau of Prisons	1296.5	1308.2	1399.9	7%
Criminal Division	20.4	20.1	21.8	8%
Drug Enforcement Administration	730.3	731.0	734.0	0%
Federal Bureau of Investigation	222.6	200.7	214.6	7%
Immigration and Naturalization Service	141.2	146.1	142.9	–2%
Interpol	1.9	1.9	2.0	5%
U.S. Marshals Service	217.6	233.3	238.9	2%
Office of Justice Programs	543.1	541.3	555.0	3%
Organized Crime Drug Enforcement	363.5	385.2	391.4	2%
Support of U.S. Prisoners	164.1	185.8	192.3	3%
Tax Division	1.1	1.2	1.4	20%
Exec. Office for Weed and Seed	0.0	6.6	6.8	3%
Total, Justice	**4321.1**	**4460.7**	**4564.2**	**2%**

NATIONAL DRUG CONTROL BUDGET SUMMARY
Agency Funding Levels
($ Millions)

	FY 1992 Actual	FY 1993 Enacted	FY 1994 Est. OMB Passback	93–94 % Change
Department of Labor	58.5	70.5	70.5	0%
Off. of National Drug Control Policy	124.7	118.5	91.8	–23%
Small Business Administration	0.1	0.2	0.0	–100%
Department of State				
Bureau of International Narcotics Matters	147.8	147.8	147.8	0%
Bureau of Politico/Military Affairs	75.0	52.3	53.3	2%
Emer. in the Dip. and Consular Service	0.5	0.8	0.8	0%
Total, State	223.3	200.9	201.9	0%
Department of Transportation				
U.S. Coast Guard	523.2	501.6	501.6	0%
Federal Aviation Administration	23.1	21.8	24.7	13%
National Highway Traffic Safety Administration	8.4	7.7	7.7	0%
Total, Transportation	554.7	531.1	534.0	1%
Department of the Treasury				
Bureau of Alcohol, Tobacco, and Firearms	135.9	152.4	152.4	0%
U.S. Customs Service	785.8	563.0	563.0	0%
Federal Law Enforcement Training Center	16.3	21.9	21.9	0%
Financial Crimes Enforcement Network	14.1	16.9	16.9	0%
Internal Revenue Service	105.2	111.1	111.1	0%
U.S. Secret Service	43.3	55.2	55.2	0%
Treasury Forfeiture Fund	0.0	191.6	191.6	0%
Total, Treasury	1100.6	1112.0	1112.2	0%
U.S. Information Agency	9.7	10.1	10.1	0%
Department of Veterans Affairs	692.9	757.4	783.9	4%
Total Fed. Program	$11,884.9	$12,037.0	$12,366.4	3%

National Drug Control Budget by Function
FY 1984 - FY 1994
($ Millions)

Three Way Split	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 94 Passback	FY93 - FY94 Change $	FY93 - FY94 Change %
Domestic Law Enforcement	$776.3	$979.2	$1,120.9	$1,807.5	$2,067.3	$2,839.6	$4,342.2	$4,601.4	$5,228.5	$5,542.0	$5,651.1	$109.1	2%
	32.9%	35.6%	38.9%	37.7%	43.9%	42.6%	44.5%	41.9%	44.0%	46.0%	45.7%		
International/Interdiction	802.7	916.5	891.7	1,571.4	1,157.4	1,744.7	2,252.0	2,661.4	2,745.4	2,357.0	2,425.5	68.5	3%
	34.0%	33.3%	31.0%	32.8%	24.6%	26.2%	23.1%	24.3%	23.1%	19.6%	19.6%		
Demand Reduction	784.1	855.2	868.4	1,413.3	1,483.1	2,077.6	3,162.3	3,710.8	3,911.0	4,138.0	4,289.8	151.8	4%
	33.2%	31.1%	30.1%	29.5%	31.5%	31.2%	32.4%	33.8%	32.9%	34.4%	34.7%		
Total	**$2,363.2**	**$2,750.9**	**$2,881.0**	**$4,792.2**	**$4,707.8**	**$6,661.8**	**$9,756.5**	**$10,973.5**	**$11,884.9**	**$12,037.0**	**$12,366.4**	$329.4	3%

Office of National Drug Control Policy

February 18, 1993

To: Jose Serda

From: Sue Thau

3 pages to follow

Call (202) 966-4361, if there is a problem

TO: Molly Brostrom
FROM: Sue Thau
SUBJECT: Request for PITCH to present to the Substance Abuse, Big Benefits and Underserved Population Groups

Per our conversation on Monday, attached is a two pager describing who Pitch is and what our President, Val Jackson would like to discuss with the three groups cited above.

Please contact me at (202) 966-4361 to schedule appointments for Val Jackson to present to the above cited groups, if they are interested.

I look forward to hearing from you soon. Thanks for your help!

HEALTH CARE REFORM
A CASE FOR INCLUSION OF A SUBSTANCE ABUSE CONTINUUM OF CARE

The PREVENTION, INTERVENTION AND TREATMENT COALITION FOR HEALTH (PITCH) is a national coalition of agencies, individuals and groups dedicated to helping people who are at high risk for, or who are involved with alcohol, tobacco and other drug abuse. The members of PITCH work in neighborhoods across the country and have day to day contact with families whose lives and well being are impacted by alcohol, tobacco and other drugs. Many of these individuals and families are the under and uninsured Americans who are a major focus of President Clinton's Healthcare Reform.

There are a number of groups who represent the providers of alcohol, tobacco and other substance abuse services. Some of them have presented to the Task Force about treatment issues in Health Care Reform. PITCH is the only organization that consistently speaks about prevention and reduction of risk factors as a key part of the substance abuse continuum.

PITCH believes that healthcare reform without an array of prevention services is like chasing a locomotive without brakes down a hill. Healthcare reform will be out of control before it has a chance to be successful.

PITCH would, therefore, like to discuss the following issues with the Task Force:

1) ***The known high risk factors of people who are currently under or uninsured. The Center for Substance Abuse Prevention has identified a set of high risk factors that indicate the likelihood of someone abusing substances...a behavior that is a common denominator of greatly escalated health and social services costs. Untreated substance abusers use ten times the insurance benefits for health care than people without that diagnosis. AIDS, teen pregnancy, impaired physical health, tobacco use, delinquency, crime, domestic violence,traffic injury and death, homicide, and suicide are a short list of other expensive consequences;***

   The community-based prevention movement, consisting of nonprofit citizens' organizations, has worked since the mid 70's to prevent drug use before it starts. Analysts have estimated that these prevention services have saved at least $16 billion in treatment costs to 2.5 million people since 1978, because fewer young people used illicit drugs.

2) ***The care of high risk individuals can be most successful if health care reform provides for an array of prevention services for the insured.***

3) ***An array of prevention services when matched with high risk symptoms can be very effective in cutting health care costs. Studies have shown, for instance, that children are less likely to begin using drugs at an early age if they receive prevention skills including resiliency training, alcohol and other drug abuse information and, for economically deprived children, alternative activities. The evidence suggests that early***

initiation of alcohol and other substance abuse is among the strongest predictors of serious chronic substance abuse. Other studies have documented that comprehensive community and school based prevention programs and policies have cut in half the likelihood that young people will become involved with alcohol, tobacco and other drugs.

4) An army of prevention services can be implemented in a managed healthcare setting through:

a) Incentives for communities to adopt policies that have shown to decrease alcohol, tobacco and other substance abuse;

b) Early, routine, identification of high risk children and adolescents combined with an assessment and prescription for risk reduction;

c) A set of contracted community-based services, including parent education for substance abuse risk reduction information, education, skill building, alternatives and training, available to healthcare managers. These proven programs can counter high risk behavior before expensive healthcare response must be implemented;

5) Recommendations to pay for prevention services.

a) Some or all of the funds currently utilized for prevention services may be redirected to help pay for universal health care. While PITCH supports, without reservation, the goal of health care for all, particularly health care that includes substance abuse treatment for all who need it, ways must be found to continue the financial support for community-based prevention, so as to continue to reduce the number of people who will need treatment. We propose two options for such support: 1) designating for prevention a share of any new taxes that may be levied on alcohol and tobacco products to pay for health care reform and 2) designating for primary prevention a share of any asset forfeited or seized in conjunction with illicit drug trafficking.

b) Because the federal government is contemplating tax increases on both alcohol and tobacco, and because mechanisms are already in place for asset forfeiture funds to go into the federal treasury, there is an opportunity to model this to state, county and municipal governments as well, thus making funds available to replicate programs and approaches shown to be effective through the categorical demonstration grants.

c) If the Federal Government would dedicate $1 per week to preventative services for children and youth in this country, we could invest in our future and, in the process, save billions of dollars now spent on healthcare.

From Ricia McMahon

NEW
STANDARDS
INCORPORATED

Building Trust and Understanding for Outcomes Measurement

February 27, 1993

Ms Ricia McMahon
Office of National Drug Control Policy
750 Seventeenth Street, N.W.
Washington, D.C. 20500

Dear Ms McMahon:

As per our phone conversation, I am sending a short information piece designed for business leaders, legislators, and other lay audiences and my vita. Over a decade of experience as a clinical auditor and applied research scientist has given me the opportunity to work with providers and public agencies throughout the United States, Canada, and parts of Europe. The auditing role gives one a perspective based on empirical evidence obtained from a point of relative impartiality. I would appreciate the opportunity to share more of my observations from this perspective with you and others from your office.

My evaluations have been in the addictions and mental health field, but some principles would seem to apply to areas of medicine beyond behavioral health. I argue that some ills of the general health care delivery system in the United States center on the following:

* Lack of basic outcome accountability - Routine outcome auditing of clinical practice is relatively rare so that we do not have sound empirical baselines for expected results. The recent findings concerning mammograms are a case in point. An annual mammogram appears to be beneficial for older women, but can engender a false sense of security without good detection in younger women. The failure to require routine audits of clinical care is analogous to investing in businesses which have no an annual financial audits.

* Failure to provide rational incentives to balance efficacy and efficiency - The fee for service model of health care placed the emphasis on providing what was perceived necessary for maximal recovery without much regard for cost. Many of the HMO and managed care models place the emphasis on cost containment but have minimal, if any, incentives to achieve average, much less optimal, results.

* Excessive reliance on isolated clinical trials - Controlled clinical trials conducted with standard research methodologies are essential for some types of research work; however, they are not sufficient to establish and monitor standards of care. Academic research does not require sufficient replication of work by independent researchers nor does it guarantee that the findings of in the lab can be effectively translated into routine care. Monitoring of care as it is actually delivered in routine practice can provide practical outcome baselines.

* Failure to consider returns on health care investments - Three areas of health care come to mind which actually can return more to the health care system than they cost: immunizations, addictions treatment, and mental health services. To my knowledge, only these three areas have demonstrated consistent returns in terms of reducing the net health care cost. For example, medical costs after addictions treatment drop dramatically and are proportional to the recovery from the addiction. In contrast organ transplants are extremely costly and result in continued costs to the health care system. If containment of health care cost is the goal, perhaps we should pay more attention to funding services which affect many individuals and cut overall costs.

Public policy ideally is based on sound empirical data. Like playing the piano, the theory is simple (hit the right key at the right time for the right length of time); the execution is the difficult part.

Nowhere is the theory versus execution gulf greater than in prevention. We as a nation have expended large sums and great efforts on a variety of prevention models only to find that touted results have been transitory. My experiences in reviewing and conducting prevention evaluations has suggested several weaknesses in our approaches to prevention.

* The possibility of multiple etiologies - Different behaviors may have different etiologies. That is, initiation of use, continuation of use, development of a disorder, and relapse all may have distinct etiologies within the same person. Furthermore, population subgroups may differ in etiologies or the etiologies may be modified by age. For example, the Minnesota Student Survey of 1989 found that children in grade school appear more likely to begin using alcohol to escape from unpleasant feelings while high school aged children may be more likely to initiate use as a result of peer pressure and experimentation.

* Looking for a score rather than a foundation - Most efforts are focused on the reduction of a target behavior such as use of alcohol, tobacco, or other drug. However, if the evaluation is done properly, we should also learn why a given approach did or did not appear to work and not just whether the prevention effort could demonstrate an effect. Many people view evaluation only as giving a score at the end of

the project and do not allocate sufficient evaluation resources to develop a foundation for better efforts in the future.

I would appreciate the opportunity to share additional perspectives with you and others in your organization. As one who has had to demonstrate the value of his services to clients in both the private and public sector, I think that my expertise as an auditor, scientist, and marketer may be of interest to you and of service to the Office of National Drug Control Policy.

At a minimum, I suggest we communicate further in a sharing of ideas. If there is a possibility for a more formal relationship, I would welcome your counsel. Thank you for your time and consideration.

Sincerely,

Norman G. Hoffmann

Norman G. Hoffmann, Ph.D., L.P.

ADDICTIONS TREATMENT:

Wise Investment Yields Excellent Returns

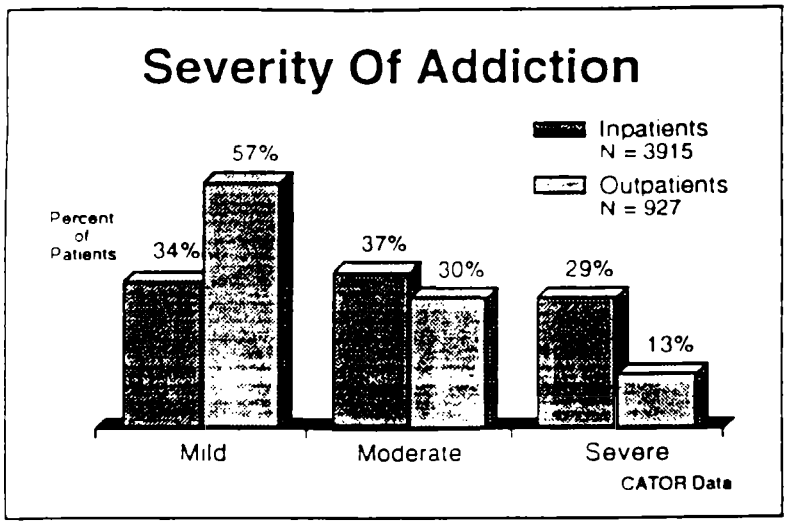
by
Norman G. Hoffmann, Ph.D.

- Better-prognosis patients can be treated in less costly outpatient programs to save resources for those who do require inpatient services.
- For best results, addictions should be treated as chronic illnesses, with a formal continuum of care extending at least one year.
- Job problems show marked reductions after treatment, yielding a marked savings for employers.
- Hospitalization rates are cut in half after treatment; medical care cost reductions offset a major portion of treatment expenses.
- Auto accidents and arrests decrease two-to fourfold after treatment, with corresponding potential savings in insurance and public safety costs.
- Treatment benefits are proportional to the recovery rates achieved.

In Short:

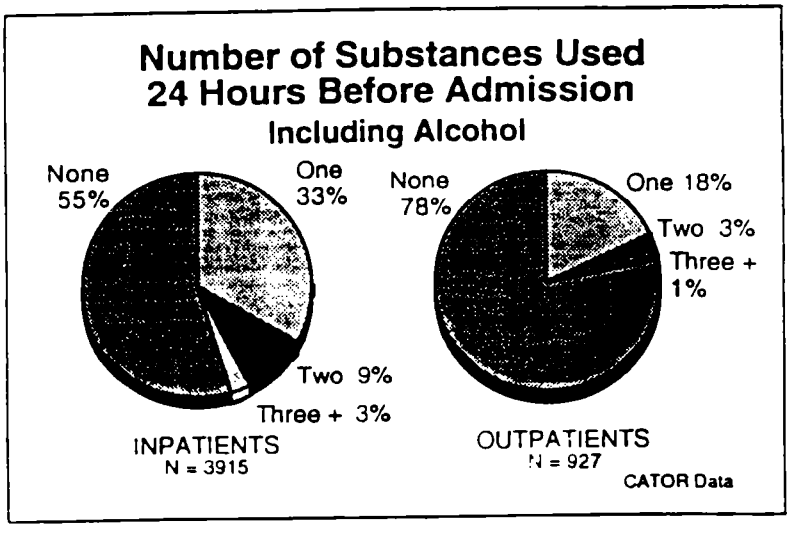
1. **Proper treatment placement yields efficient use of services.**
2. **An adequate continuum of care enhances treatment outcomes.**
3. **Successful treatment is the most cost-effective.**
4. **Addictions treatment has the potential to pay back more than its cost.**

1993
Data source: CATOR a division of New Standards, Inc.
1080 Montreal Avenue, Suite 300
St. Paul, MN 55116
1-800-755-6299



Inpatient Treatment serves a more impaired population.

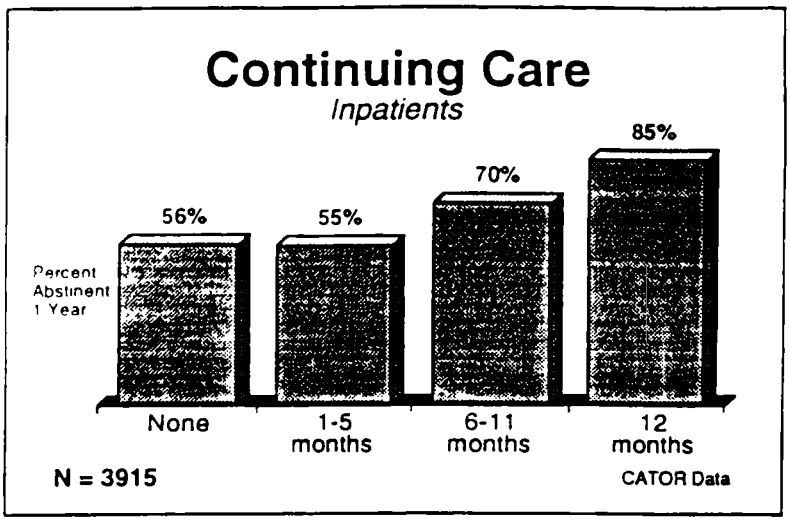
Recent use may require medical supervision and suggest greater relapse risk.

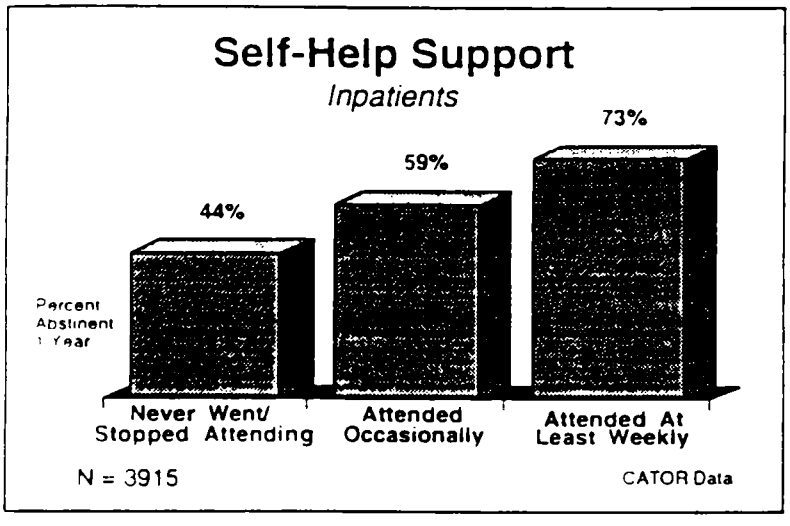


Inpatients tend to be more severely affected by their addiction, as manifested by more late-stage alcoholism symptoms, greater variety of drug use, greater need for medical services, and more impairments in a variety of life areas. The issue here is not whether outpatient treatment is as good as inpatient but rather, which level of care is required to best begin the journey to recovery.

The most logical strategy would be to treat all those individuals capable of benefiting from outpatient services as outpatients and reserve inpatient services for those who require close clinical supervision to maintain abstinence or whose environments are so disruptive that residential care is indicated. The rationale for this strategy is compatible with other areas of medicine and the concept of using the least restrictive or intrusive services possible. However, this does not imply that outpatient treatment should always be tried first. Individuals who are severely impaired should logically be treated at the level of care necessary at that time. **National criteria for placement, continued stay, and discharge readiness are currently available to assist in the placement process**(1).

After acute care a continuum of weekly care provides the best results.

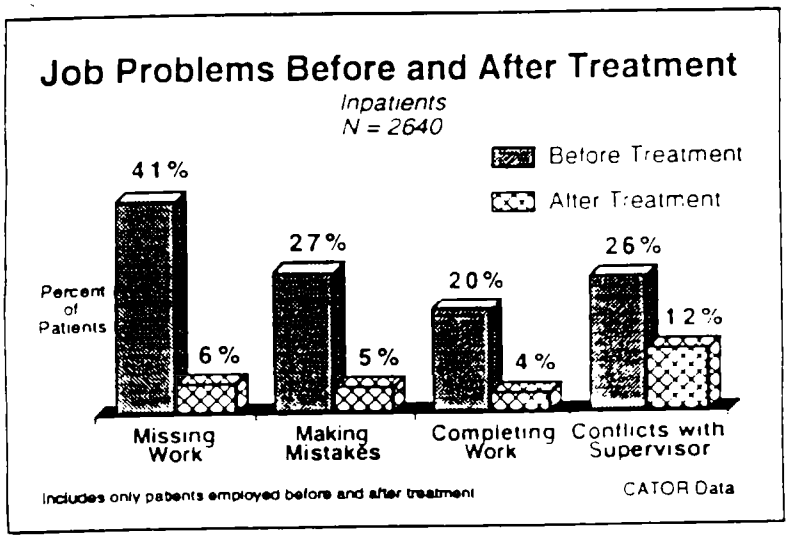




Self-help group attendance should be encouraged.

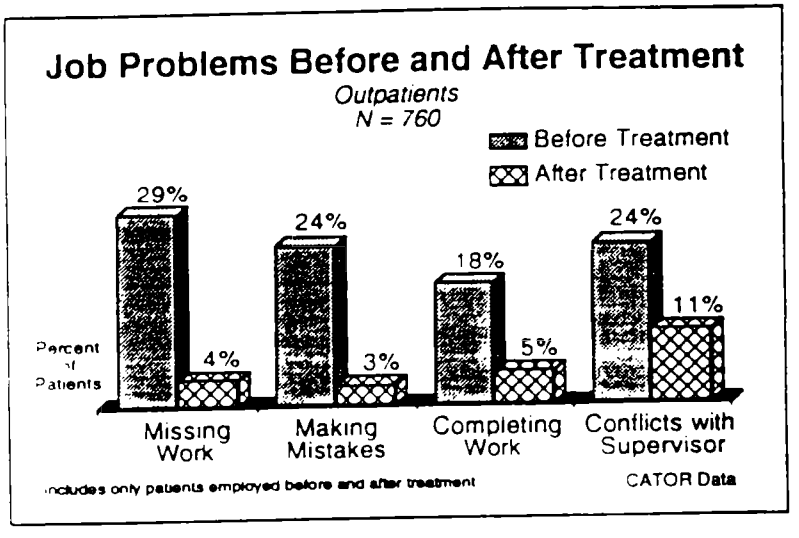
Whether the patient is treated initially as an inpatient or an outpatient, continued professional contact with the patient for a year yields the best results (2). Patients tend to encounter a variety of emotional, interpersonal, and other problems in the first year after beginning treatment that contribute to the risk of relapse. Self-help support group attendance can make an important contribution to recovery (3), but a combination of adequate support systems and professional services provided as necessary appears to yield the best results (2).

About 60% of patients maintain total abstinence from alcohol and other drugs during the first year. However, as these data demonstrate, such a statistic is relatively meaningless in view of the range of recovery rates associated with both self-help and utilization of a continuum of care. Patients who do not use either self-help or continuing care for a minimum of six months after acute care have less than a 50% probability of remaining abstinent for the first year. In sharp contrast, those who do have an 80% probability of recovery.



Work problems show dramatic improvements after treatment.

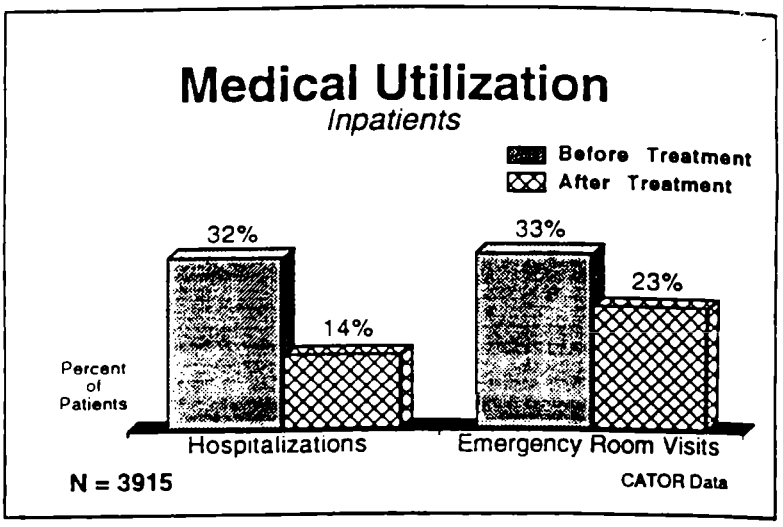
These changes demonstrate definite benefits for employers.

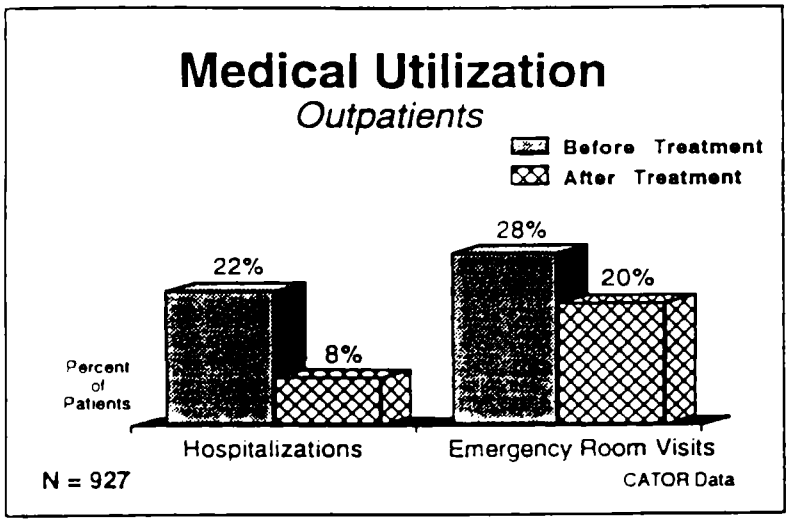


Dramatic improvements in vocational functioning have been documented in more than a cade of treatment evaluation. Work absenteeism is consistently cut dramatically after treatment ,5,6). Completion of work and mistakes can be costly to both employer and employee. In addition, nflicts with supervisors and peers also are likely to cause disruption at the work place. Employees who ve completed treatment are much less likely to report problems at the work place. Job-related problems e just one of the areas where treatment is capable of demonstrating cost offsets for employers.

In view of the data presented on the continuum of care, treatment results are likely to be much tter with at least one year of continued services. Employers should insure not only that their workers e adequately covered for such a continuum of care, but also make participation in such care a quirement. A very high proportion of workers who participate in a continuum of care return to the job ean and sober.

Addictions treatment can help contain total health care costs.





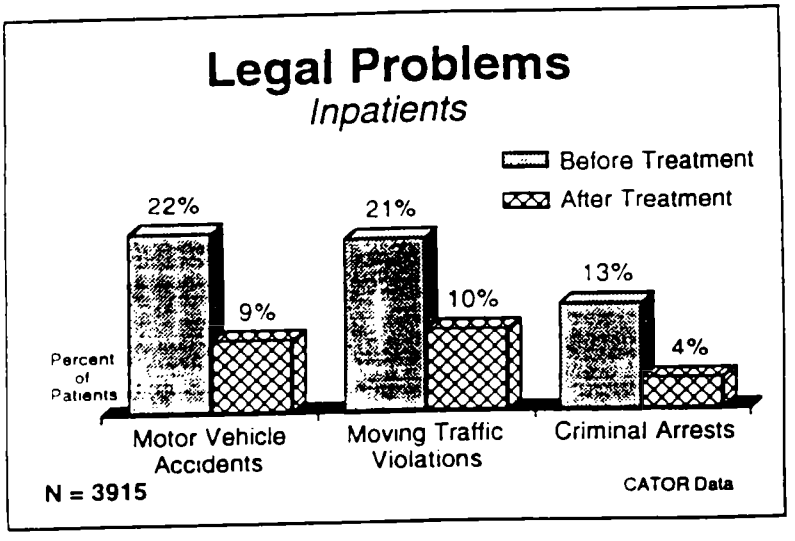
Addictions treatment can have a net benefit for health care.

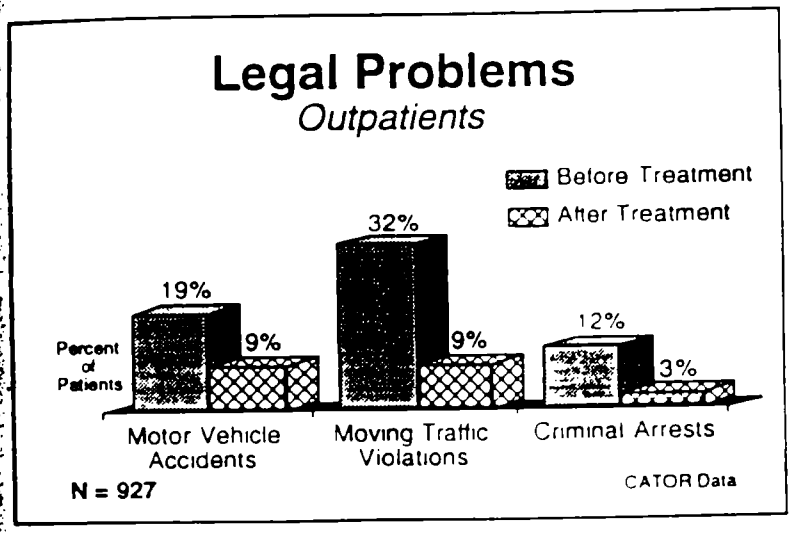
Reductions in medical care utilization are a critical benefit of addictions treatment (7,8,9). Expensive medical services such as hospitalizations and emergency room use are significantly reduced after addictions treatment. Medical and psychiatric admissions tend to drop by half, and admissions for detoxification are reduced by a much greater margin.

A significant portion of our medical care costs are dedicated to the treatment of the side effects of addictions. Although alcoholics are estimated to constitute about 10% of the adult population, they account for between 20% to 30% of all medical hospital admissions (10). A substantial proportion of all accidents, suicide attempts, and assaults are attributed to alcoholism or other addictions.

Treatment for addictions actually is one of the few areas of health care where a service has the potential of making a long-term contribution to the reduction of health care costs. Adequate cost-effective treatments are available. If properly used, they may help keep health care costs in check.

A decrease in auto accidents benefits every driver.

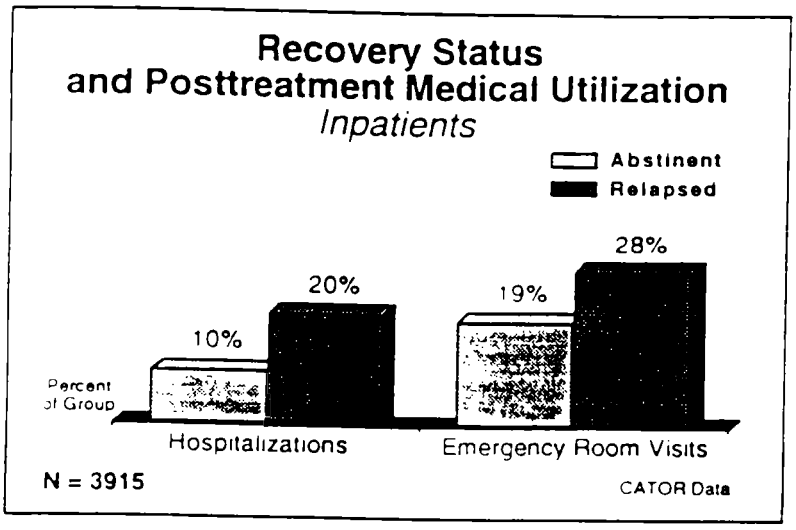




Addictions treatment is part of the solution to crime.

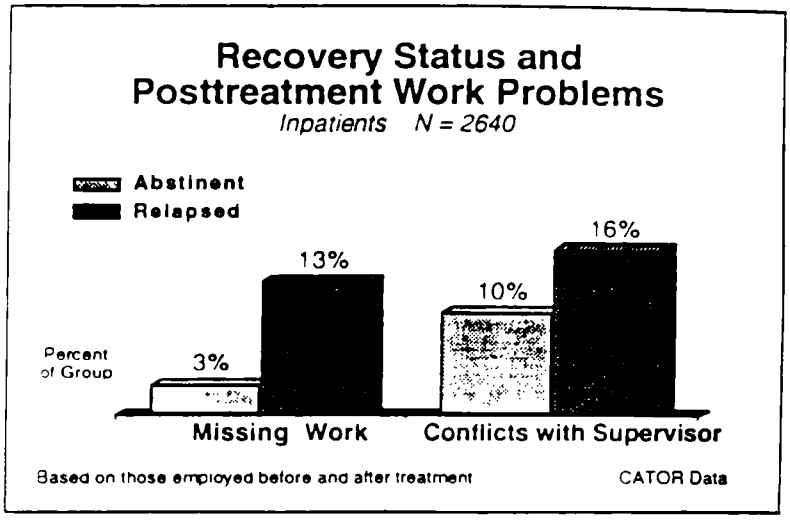
Addictions treatment provides benefits in a wide range of areas. The reductions in motor vehicle accidents have relevance to everyone who drives a car. The high accident rates of the addicted individuals result in increased premiums for all drivers. Despite efforts to discourage drunken driving, addicts still compose a disproportionate number of cases of auto fatalities. Addicts who are referred to treatment as a result of a DUI conviction are just as likely to be successful in recovery as non-coerced patients. This is evidence that treatment should be more widely considered as part of the effort to reduce the drunken driver problem (11, 12).

The reductions in all types of arrests suggest that we as a society should be placing more emphasis on treatment as part of the solution for crime rather than expecting law enforcement to be a solution for addictions.



Maximum benefits are derived from successful treatment.

Optimal benefit for best cost should be the goal for purchasers of treatment services.



Successful treatment provides more benefits than unsuccessful treatment. **Patients who remain abstinent for one year have significantly fewer work problems, require less medical care, and are less likely to have an auto accident or to be arrested than those who relapse.**

The fact that successful treatment is the most cost-effective would seem to be self-evident, but many policies of employers, insurers, and managed-care companies do not reflect this reality. The continuum of care is often too limited or the financial incentives such that post-acute care service utilization is discouraged. In addition, the focus on placement and continued stay is almost exclusively on how little service can be provided rather than the overall perspective on what services are likely to produce the optimal results for a given cost. This would be analogous to a business that always buys the cheapest product without regard to quality. A variety of logistic, economic, and environmental factors, in addition to clinical parameters, affect treatment utilization and placement (13). More emphasis should be placed on clinically justified placement and the continuum of care indicated by empirical evidence.

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Further information can be obtained from
New Standards, Inc.
1080 Montreal Avenue, Suite 300
St. Paul, MN 55116
Phone: (612) 690-1002

March 2, 1993

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear First Lady Clinton:

We applaud your leadership and dedication to confronting our nation's serious health care crisis. We are writing to urge your strong support for benefits for treating and preventing alcoholism and other drug dependencies in national health care reform. We look forward to working with you and hope we can help you as you grapple with our nation's serious health problems.

The undersigned organizations work on alcohol and other drug prevention, treatment and research, maternal and child health, child welfare, AIDS, women's and legal issues. We are all dedicated to improving the lives of families and believe that untreated alcohol and other drug problems present one of the greatest threats to family functioning and health.

Millions of Americans -- especially underserved populations in the inner cities and rural communties -- have alcohol and other drug problems and are not able to get treatment. In the last few years, the problem has grown worse. The Institute of Medicine reported in 1990 that each year 2 to 3 million individuals with alcohol and other drug problems need but cannot obtain treatment.

The costs of untreated alcohol and other drug problems are enormous. The Bush Administration estimated that they cost our country nearly $300 billion annually in lost productivity and wages.

Prevention and treatment will save lives, families and money. A University of California study found that every $1 spent on alcohol and other drug treatment saves society $11.54 in health care and criminal justice costs, and lost productivity for business. Prevention works. It can prevent young people from starting to use alcohol and other drugs and can consistently keep rates of use down.

We cannot afford health care reform without alcohol and other drug prevention and treatment benefits. We urge you to include these benefits in our nation's health care reform package and look forward to assisting you in this monumental effort. Please feel free to call Susan Galbraith or Ellen Weber at the Legal Action Center at 202-544-5478 if you have questions or need more information.

Sincerely,

AIDS Action Council
AIDS National Interfaith Network
Alcohol and Drug Problems Association
American Association for Marriage and Family Therapy
American College of Nurse-Midwives
American Counseling Association
American Public Health Association
American Society of Addiction Medicine
Association of Maternal and Child Health Programs
Center for Science in the Public Interest
Center for Women Policy Studies
Child Welfare League of America
Coalition on Addiction, Pregnancy and Parenting
Council of Jewish Federations
Employee Assistance Professionals Association
Family Service America
Legal Action Center
International Certification Reciprocity Consortium for Alcohol and Other Drug Abuse
March of Dimes
National Abortion Rights League
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Association of Counties
National Association of Protection and Advocacy Systems
National Association of State Alcohol and Drug Abuse Directors
National Coalition of State Alcohol and Drug Treatment and Prevention Associations
National Coalition for the Homeless
National Council on Alcoholism and Drug Dependence
National Drug Strategy Network
National Family Planning and Reproductive Health Association
National Treatment Consortium for Alcohol and Other Drugs, Inc.
National Women's Health Network
Nations Health
Therapeutic Communities of America
Women's Legal Defense Fund
Youth Work Center

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 510 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

March 5, 1993

The Honorable Anthony Beilenson
U.S. House of Representatives
Washington, DC 20515-0523

Dear Representative Beilenson:

The undersigned organizations are writing to urge you during the mark-up of the Budget Resolution to redirect all or a substantial portion of the approximately $3 billion now spent on ineffective international counter-narcotics and interdiction efforts to the Department of Health and Human Services for drug and alcohol treatment and prevention services. Specifically, we urge you to transfer the following sums to create desperately needed services for women and children, youth, individuals at high risk for HIV disease and individuals involved in the criminal justice system.

* the $1.14 billion currently allocated to the Department of Defense interdiction and counter-drug activities;

* the approximately $700 million remaining in the Andean Drug Initiative; and

* the $1.1 billion currently allocated to Coast Guard and Customs Service.

Experts agree that our Nation's drug problem is driven by demand for drugs, not supply. Accordingly, in these times of limited resources, it is essential that funds go to only those drug control efforts that reduce demand effectively.

Treatment and prevention reduce the demand for drugs and criminal activity associated with such use. Studies have documented that a substantial number of individuals -- between 56% and 75% depending on the treatment modality -- stopped using heroin and cocaine after treatment. In addition, one study on criminal justice recidivism rates reported a 74% drop in arrest rates for clients who received treatment.

International counter-narcotics and interdiction efforts, on the other hand, have very little effect on reducing the supply of illegal drugs in the United States. According to the General Accounting Office, the billions of dollars funnelled into the Coast Guard and Customs Service's interdiction

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efforts and the Department of Defense's international counter-narcotics activities have not reduced drug flow into the United States and will not do so regardless of how effectively these programs are carried out. Moreover, these efforts cannot reduce demand because supplies cannot be reduced sufficiently to affect market price or put a dent in the relatively minute amount of drugs needed to satisfy total consumption in the United States.

Treatment, prevention and research will reduce the demand for drugs if services are provided to children and youth, women of childbearing age and individuals in the criminal justice system who want and need services. We, therefore, urge you to shift the above funds to critical drug and alcohol treatment, prevention and research efforts as part of the FY 1994 Budget Resolution.

Thank you for consideration of our views.

Sincerely,

AIDS Action Council
American Psychological Association
American Public Health Association
Center for Science in the Public Interest
Children of Alcoholics Foundation
Child Welfare League of America
Legal Action Center
National Association of Alcoholism and Drug Abuse Counselors
National Association of Addiction Treatment Providers
National Association of State Alcohol and Drug Abuse Directors
National Coalition of State Alcohol and Drug Treatment and Prevention Associations
National Council on Alcoholism and Drug Dependence
National Council of Community Mental Health Centers
National Drug Strategy Network
Prevention, Intervention and Treatment Coalition for Health
Therapeutic Communities of America

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MODEL LEGISLATION MANDATING NATIONAL HEALTH INSURANCE BENEFIT FOR PREVENTION AND TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION Revised 2/12/93

I. INTRODUCTION AND PURPOSE

Alcoholism and drug dependencies can be prevented and treated effectively at low cost but, if they are left untreated, society will very quickly pay a much higher price. Though various national health care reform bills provide health benefits for the illnesses caused by alcoholism and drug dependencies, few cover drug and alcohol prevention and treatment itself.

The adverse social consequences of alcohol and other drug problems are associated with considerable economic costs. In the most recent comprehensive economic analysis, conducted in 1983, the cost of alcohol problems in America were estimated to exceed $70 billion per year, with the majority of these costs attributed to reduced productivity. An additional $44 billion in economic costs were attributed to drug problems. Prevention, early intervention and treatment will save billions of dollars each year.

The purpose of this proposal is to ensure that coverage of alcoholism and drug addictions prevention and treatment will be included in all proposals mandating private and/or public health insurance coverage for individuals and families. If coverage is not provided, our society will pay far more for the health care, social and economic problems that result from alcohol and drug problems.

This model outlines the necessary components for a comprehensive continuum of care. Individuals will be assessed for the severity of their addiction, and enter treatment at the level appropriate for their medical and psychosocial needs. This continuum of care is necessary for effective prevention and treatment whether it is provided through private or public sector programs.

All individuals should have access to the appropriate level of care for treatment of their addiction whether their payment source is private insurance, Medicaid, Medicare or federal and state dollars dedicated to treatment. Federal, state and local financing will continue to be needed to address larger issues related to poverty such as housing, unemployment and education.

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It may become necessary to have substantial co-payments in order to limit excessive use of health care services. In that event, wealthier individuals should pay a higher proportion of their health care costs themselves. This could be achieved by having the co-payment percentage rise with income. The poor should not be deprived of health care because of their inability to pay. The lowest income members in society could be protected through an exemption from co-payment requirements for those below a certain income level. No co-payment should be required for preventive services.

II. SPECIFICATIONS OF PREVENTION AND TREATMENT FOR ALCOHOL AND DRUG ABUSE AND DEPENDENCE

Coverage for the prevention and treatment of alcohol and drug abuse and dependence shall be comprehensive and allow for services in the setting most appropriate for each individual. Individualized assessments should be based on clinical necessity and govern the intensity and duration of treatment.

The system of care must take into account that individuals entering treatment have diverse needs, some requiring prevention, some rehabilitation and others requiring more intensive habilitation efforts. While most individuals will not require all the services outlined in the model, the model should be flexible enough to accomodate individuals with diverse needs. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, will be provided for children.

At the minimum, benefits should allow for the following services, **with appropriate applications of individualized services through case management:**

(1) prevention - clinical screening, health promotion and education on risks of drug and alcohol use;

(2) intervention - including assessment, diagnosis, and referral;

(3) detoxification - 10 days of treatment in a hospital, non-hospital, or ambulatory detoxification program as medically necessary in any calendar year, unless medical complications require additional days;

(4) outpatient treatment - a full continuum of outpatient services should be provided including:

a. intensive day and evening treatment: 40 days in any calendar year;

b. outpatient - 60 visits in any calendar year;

c. continuing care - 60 visits in any calendar year;

d. family outpatient care, including preventive services for children irrespective of treatment status of parent: 60 visits in any calendar year;

(5) residential treatment -

a. short-term: 30 days of treatment in a hospital or free-standing program in any calendar year;

b. long-term: up to 18 months of treatment in a residential program (halfway and quarterway houses, therapeutic communities);

(6) case management - unlimited and determined as clinically appropriate; and

(7) pharmacotherapeutic intervention - unlimited and determined as clinically appropriate.

III. RATIONALE

Alcoholism and drug addiction are among the leading health problems in our nation; therefore, any legislation mandating reform for the private and public health care financing systems should include comprehensive coverage for prevention and treatment of alcoholism and drug addictions.

Alcoholism and drug addictions are responsible for staggering economic loss, the deterioration of families, the spread of HIV/AIDS, and increased crime. These chronic illnesses cost billions of dollars each year and result in thousands of deaths.

Economic loss: Accidents at home and on the road resulting from drug and alcohol abuse cause a tremendous financial loss. Substance abuse results in huge economic losses in the workplace as well: employee productivity is greatly reduced, while absenteeism, health-related expenses, accidents and thefts all increase.

Social costs: Beyond the economic costs are the human costs. Individual lives are disrupted and entire families suffer when one member has an untreated alcohol or drug problem. Many families are destroyed as divorce rates increase and children are placed in foster care.

Increased crime: The proportion of offenders with alcohol or drug problems is overwhelming. By some estimates between 75% and 80% of offenders are substance abusers. Many offenses are directly alcohol and drug related, crimes committed to support continued drug use; other offenses are committed under the influence of alcohol or drugs. Numerous studies have established that treatment is far less expensive and far more effective in reducing crime than locking people up.

HIV/AIDS: Alcohol and drug abuse increase the spread of HIV/AIDS. Today, drug abusers account for 32% of those with AIDS, nationwide. Treatment for alcohol and drug abuse is one of the few ways we know works to prevent the spread of HIV/AIDS.

Many individuals who need alcohol or drug treatment cannot get it because they cannot afford private treatment and publicly funded programs are full. The importance of mandating coverage is clear: Treatment is the best answer we have to decreasing the economic loses, social costs, crime rates, and health-care costs (including birth defects and the spread of HIV/AIDS) caused by alcohol and drug abuse.

A comprehensive alcoholism and drug dependencies prevention and treatment benefit will help reduce the stigma associated with these diseases; individuals and families will be encouraged to seek preventive services and early treatment; early treatment increases the likelihood of successful recovery.

Forty (40) states currently require private health insurers to make available some reimbursement for alcohol and drug treatment. Many states provide Medicaid support for detoxification, outpatient and case management services.

National leadership is needed now to address our nation's drug and alcohol crisis. Stable financing for the prevention and treatment network is crucial if we are to conquer this tragic problem.

IV. QUALIFIED SERVICE PROVIDERS

Alcoholism and drug dependencies treatment may be provided by any of the following licensed or certified professionals with a specialty in addictions: alcoholism and drug addictions counselor, physician, nurse, psychologist, social worker, mental health worker, marriage and family therapist, acupuncturist, professional counselor or prevention specialist and will include treatment provided in programs licensed by the single state alcohol and drug agency.

Alcoholism and Drug Dependencies Prevention and Treatment Benefit Definitions*

(1) Prevention - patient education about the risks associated with alcohol and drug use.

(2) Intervention (including assessment, diagnosis and referral) -a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral of the individual.

(3) Detoxification - the medical and psychological management of an individual while he/she withdraws from alcohol and/or drugs.

(4) Outpatient services -

(a) Intensive outpatient/day treatment - an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of treatment consisting of regularly scheduled sessions of a minimum of nine (9) treatment hours per week within a structured program. Services are tailored to meet the individual's needs, and include detoxification, medical management and psychological support.

(b) Outpatient services - an organized non-residential service or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, treatment and recovery services to addicted patients. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

(c) Continuing care - a structured therapeutic involvement designed to enhance, facilitate, and promote the transition from primary care to ongoing recovery. The principle criterion for admission to continuing care is participation and satisfactory completion of a primary care treatment and intent to remain abstinent of alcohol and/or other nonmedical psychoactive substances.

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* Some of these definitions were taken directly from the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, American Society of Addiction Medicine, March 1991.

(d) Family outpatient services - an organized, non-residential services or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, prevention, treatment and recovery services to the families of addicted individuals. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

(5) Residential treatment -

(a) short-term -- an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care, and treatment for addicted patients in a residential setting. Clinical services includes: medical; educational; and individual, group and family therapy.

(b) long-term --

Halfway house care - an organized, long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual including educational and vocational rehabilitation and locating permanent housing.

Three-quarter-way house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides ongoing support and supervision for individuals who are resuming activity in the community.

Therapeutic community - an organized long-term residential service (up to 18 months) with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual, including educational and vocational rehabilitation and locating permanent housing.

(6) Case management - supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.

(7) Pharmacotherapeutic intervention - an organized medical intervention with a patient under the supervision of a licensed physician that utilizes approved medications such as methadone or Antabuse in conjunction with comprehensive medical, casework and counseling services.

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The Need for Specific Coverage for Drug and Alcohol Treatment in National Health Care Reform

March 5, 1993

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The Need for Specific Coverage for Drug and Alcohol Treatment in National Health Care Reform

EXECUTIVE SUMMARY

Coverage for the continuum of drug and alcohol services should and must be included (most preferably without a capitation rate) in any national health care benefit package. As we outline in this document:

1. **Quality drug and alcohol treatment and prevention services save tens of thousands of lives every year**

2. **Extensive research shows that treatment and prevention save this nation tens of millions of dollars by avoiding:**

   * **far more expensive medical care for HIV disease and other complications that arise from untreated drug and alcohol dependence**

   * **criminal justice, foster care, lost productivity and other social and economic costs**

I. A Comprehensive Continuum of Services

National health care reform should include coverage for the prevention and treatment of alcohol and drug abuse and dependence that is comprehensive and includes services in a continuum of care in the least restrictive and most appropriate setting for the individual.

To the extent possible, treatment should be provided in community based non-profit programs, which tend to be far less costly than hospital-based and free-standing for-profit programs. Treatment effectiveness studies have demonstrated that the most critical determinant for positive treatment outcome is the length of time an individual is in treatment. Therefore, the reformed health care delivery system and the benefit should not be structured in a manner to rely heavily on short-term intensive interventions in acute care settings but include an array of acute, rehabilitative and continuing care services.

Alcohol and Drug Prevention and Treatment Services for which coverage must be included in national health care reform include (these services are described in greater detail in the body of the document):

1. Prevention

2. Assessment and Diagnostic Services

3. Methadone Maintenance and other Medication Management Services

4. Withdrawal Services (medical and psychological management of an individual during alcohol and drug detoxification)

5. Outpatient/Ambulatory Services

   * Short-Term Individual, Group or Family Addictions Counseling

   * Extended Addictions Counseling and Continuing Care (for individuals who are seriously impaired and require ongoing supportive services in order to resume functioning)

   * Partial Hospitalization (for individuals who need intensive, structured and ongoing services)

6. Residential Services

7. Specialized Services for Children and Adolescents

Assessments for patient placement should be standardized nationally and use patient placement criteria such as the Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders developed by the American Society of Addiction Medicine (ASAM). Treatment should be provided by licensed or certified professionals with a specialty in addictions and in programs licensed by the single state drug and alcohol agency.

Utilization Review/Managed Care

Utilization review/managed care designed to assess the level of care an individual needs and to assist him/her in obtaining that care -- **not** channel everyone into the least costly level of care regardless of the care needed -- should be a component of health care reform. Our recommendations for the standards that should be used are outlined on page six of this document.

II. Cost-Effectiveness of Treatment

A wealth of research now exists that demonstrates that treatment works **and** that it saves enormous amounts of money that would otherwise be spent on much more expensive health care as well as criminal justice, foster care and other costs.

The cost savings generated by preventing and treating alcohol and drug dependence are enormous. A cost-benefit analysis conducted by the University of California estimated that every $1 spent on treatment and prevention saved $11.54 in social costs.

1. **Health Care Savings**

a. **Emergency Rooms and Other Medical Treatment**

* People with alcohol disorders account for between 15% and 30% of all hospitalized patients.[1] Many of these are undiagnosed alcoholics being treated for the consequences of their drinking.

* Emergency room and other hospital care typically costs between $400 and $600 per day, **far more** than the cost of drug and alcohol prevention and treatment.

* A California study found that providing alcohol treatment reduces not only the alcoholic's medical expenses, but those of the **whole family**.

b. **Health Care for Children**

* The total annual cost of health care for babies born with fetal alcohol syndrome (FAS) is $1.6 billion. Treatment and prevention can prevent all FAS cases.

* Over 4.5 million women of child bearing age are estimated to have used an illegal drug in the past month. Neo-natal hospital costs can range between $3,500 and $10,000, and the costs of long term care will mirror that for FAS. Treatment and prevention can also eliminate these costs.

c. **Treatment for HIV Disease and AIDS**

* The average person diagnosed with AIDS requires $32,000 worth of medical treatment each year, and IV drug users often require even more medical care.

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[1] A. Umbricht-Schneiter, et al., "The Impact of Alcohol-Associated Morbidity in Hospitalized Patients," Substance Abuse 12((3), 145-55, 1991.

* The average lifetime medical cost of HIV-related illness for each Medicaid eligible IV drug user in New York was estimated to be $90,188 (based on 1988 data).

2. **Foster Care, Criminal Justice and Other Savings**

Drug and alcohol dependence are major causes of our nation's escalating foster care and criminal justice costs, as well as a host of other social problems. Treatment and prevention are far more cost-effective than filling our jails and prisons with offenders who have drug problems and overwhelming our foster care rolls with children of drug and alcohol dependent parents.

Conclusion

Untreated drug and alcohol problems impose heavy costs on society, far more than the cost of effective treatment. Because treatment constitutes primary prevention for AIDS and so many other costly health and social problems, we cannot afford not to include a comprehensive drug and alcohol benefit in national health care reform.

The Need for Specific Coverage for Drug and Alcohol Treatment in National Health Care Reform

Introduction

Drug dependence and alcoholism are among our nation's leading health problems. Approximately 6.5 million individuals require treatment for a drug problem and as many as 22 million Americans are alcoholic or suffer from alcohol-related problems. These diseases cause great human suffering and impose substantial costs in terms of criminal activity, foster care and lost productivity. Moreover, they are directly linked to many costly health problems including HIV disease, fetal alcohol syndrome, cardio-pulmonary disease, cirrhosis, and injuries resulting from vehicular accidents and other alcohol and drug related incidents. The Bush Administration estimated that drug use alone cost our nation over $300 billion each year.

We need not shoulder these staggering costs. Drug dependence and alcoholism are highly treatable diseases if comprehensive services are tailored to an individual's needs and are provided at the time an individual seeks services. Providing treatment is far less costly than the price being paid now for treating drug- and alcohol-related problems in emergency rooms and other hospital beds, incarcerating individuals with drug and alcohol problems, caring for children affected by maternal drug and alcohol use and treating individuals with HIV disease and other health problems. Our nation will lose a golden opportunity to trim health and other social costs if a comprehensive drug and alcohol treatment and prevention benefit is not included in national health care reform.

The purpose of this document is to identify the types of services that constitute drug and alcohol treatment and to summarize research on the effectiveness of treatment and the cost-offsets that can be realized if comprehensive treatment is available.

Section one identifies the goals of drug and alcohol treatment and the services that constitute such treatment. Section two discusses general medical, psychosocial and economic factors that govern patient placement. Section three outlines the components of a quality utilization review procedure. Section four summarizes the evidence on the cost effectiveness of treatment.

I. A Comprehensive Continuum of Services

National health care reform should include coverage for the prevention and treatment of alcohol and drug abuse and dependence that is comprehensive and includes services in a continuum of care in the least restrictive and most appropriate setting for the individual. Services should be available to adults and youth and special attention should be given to accommodating women with young children. Access to treatment for women and children has been seriously impeded because the treatment system is structured to serve individuals, not families. A reformed system must enable women to enter and remain in treatment with their children.

To the extent possible, treatment should be provided in community based non-profit programs, which tend to be far less costly than hospital-based and free-standing for-profit programs. Treatment effectiveness studies have demonstrated that the most critical determinant for positive treatment outcome is the length of time an individual is in treatment. Therefore, the reformed health care delivery system and the benefit should not be structured in a manner to rely heavily on short-term intensive interventions in acute care settings but include an array of acute, rehabilitative and continuing care services.

Co-payments and deductibles for drug and alcohol services should be set at the same rate as for other health care services. Co-payment percentage should rise with income. The poor should not be deprived of health care because of their inability to pay. Individuals below a certain income level should be protected through an exemption from co-payment requirements. No co-payment should be required for preventive services.

Utilization review should be a central feature of health care reform and should be applied universally to all health care services. The goal of utilization review should be to assist individuals in getting the proper level of services in the appropriate settings. Guidelines for quality utilization review are provided in Section III.

A specific drug and alcohol treatment benefit is described below. Assessments for patient placement should be standardized nationally and use patient placement criteria such as the Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders developed by the American Society of Addiction Medicine (ASAM).[2] Treatment should be provided by licensed or certified professionals with a specialty in addictions and in programs licensed by the single state drug and alcohol agency.

The goals of alcoholism and drug dependencies treatment are:

1. to safely withdraw the individual from alcohol and other drugs;

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[2] American Society of Addiction Medicine, Patient Placement Criteria for the Treatment of Substance Abuse Disorders. March 1991.

2. to assess the physical, psychological, emotional and familial problems that have been caused and/or exacerbated by chronic alcohol and drug use and develop a structured individualized treatment plan to address these problems;

3. to assist the individual in identifying and accepting their addiction, the consequences of continued alcohol and drug use, and the need to take personal responsibility for ongoing recovery;

4. to provide information on alcoholism and drug addictions as chronic, bio-psychosocial disorders;

5. to assist individuals in restructuring their lives to maintain abstinence;

6. to assist the individual in becoming a part of sober communities for ongoing assistance in staying alcohol and drug free (such as A.A., N.A.);

7. to improve the individual's level of functioning in society — in relationships, in families, in work and, if necessary, assist individuals in acquiring basic educational, employment and living skills; and

8. to reduce illegal activities.

Alcohol and Drug Prevention and Treatment Services include the following services:

1. Prevention — patient education about the risks associated with alcohol and drug use. This typically takes place in a doctor or nurse's office or community health center. Prevention can include the following types of activities: identifying the risks associated with drinking or drug use during pregnancy; discussing the risks of using alcohol and other drugs in combination with prescription drugs; and screening adolescents and youth for alcohol and drug use and counseling on the risks of this use.

2. Assessment and Diagnostic Services — a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral and treatment of the individual.

3. Medication Management Services — brief office or clinic visits supervised by licensed physicians that utilize FDA approved medications such as methadone or Antabuse. Medical management services are most successful

when provided in conjunction with comprehensive medical, casework and counseling services.

4. Withdrawal Services — the medical and psychological management of an individual while he/she detoxifies from alcohol and/or other drugs. The goals in this phase of treatment are to safely detoxify the individual from alcohol and drugs and to facilitate their timely entry into continuing treatment. Withdrawal services have been successfully provided in both a medical and a social model (emphasizes non-pharmaceutical methods for detoxification in a community-based setting) setting when appropriate individual assessment is conducted.

5. Outpatient/Ambulatory Services — **Short-Term Individual, Group or Family Addictions Counseling** when furnished by a licensed or certified alcoholism and drug dependencies health professional. The goal of the service is to assist individuals with making major lifestyle, attitudinal and behavioral changes that will help them to remain alcohol and drug free and able to cope with major life tasks without the use of alcohol and drugs.

Extended Addictions Counseling and Continuing Care for individuals who are seriously impaired and require ongoing supportive services in order to resume functioning. These services may include assistance with maintaining abstinence, psychosocial counseling for impaired family functioning and support in obtaining employment, housing and other basis services. Services are provided by a licensed or certified alcoholism and drug dependencies health professional and based.

Partial Hospitalization for individuals who need intensive, structured and ongoing services. The nature of services are correlated with the individual's needs and include counseling and medical management as appropriate.

6. Residential Services — **Short-term and long-term** based on a clinical evaluation of the need for inpatient/residential care and development of a treatment plan and subject to periodic utilization review. An organized service with designated addiction personnel or addiction-credentialed clinicians that provide a planned regimen of 24-hour professionally-directed evaluation, care and treatment for addicted patients in a residential setting. Clinical services include: medical; educational; and individual, group and family therapy. This level of care is required when a clinical evaluation indicates that the individual's level of impairment is so severe that outpatient services are counter-indicated.

Services for Children and Adolescents

Children and adolescents will need specialized services to address the problems arising from growing up in a family where alcoholism and drug dependence are problems and adolescents will need specialized services to address their addictions. Therefore, in addition to the specific services outlined above, children and adolescents should have coverage for:

- The current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid for screening of their physical, psychological and developmental factors;
- Access to specialists for medical, psychological and developmental services based on the EPSDT screen;
- Health education programs for families that include developing and improving parenting skills and other risk reduction activities;
- The full range of services offered to adults but in settings where personnel are trained to work with adolescents. Again, standardized patient placement criteria should be used to determine the appropriate level of care using guides like the ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders.

II. General Medical, Psychosocial and Economic Factors that Govern Patient Placement

The American Society on Addiction Medicine has developed Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. ASAM identifies six primary problem areas for evaluation when making placement decisions: acute intoxication and/or withdrawal potential; biomedical conditions and complications (such as psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, transient neuropsychiatric conditions); emotional/behavioral conditions or complications; treatment acceptance or resistance; relapse potential; and recovery environment. Assessment of the individual's medical status and functioning in each of these areas will determine the appropriate level of care and length of time needed in treatment.

In addition to these problem areas, it is important to assess the individual's economic situation including housing, employment and health insurance coverage. Many individuals entering treatment have long-term chronic drug and alcohol addictions. They require services that are habilitative and that will enable them to eventually function independently. The process of habilitation is often lengthy (up to two years) and requires

ongoing psychological and lifeskills support. Finally, many individuals live in environments where drugs, alcohol, violence and crime are inextricably linked. They may need to leave these neighborhoods and assistance with establishing themselves in new and safer environments.

III. Utilization Review/Managed Care

Utilization review/managed care should be a component of health care reform. The purpose of utilization review is to assess the level of care an individual needs and to assist him/her in obtaining the appropriate care. Utilization review should not be used to channel all people into the least costly level of care. Standards should govern how utilization review operates. A good utilization review plan should include at least the following:

1. a process for certifying or licensing the bodies conducting utilization review;

2. a disclosed description of the specific admission and treatment criteria used in determining the justification for any form of hospital, inpatient, residential or outpatient services;

3. a description of an emergency preauthorization procedure that will include the process for allowing a smooth admission process for detoxification;

4. a description of the procedures the review agent will follow when making decisions — including confidentiality protections, process for making admissions decisions within 24 hours, a process for obtaining a second opinion within 24 hours in the case of any adverse determination;

5. a description of an independent appeals process;

6. the names, addresses, telephone numbers and qualifications of the personnel who will be performing utilization review for alcohol and drug treatment services — with minimum qualifications;

7. procedures to ensure that the review agent will be readily accessible by telephone to the insured and providers at least 40 hours per week during normal business hours, assurances that a toll-free telephone line will be provided for insureds, hospitals, and physicians to contact the review agent;

8. procedures to ensure that the review agent will respond by telephone to insureds and/or providers within four business hours;

9. procedures by which the review agent shall notify the insured and the providers when payment for alcohol or drug treatment is denied or limited, including a written statement for the denial or limitation;

10. policies and procedures to ensure that all applicable state and federal laws that protect the confidentiality of individual medical records are followed; and

11. procedures to ensure that no review agent shall enter a hospital or other treatment facility of a provider to interview an insured unless such activity has been approved in advance by such insured's attending physician and such attending physician or designee shall be able to attend such activity which shall occur only during regular business hours.

IV. Cost-Effectiveness of Treatment

A. Effectiveness of Treatment Numerous studies have concluded treatment substantially reduces drug and alcohol use and the serious social and health consequences related to such use. The Treatment Outcome Prospective Study (TOPS), sponsored by the National Institute on Drug Abuse (NIDA) tracked the progress over a five-year period of 10,000 clients who obtained treatment in 37 residential, methadone maintenance or out-patient drug free programs.[3] According to TOPS:

* After a year in treatment, 75% of the clients in out-patient drug free programs and 56% of the clients in residential therapeutic community treatment had stopped using heroin or cocaine.

* Heroin use by clients in methadone maintenance declined by 70%.

In addition to substantial reductions in drug use, treatment had a significant effect on criminal activity and employment status.

* 70% of the outpatient and 97% of the residential therapeutic community clients who admitted to having committed a predatory crime in the year prior to treatment had no criminal activity during or in the first six months after participating in treatment.

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[3] The results of the study are reported in R. Hubbard, Drug Abuse Treatment, A National Study of Effectiveness, (1989).

* The portion of clients in all three treatment modalities who committed predatory crimes in the three to five-year post-treatment period was one-third to one-half the pretreatment proportion.

* The employment rate of clients in residential treatment doubled, from 12.4% to 24.8%, and the employment of clients in outpatient treatment rose from 24.7% to 38.7%.

TOPS also concluded that the level of post-treatment criminal activity for criminal justice clients also declined substantially and that these individuals do as well or better than other clients in treatment. Criminal justice clients tended to stay in treatment longer than other clients, resulting in more positive outcomes.

A subsequent NIDA-sponsored study reported that methadone maintenance treatment effectively reduced IV drug use by 71%.[4] With over 32% of AIDS cases being linked to IV drug use and 70% of all pediatric AIDS cases being linked to maternal exposure to HIV through drug use or sex with a drug user,[5] treatment is clearly the most effective primary prevention tool for HIV disease. For this reason, the National Commission on AIDS recommended that accessible treatment be made available to all who need and request it.[6]

B. Cost of Treatment The 1990 Drug Services Research Survey (DSRS), sponsored by NIDA, provides the most recent information on treatment cost. DSRS reported the treatment charges billed to clients in 118 non-correctional treatment facilities during the 12 months between September 1, 1989 and August 31, 1990.[7] The types of treatment programs surveyed included inpatient hospital, residential, outpatient drug free and methadone maintenance.

According to the DSRS data, the treatment charges varied dramatically depending upon the setting of treatment. The mean per diem charge for clients who completed treatment and were billed for their care (but not the full amount) was:

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[4] J. Ball et al., "Reducing the Risk of AIDS Through Methadone Maintenance Treatment, Journal of Health and Social Behavior, 1988.

[5] Centers for Disease Control, HIV/AIDS Surveillance, January 1993.

[6] National Commission on Acquired Immune Deficiency Syndrome, "The Twin Epidemics of Substance Use and HIV," 1991.

[7] While the data presented reflects the charges billed to clients, not the actual cost of treatment, this data is a proxy for cost of treatment.

hospital inpatient	— $449
residential	— $ 85
methadone	— $96[8]
outpatient drug free	— not available because the number of days in treatment was unknown.

The mean per diem charge for clients who completed treatment and were billed the total charge for their care was slightly higher:

hospital inpatient	— $486
residential	— $139
methadone	— $116
outpatient	— not available.

In addition, a recent survey conducted by the Therapeutic Communities of America on the cost of care in long-term therapeutic communities averages $80 per day for adolescents and $60 per day for adults.

These charges are instructive when determining the range of drug and alcohol services that should be included in a health care benefit. Clearly, inpatient hospital care, which is the type of service most frequently covered in private health insurance plans,[9] is far more expensive than residential treatment services. Moreover, research sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that compared patient health care expenditures and recurrent treatment of Medicare clients who received alcohol treatment in hospital inpatient programs versus freestanding treatment programs concluded that (a) clients served in freestanding programs had lower average health care expenditures than those treated in hospitals and (b) clients in freestanding programs has less recurrent treatment than those in hospital-based programs.[10] Accordingly, a drug and alcohol benefit should include a broad range of treatment settings and modalities to ensure the most cost-effective care.

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[8] The final DSRS report emphasized that the per diem estimate for methadone treatment is highly questionable because the charge data was gathered from a very small client sample. Indeed, the American Methadone Treatment Association estimates that the weekly charge for methadone treatment care ranges from $70 to $80 per week. This charge covers medication, counseling, nursing services and an annual physical examination.

[9] The DSRS data confirms that individuals who pay for their treatment with private insurance most frequently obtain inpatient hospital care: 38.2% obtain hospital care and 22.9% obtain outpatient drug free care.

[10] A. Lo and A. Woodward, "An Evaluation of Freestanding Alcoholism Treatment for Medicare Recipients, 88 Addiction 53-68 (1993).

C. Cost-Offsets and Economic Benefits of Drug and Alcohol Treatment

The above treatment costs pale in comparison to the cost of providing health care to people with untreated alcohol or drug dependence, providing health care to children affected by maternal drug and alcohol use and those with HIV disease and alcohol and drug problems, placing children in foster care, and incarcerating individuals with drug and alcohol problems.

1. Health Care Savings

a. Emergency Rooms and Other Medical Treatment

* People with alcohol disorders account for between 15% and 30% of all hospitalized patients.[11] Many of these are undiagnosed alcoholics being treated for the consequences of their drinking.

* Hospital care typically costs between $400 and $600 per day, and an average hospitalization costs $5,500.

The health care cost savings resulting from drug and alcohol treatment are enormous. Several studies have examined these savings. A California study found that prior to entering treatment, monthly medical bills for alcoholics and their families averaged $135, while the average medical costs for non-alcoholics and their families were $20 per month. Five years later, the monthly medical costs for families in which the alcoholic member had completed treatment had dropped to $22 while inflation had brought the non-alcoholic families' medical expenses to $50 per month.[12] Thus, providing alcohol treatment reduces not only the alcoholic's medical expenses, but those of the whole family.

Several other studies confirm that the health care expenditures of alcoholics decline substantially after treatment relative to non-alcoholics or to untreated alcoholics. For example, a 1992 study which examined the health records for a 14-year period of over 3,000 alcoholics who had received treatment revealed that health care costs of treated

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[11] A. Umbricht-Schneiter, et al., "The Impact of Alcohol-Associated Morbidity in Hospitalized Patients," Substance Abuse 12((3), 145-55, 1991.

[12] Blue Cross/Blue Shield of California, "Medical Care and Alcoholism Treatment Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage for Alcoholism," 1973-1979.

alcoholics were 24% lower than the health care costs for a control group of untreated alcoholics.[13]

Two other studies have examined the health care expenditures of alcoholics six-months prior to entering treatment, one-year after treatment and three to six years after treatment. Both reveal that health care expenditures in the six months prior to treatment increased steadily, but declined one-year after treatment and remained at or below the one-year level three to six years after treatment.

In the first study, health care expenditures for alcoholics under 44 years increased to up to $350 per month in the six months prior to treatment, but then dropped to $100 per month one year following treatment and remained at or below $100 per month three years later.[14] In the second study, health care expenditures for alcoholics under 50 years increased to up to $600 per month six-months prior to treatment, but then dropped to below $200 per month one-year post-treatment and $100 per month six-years post-treatment.[15]

b. **Health Care for Children**

* Assuming an incidence rate of 1.9 children per 1,000 births are born with fetal alcohol syndrome (FAS), the total annual cost of care is $1.6 billion, of which $1.3 billion is for residential care and support services for mentally retarded persons over 21 years, $118 million for neonatal intensive care services and $118 million for full-time residential care for severely mentally retarded persons under 21 years.[16] Treatment can prevent all FAS cases.

* Over 4.5 million women of child bearing age are estimated to have used an illegal drug in the past month. Neo-natal hospital costs can range between

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[13] H.D. Holder and J.O. Blose, "The Reduction of Health Care Costs Associated With Alcoholism Treatment: A 14-Year Longitudinal Study," Journal of Studies on Alcohol 53(4), 293-302, 1992.

[14] H.D. Holder and J.O. Blose, "Alcoholism Treatment and Total Health Care Utilization and Costs: A Four-Year Longitudinal Analysis of Federal Employees," Journal of the American Medical Association, 256(11), 1456-1460, 1986.

[15] J.O. Blose and H.D. Holder, "The Utilization of Medical Care by Treated Alcoholics: Longitudinal Patterns by Age, Gender, and Type of Care," Journal of Substance Abuse, 3(1), 13-27, 1991.

[16] D.P. Rice, et al., The Economic Costs of Alcohol and Drug Abuse and Mental Illness, 1990 at 153.

$3,500 and $10,000, depending upon the level of care and length of stay required for each infant.[17] The costs of long term care for persons with FAS sheds light on the potential future costs of caring for individuals affected by maternal cocaine and crack use. These costs can be eliminated with treatment.

c. **Treatment for HIV Disease and AIDS**

* The average person diagnosed with AIDS requires $32,000 worth of medical treatment each year. IV drug users often require more medical care than other persons with the disease because of their generally poorer state of health and inability to obtain outpatient and preventive care.[18]

* The average lifetime medical cost of HIV-related illness for each Medicaid eligible IV drug user in New York was estimated to be $90,188 (based on 1988 data).

3. **Foster Care Savings**

* Approximately one-third (1/3) of the children placed in foster care are children of persons with drug problems. The annual cost of foster care for a child ranges from $13,000 to $36,000.[19] Treatment is far less costly than placing one or more children in foster care for an indefinite period of time.

4. **Criminal Justice Savings**

* Up to 75% of all federal and state prison and local jail inmates, probationers and parolees need comprehensive drug treatment and aftercare services. The annual cost of incarcerating an individual is $30,000 a prison bed and the cost of building a new prison is $100,000 per bed. Treatment is far less costly than repeated incarceration of drug dependent offenders.

TOPS examined the cost-effectiveness of treatment when measured against crime-related costs. The study examined two general measures of crime-related costs:

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[17] Phibbs et al., "The Neonatal Costs of Maternal Cocaine Use," The Journal of the American Medical Association, September 18, 1991.

[18] National Commission on Acquired Immune Deficiency Syndrome, Americans Living With AIDS: Report of the National Commission on Acquired Immune Deficiency Syndrome 1991, p. 70 (1991).

[19] Packard Foundation, 1991.

* costs to society which include (a) the costs to victims such as medical treatment, loss of property and reduced productivity resulting for the crime, (b) criminal justice costs such as police, adjudication and incarceration costs, and (c) crime career/productivity costs which include the cost of removing the offender from the productive economy; and

* costs to law-abiding citizens which include the costs to victims, criminal justice costs and theft costs.

TOPS found substantial economic benefits resulting both during and one year after treatment for each client served in residential, out-patient drug free and methadone maintenance programs.

Savings in the costs to law-abiding citizens

	During Treatment	One-Year Post-Treatment
Residential	$12,206	$13,731
Methadone	4,854	4,000
Out-patient	2,792	5,986

Savings in the costs to society

	During Treatment	One-year Post-Treatment
Residential	$ 5,756	$ 7,811
Methadone	2,022	3,362
Out-patient	2,785	6,789

Indeed, the savings realized during treatment offset the cost of the treatment provided. The greater savings after treatment is linked in large part to the reduction in criminal activity because the individual has been rehabilitated.

Conclusion

Untreated drug and alcohol problems impose heavy costs on society, far more than the cost of effective treatment. Because treatment constitutes primary prevention for AIDS and so many other costly health and social problems, we cannot afford not to include a comprehensive drug and alcohol benefit in national health care reform.

The National Report on Substance Abuse

A Bi-Weekly Newsletter

Volume 7, Number 8 | BURAFF PUBLICATIONS | March 26, 1993

Prevention

Key Clinton Adviser Predicts Health Care Reform Will Include Coverage for Addiction Treatment

The Clinton administration is committed to substance abuse treatment and prevention and will include treatment coverage in the standard benefit under its health care reform proposal, a key White House adviser predicted March 17.

Carol Rasco, assistant to the president for domestic policy, told community leaders at the Fighting Back Leaders Forum that President Clinton's failure to nominate a drug czar thus far does not mean he is backing away from his campaign rhetoric about drug treatment.

An emphasis on treatment and prevention is going to be a "hallmark" of Clinton's presidency, Rasco said. She predicted that this will "spill over into the core benefits package . . . I firmly believe that."

Hillary Rodham Clinton, who heads the President's Task Force on National Health Care Reform, hinted at the same thing the day before when she told reporters that substance abuse is "a problem that permeates the whole system" and must be dealt with under health care reform.

A further indication that the task force is leaning toward recommending cover-

(Continued on p. 7)

Federal Policy

Officials Criticize GAO Advice to Congress On Ending MRO Review of Negative Drug Tests

A General Accounting Office (GAO) recommendation that the federal government eliminate medical review of negative drug test results was challenged March 11 by officials of the federal drug testing program.

Dr. Joseph H. Autry III, director of the division of workplace programs of the Substance Abuse and Mental Health Services Administration (SAMHSA), said the agency's "overriding concern" in regulating federal drug testing is the protection of confidentiality and privacy.

Autry made the comment at the quarterly meeting of the Department of Health and Human Services' Drug Testing Advisory Board, which he chairs.

Walter F. Vogl, a forensic toxicologist with SAMHSA's drug testing section, said GAO "did not address the issue of confidentiality" and overlooked the fact that a medical review officer (MRO) is the only person who can ensure that the chain of custody of the test specimen has been maintained and who can render a final opinion on whether the specimen was adulterated.

The GAO recommendation on reviewing negative tests was one of several in a report to Congress (SUB, Jan. 15, p. 1) titled *Employee Drug Testing: Opportunities Exist to Lower Drug-Testing Program Costs.*

A key argument for reviewing negative results is that it prevents a federal agency from figuring out which employees have tested positive. If only positive results were sent to MROs and the rest were returned to the agency, someone could deduce

(Continued on p. 2)

Inside

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DOT's review of the comments had been delayed by the public hearings on other proposed alcohol and drug testing rules (SUB, March 12, pp. 1-6), but would begin soon.

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Dennis Bennett, Program Analyst, Drug Enforcement and Program Compliance Branch, Office of the Secretary, Department of Transportation, 400 Seventh St., S.W., Room 9404-A, Washington, D.C. 20590; (202) 366-3784.❑

Research

GAO: Treatment Alternatives Program Deserves Greater Emphasis by ONDCP

The national drug czar should put greater emphasis on a program that provides drug offenders with treatment alternatives to criminal penalties, the General Accounting Office (GAO) has recommended.

The Treatment Alternatives to Street Crime (TASC) program "appears to offer promise in helping reduce offender drug use," but its results are "not yet conclusive," GAO said in a report to Rep. Charles B. Rangel (D-NY), the chairman of the House Select Committee on Narcotics Abuse and Control.

In its 1992 drug control strategy, the Office of National Drug Control Policy (ONDCP) recommended that TASC be expanded, GAO noted.

But the congressional watchdog agency said if federal efforts to promote TASC are limited to providing information and technical assistance, they may not be sufficient to expand the program.

"No specific cities have been targeted and although federal officials have encouraged states to use criminal justice block grant funds for TASC, these funds are generally not used for TASC," the GAO report said.

TASC Originally Funded by LEAA

TASC was established in 1972 by the White House "to reduce the criminal behavior of drug-abusing offenders by using the threat of legal sanctions to motivate them to enter treatment," GAO said. It was initially funded by the now-defunct Law Enforcement Assistance Administration (LEAA).

A federal panel said in 1976 that TASC offenders had shown "dramatic declines in recidivism" and recommended a rapid expansion of the program. TASC projects mushroomed, growing in number to 130 in 39 states when direct federal funding ended in 1982.

The number has now reached 195, but they exist in only 26 states and two territories, GAO said. State and local governments provide most of the funding.

GAO said TASC programs:

- coordinate the efforts of criminal justice agencies and treatment providers;
- provide an incentive for drug offenders to enter treatment by threatening criminal penalties as the alternative;
- match offenders with the most appropriate treatment; and
- monitor participants' behavior with drug testing.

"Drug abuse experts we spoke with were unaware of any other program that combined all of these necessary elements in one program," GAO said.

GAO recommended that the director of ONDCP identify additional cities that could benefit from TASC programs and work with the relevant federal and state officials to reach an agreement on how TASC should be funded.

Single copies of the GAO report, *Drug Control: Program for Drug Offenders Needs Stronger Emphasis* (GAO/GGD-93-61), are available free from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; (202) 512-6000.❑

Needle Exchanges

'Frisco Declares Health Emergency To Curb Spread of HIV Among Addicts

SAN FRANCISCO — In a direct challenge to state law, Mayor Frank Jordan declared an AIDS public health state of emergency March 15 and authorized the use of city funds for a needle exchange program to curb the spread of HIV infection among drug addicts.

Jordan, a former San Francisco police chief, bypassed a state law that prohibits the distribution or sale of hypodermic needles without a license by using his authority under the city charter and California government code.

The San Francisco City Attorney's office said a legal challenge from the state attorney general was unlikely because both state and local law authorize the mayor to declare a state of emergency.

In declaring an emergency in a city where AIDS has claimed the lives of more than 10,000 citizens and 30,000 people have tested HIV-positive, Jordan said, "San Francisco has a very serious health problem. It is a real tragedy. I am confident that this measure has the strong support of all San Franciscans dedicated to ending the HIV epidemic in our city."

In addition to needle exchanges, Jordan's action authorized two additional drug treatment programs.

Board of Supervisors Ratifies Action

The San Francisco Board of Supervisors unanimously ratified the mayor's action, sending a signal to Sacramento where Gov. Pete Wilson (R) last fall vetoed a bill that would have allowed San Francisco and other cities to establish legal needle exchange programs. Assembly Speaker Willie Brown (D) has reintroduced new needle exchange legislation (AB 260) this year, endorsed by the city and the non-profit San Francisco AIDS Foundation.

Reported Documents Available from SUB

Full text of the court decisions reported in SUB, as well as complaints, briefs, and most other documents covered in the publication, are available to Buraff subscribers for a nominal fee. To order a document or obtain more information concerning this service, call Terry Peters at 202-862-0930.

Susan Galbraith, co-director of national policy for the Legal Action Center, told SUB the proposal also represents the views of the National Coalition of State Alcohol and Drug Treatment and Prevention Associations.

Another coalition in the substance abuse field did not officially endorse the center's proposal, but the disagreement is political rather than professional, she said.

"There was not complete consensus on the benefit," Galbraith said, referring to the National Coalition on Alcohol and Other Drug Issues, which includes the Legal Action Center and a long list of other national groups such as the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the National Association of Addiction Treatment Providers (NAATP).

The Society of Americans for Recovery (SOAR) recently proposed that health care reform legislation create a standard benefit package that would cover up to 35 days of residential treatment and 130 hours of outpatient care for alcoholism and drug addiction (SUB, March 12, p. 7).

Contact Galbraith at the Legal Action Center, 236 Massachusetts Ave., N.E., Suite 510, Washington, D.C. 20002; (202) 544-5478.❑

Prevention, from p. 1

age of addiction treatment emerged later in the week. *The Washington Post* reported March 19 that the task force had decided to model its recommended core benefits package on the one typically provided by health maintenance organizations (HMOs), which includes some alcohol and drug abuse treatment services.

The core benefits package, also called the standard or minimum benefits package, is the coverage that health insurers would be required to offer everyone under a reformed health insurance system.

Rasco told the Fighting Back forum that the drug czar would be a member of the Domestic Policy Council, and said she had already hired a drug liaison who will serve as her contact with the Office of National Drug Control Policy (ONDCP), the drug czar's office.

As for the president's delay in naming a drug czar, Rasco said, "We're treading water just as fast as we can."

The forum was sponsored by the Fighting Back national program office in Nashville. The program, funded by the Robert Wood Johnson Foundation, promotes community efforts to discourage the use of alcohol and other drugs by children and adolescents, and to reduce deaths, injuries, health problems, and crimes related to substance abuse.

Dr. Steven A. Schroeder, president of the Robert Wood Johnson Foundation, told the forum that substance abuse, not heart disease or AIDS, is the nation's "number one health problem."

Schroeder said "an overemphasis on the supply side" (law enforcement and drug interdiction) has hindered the country's anti-drug policies in recent years.

"I have a feeling she [Hillary Clinton] understands that issue," said Schroeder, who has been co-chairing foundation-sponsored public meetings on health reform attended by Hillary Clinton. "I know Secretary Shalala does." Donna E. Shalala is the secretary of health and human services.

Schroeder lamented that drugs, which once rated as the top domestic issue in public opinion polls, "have now fallen off the radar screen."

Contacts: Fighting Back National Program Office, 2553 The Vanderbilt Clinic, Nashville, Tenn. 37232; (615) 936-0678.

Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, N.J. 08543; (609) 452-8701.❑

THE NATIONAL REPORT ON SUBSTANCE ABUSE

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Published 24 times a year at Washington, D.C., by Buraff Publications, 1350 Connecticut Ave. N.W., Suite 1000, Washington, D.C. 20036. (202) 862-0990; Editorial inquiries: (202) 862-0930; Customer service: 1 (800) 333-1291; Price: $377

SUB SCOPE

A regular look at events and trends in substance abuse prevention and treatment

■ J. Michael Walsh, executive director of the President's Drug Advisory Council, has been appointed acting associate director of the Office of National Drug Control Policy (ONDCP), making him the "acting deputy drug czar."

Walsh told SUB March 11 he didn't expect the Clinton administration to appoint a drug czar for another couple of months (until a health care reform plan has been proposed) and said he had no hunch about who it would be.

Meanwhile, speculation on possible drug czar nominees continues. A report that President Clinton was seriously considering former New Jersey Gov. Thomas P. Kean for the post stirred an immediate response from the Drug Policy Foundation, a national drug policy reform group.

"Governor Kean's record is all too typical of the Republican preference for tough-on-drugs rhetoric, massive escalation of imprisonment and neglect of the need for treatment and prevention," said Arnold S. Trebach, president of the reform group, in a March 5 letter to Clinton.

Trebach reminded Clinton of his campaign promise to appoint "a national drug expert" to his Cabinet and noted that Kean does not qualify.

More recently, the name of former Georgia Democratic congressman Ben Jones, a recovering alcoholic, has resurfaced as a possible drug czar nominee.

The Employee Assistance Professionals Association Inc. (EAPA) urged members to write to the White House in support of Jones because of his strong support of employee assistance programs and addiction treatment.

Harold E. Hughes, a former Democratic senator from Iowa, told SUB Feb. 16 that his name had been mentioned to the White House as a possible drug czar nominee.

"I really am not looking for a job," said Hughes, who heads the Society of Americans for Recovery (SOAR). But he said he told the White House in early February that he would consider taking the post if it were offered.

In January, the National Drug Strategy Network reported that Lee Brown, formerly police chief of New York, Houston, Atlanta, and Portland, Ore., was rumored to be on "the short list" for ONDCP director.

Other names that have been floated as candidates for drug czar include former surgeon general C. Everett Koop, former secretary of health, education, and welfare Joseph A. Califano Jr., and Mathea Falco, a visiting fellow at New York's Institute for Prevention Research and the author of *The Making of a Drug-Free America: Programs That Work.*

Falco and Jones were among those mentioned as possible drug czar nominees soon after the Nov. 3 election (SUB Special Report, Dec. 4, 1992). Falco was the most prominently mentioned, but speculation about her has faded in recent weeks.

Walsh told SUB he believes the names that have been bandied about are a product of pure speculation and wishful thinking rather than an indication that certain individuals are being considered by the administration.

"I really don't believe there is a short list," Walsh said.

■ The possibility of regulating evidential breath testing devices (EBTs) is under preliminary consideration by the Food and Drug Administration.

Eugene Berk, an FDA consumer safety officer, told SUB March 16 that FDA was discussing the issue. Asked if regulation might extend to the use of EBTs for workplace testing, Berk said FDA "probably would use the same logic" as it has in regulating testing devices for "drugs of abuse."

In the case of such drug testing devices, Berk said, FDA has regulated them regardless of whether they are used as medical devices. Berk emphasized that FDA's consideration of regulating EBTs was "real preliminary."

The issue of FDA regulation of EBTs was raised Feb. 25 at the Department of Transportation's hearing on proposed alcohol and drug testing rules.

S. Wayne Kay of Enzymatics Inc., a Horsham, Pa., manufacturer of saliva tests, testified that the DOT proposals would conflict with the Food, Drug, and Cosmetic Act. Kay said using EBTs to detect alcohol use and to refer some employees to a substance abuse professional would bring EBTs under the act's definition of medical devices.

The use of medical devices not approved by FDA is illegal, Kay said, and EBTs have no such approval because they are currently unregulated. The saliva test made by Enzymatics does have FDA approval, he said.

Kay urged DOT to amend its proposals to permit the use of saliva testing for alcohol screens, a change that presumably would benefit Enzymatics financially.

■ Dr. Philip R. Lee was nominated by President Clinton March 12 to be assistant secretary for health in the Department of Health and Human Services. Lee, 68, is director of the Institute for Health Policy Studies at the University of California at San Francisco.

Lee was the assistant secretary for health and scientific affairs in the then-Department of Health, Education, and Welfare from 1965 to 1969 in the Johnson administration when both Medicare and Medicaid were created.

If confirmed, Lee would preside over the Public Health Service, which includes the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH).

NIH is now the parent agency for the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Both agencies were transferred to NIH under 1992 legislation that reorganized the Alcohol, Drug Abuse, and Mental Health Administration and renamed it SAMHSA.

■ The President's Commission on Model State Drug Laws will hold its fifth public hearing March 31 in Washington, D.C. Testimony will focus on families, schools, and workplaces.

The bipartisan 24-member commission is scheduled to issue a report in May that will recommend a comprehensive package of model, drug-related legislation for state and local governments. Contact David Osborne, (202) 467-9644.❑

0891-5709/93/$2.50

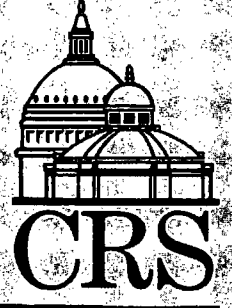
Order Code IB88009

CRS Issue Brief

Alcohol, Drug Abuse, and Mental Health Block Grant and Related Programs

Updated October 9, 1992

by
Edward Klebe
Education and Public Welfare Division



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Alcohol, Drug Abuse, and Mental Health Block Grant and Related Programs

SUMMARY

Title XIX of the Public Health Service (PHS) Act authorizes the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, which provides grants to States for: (1) prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse; and (2) support to community mental health centers for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations. The block grant is administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services.

Title V of the PHS Act authorizes substance abuse prevention activities through ADAMHA's Office of Substance Abuse Prevention (OSAP). Title V also authorizes biomedical and clinical research, as well as service-related research to evaluate various forms of alcohol and drug abuse treatment programs and community-based services for the mentally ill, through ADAMHA's three research institutes -- National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA), and National Institute of Mental Health (NIMH).

The FY1992 appropriation for the block grant was $1.360 billion. The Administration has requested the appropriation of an identical $1.360 for the block grant for FY1993. The FY1992 appropriation for OSAP was $285.1 million. The Administration's FY1993 appropriation request for OSAP is $305.5 million. The FY1992 appropriations for research at NIAAA, NIDA, and NIMH are $152.4 million, $270 million, and $505.8 million, respectively. The Administration has requested $160.2 million, $284.6 million, and $536.8 million for these institutes for research in FY1993.

A bill to amend the block grant authority, S. 1306, was passed by the 102d Congress and signed into law on July 10, 1992, as P.L. 102-321. This legislation splits the ADMS Block Grant into two discrete block grants -- one for prevention and treatment of substance abuse and the other for community mental health services. The legislation also transfers ADAMHA's three research institutes to the National Institutes of Health and replaces ADAMHA with a new services related agency -- the Substance Abuse and Mental Health Services Administration (SAMHSA). The legislation also contains provisions authorizing a model demonstration substance abuse treatment in the national capital area, a program of services for children of substance abusers, and a program of grants for trauma centers serving areas affected by drug-related violence.

ISSUE DEFINITION

Title XIX of the Public Health Service (PHS) Act authorizes the Alcohol, Drug Abuse, and Mental Health Services Block Grant, which provides grants to States for alcohol and drug abuse treatment and prevention activities and community mental health services. Title V of the PHS Act authorizes related substance abuse and mental health programs and activities in the areas of prevention and biomedical, clinical, and services-related research. These activities are administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services. A bill passed by the Congress and signed into law on July 10, 1992, among other things: splits the block grant into two separate programs, one for substance abuse services and the other focusing on mental health services; change the block grant's allocation formula; and transfer research and related activities from ADAMHA to the National Institutes of Health, leaving ADAMHA as a services agency renamed the Substance Abuse and Mental Health Services Administration (SAMHSA).

BACKGROUND AND ANALYSIS

The incidence of substance abuse -- the abuse of alcohol and illicit drugs -- and of mental illness have been for many years a matter of concern in the United States. Regarding substance abuse, the most recent national survey, the 1990 National Household Survey on Drug Abuse, indicates that 37% of the household population aged 12 and older in the U.S. reported that they had used one or more illicit drugs in their lifetimes, 13% had used illicit drugs in the past year, and 6% had used them in the last month. Of the approximately 83% of the household population that had ever used alcohol, 66% had used alcohol in the past year, and 51% had used it in the past month. The most commonly used illicit drug was marijuana, and the next most commonly used drugs were prescription-type psychotherapeutic drugs and cocaine. Estimates indicate that nearly 18 million persons aged 18 and older have problems related to alcohol abuse and alcoholism. Nearly 64% of a national survey of high school seniors in 1988 reported having used alcohol in the previous 30 days and 35% reported having five drinks or more in the two weeks before the survey.

The National Institute of Mental Health (NIMH) estimates that more than 1% of the adult population of the United States, 2.8 million persons, have serious mental illnesses, such as schizophrenia, severe forms of depression, psychosis, dementia, and others. Because of these disorders, many of these individuals are unable to complete their education, maintain employment, or otherwise lead productive lives.

Throughout the last 25 years, the Congress has enacted legislation to create and support a variety of Federal programs to support research into the causes and treatment of substance abuse and mental illness and to establish and support programs of prevention and treatment. These programs are administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services.

Program Description

Alcohol, Drug Abuse, and Mental Health Services Block Grant

Title XIX of the Public Health Service (PHS) Act authorizes the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant. As established by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Title XIX provides grants to States for the following,

-- Prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse.

-- Grants to community mental health centers for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations.

The block grant is administered by the Office for Treatment Improvement (OTI), of ADAMHA, which performs certain policy oversight and coordination activities related to the block, and, in addition, is responsible for assessing State compliance with legislative provisions for the block by reviewing State applications, annual reports and audits, conducting compliance reviews and investigations, and processing complaints.

Office of Substance Abuse Prevention

Title V of the PHS Act authorizes the establishment in ADAMHA of an Office of Substance Abuse Prevention (OSAP), which carries out a variety of substance abuse prevention activities, including the operation of a Clearinghouse on Alcohol and Drug Abuse Information, a program of Model Projects for High Risk Youth, as well as a program of Model Projects for Pregnant and Postpartum Women and Their Infants. OSAP also administers a program of grants for drug abuse demonstration projects of national significance, with $10 million of the amount appropriated to be made available for projects to (1) determine the feasibility and efficacy of programs providing drug abuse treatment and vocational training in exchange for public service; (2) conduct outreach activities to intravenous drug abusers to prevent exposure to, and transmission of, the etiologic agent for AIDS and to encourage intravenous drug abusers to seek treatment; and (3) provide drug abuse treatment services for pregnant and postpartum women, and their infants.

ADAMHA Research

Title V also authorizes ADAMHA, through the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and NIMH, to carry out and support basic and clinical, as well as service-related research. This includes support for research to evaluate the quality, appropriateness, and costs of various forms of alcohol and drug abuse treatment programs. Title V also supports service research on community-based mental health treatment programs and services, through NIMH, including evaluation of methods of providing community-based services for the mentally ill; and of the quality, appropriateness, and costs of different methods of treatment.

Appropriations

The FY1992 appropriation for the ADMS block grant was $1.360 billion, $1.292 billion of which was available for allocation to the States. The President's FY1993 budget proposal requests an identical $1.360 billion for the block grant. The FY1992 appropriation for OSAP was $276.3 million. The Administration's budget request for OSAP for FY1993 is $305.5 million. The FY1992 appropriations for research are $152.4 million at NIAAA, $270.0 million at NIDA, and $505.8 million at NIMH. The FY1993 appropriation requests for research at NIAAA, NIDA, and NIMH are $160.2 million, $284.6 million, and $536.8 million respectively.

TABLE 1. Appropriations for Selected Programs of Alcohol, Drug Abuse, and Mental Health Administration, FY1991 and FY1992
(dollars in millions)

Program	FY1991 Approp.	FY1992 Approp.	FY1993 Budget Request	FY1993 House Allowance
ADMS Block Grant	$1,268.7	$1,360.0	$1,360.0	$1,346.4
OSAP	$271.5	$276.3	$290.8	$266.6
Alcohol Abuse Research	$138.8	$152.4	$163.7	$157.6
Drug Abuse Research	$257.9	$270.0	$291.4	$280.4
Mental Health Research	$455.5	$505.8	$563.7	$542.7

Legislation in the 102d Congress

Legislation was considered in both the House and the Senate during the first session of the 102d Congress to amend and extend the ADMS Block Grant, but final action was not taken. S. 1306, the ADAMHA Reorganization Act, passed by the Senate on Aug. 2, 1991, amended the block grant authority and, in addition, restructured the agency which administers it. The Senate bill extended the block grant authority through FY1994, and amended the block grant allocation formula to reduce the current imbalance between urban and rural States in the allocation of funds. The Senate bill also provided for the transfer of the three ADAMHA research institutes to the National Institutes on Health. S. 1306 as originally passed by the Senate restructured ADAMHA as a services-oriented agency renamed the Alcohol, Drug Abuse, and Mental Health

Services Administration (ADAMHSA), consisting of the Office of Treatment Improvement (OTI), the Office for Substance Abuse Prevention (OSAP), and a new Office for Mental Health Services (OMHS).

The House early in 1992 passed legislation dividing the ADMS block grant into two blocks -- a mental health services block grant and a substance abuse services block grant. The previous year, on May 13, 1991, Representative Waxman had introduced H.R. 2311, the Community Mental Health Services Improvement Act. H.R. 2311, which established a new Community Mental Health Services Block Grant, was replaced, on June 28, by a clean bill, H.R. 2803. On November 1, Representative Waxman then introduced a new bill, H.R. 3698, the Community Mental Health and Substance Abuse Services Improvement Act of 1991. H.R. 3698 was reported to the House on Mar. 24, 1992, and passed under suspension of the rules on the same day. The House then passed S. 1306 after substituting the language of H.R. 3698. As passed by the House, the bill established separate block grants for community mental health services and substance abuse services and authorized a program of demonstration grants to improve treatment of severely disturbed children and adolescents. It also established a new Substance Abuse Treatment Capacity Expansion Program and reauthorized existing substance abuse treatment project grant programs, including programs aimed at high-risk youth and at pregnant and postpartum women.

On May 14, 1992, the conference committee on S. 1306 reported agreement on the bill (H.Rept. 102-522). The conference agreement transfers the three research institutes to NIH and establishes a new services agency to replace ADAMHA. The new agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), consists of three centers -- the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. The conference agreement also splits the block grant into two discrete block grants, one for community mental health services and one for substance abuse treatment and prevention services. The allocation formulas for the two new block grants are modified to reduce the urban weight in the current block grant formula.

The House considered the conference agreement under suspension of rules on May 19 and failed to pass it by the required three-fourths majority. On May 28, the House, under regular order, voted to recommit the bill to the conference committee for reconsideration. The major objections to the bill in the House were the implementation of the allocation formulas for the block grants, under which several States would lose part of their FY1992 allocations under the block, and the removal, in the conference agreement, of a provision in current law prohibiting States from using their block grant allocations for programs promoting needle exchange and distribution of bleach as a method of reducing HIV infection among intravenous drug abusers.

A second conference agreement on S. 1306, reported on June 3 (H.Rept. 102-546), was the same as the first one, except that, instead of removing the prohibition of States rom using block grant funds for needle exchange programs, it prohibited such programs unless the Surgeon General determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

The Senate passed the conference agreement on June 9; the House passed it on July 1. The President signed S. 1306 into law on July 10 as P.L. 102-321.

Summary of P.L. 102-321, the ADAMHA Reorganization Act

Title I of the Act establishes the Substance Abuse and Mental Health Services Administration (SAMHSA) to replace ADAMHA. This new agency consists of three subagencies. The first of these is the Center for Substance Abuse Treatment (CSAT), which administers the following programs: the Block Grant for Prevention and Treatment of Substance Abuse authorized in Title II of the Act; the Residential and Outpatient Treatment for Pregnant and Postpartum Women; the Demonstration Projects of National Significance for Treatment Improvement; the Grants for Substance Abuse Treatment in State and Local Criminal Justice Systems; and the Grants for Training in Provision of Treatment Services.

The second subagency of SAMHSA is the Center for Substance Abuse Prevention (CSAP), which administers such prevention activities as Community Prevention Programs; and the Prevention, Treatment, and Rehabilitation Programs for High-Risk Youth. The Center for Mental Health Services (CMHS) administers programs and activities for the promotion of mental health, and the prevention and treatment of mental illness: the Block Grant for Community Mental Health Services authorized in title II of the Act; Demonstration Projects related to services for seriously mentally ill individuals and children and adolescents with serious emotional and mental disturbances; Demonstration Projects for counseling and mental health services for individuals and families of individuals testing positive for AIDS; and Grants for Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances.

Title I of the Act transfers the three research institutes to the National Institutes of Health. It also establishes other responsibilities for these institutes related to their basic research missions. For instance, Title I establishes within each of the three institutes the position of Associate Director for Prevention to focus on prevention issues. It also establishes within each of NIDA and NIMH an Office on AIDS to coordinate AIDS research in such areas as transmission via drug abuse and transmission via sexual behavior, respectively. The Act establishes a Medications Development Program in NIDA to promote research in the development and use of medications to treat drug addiction. Within NIMH, the Act establishes an Office of Rural Mental Health Research.

Title II of P.L. 102-321 provides for the establishment of separate block grants for mental health services and substance abuse services. It authorizes appropriations of $450 million for FY1993 and such sums as may be necessary for FY1994 for the Block Grant for Community Mental Health Services. Funds under this block grant are allocated to the States by a formula utilizing such factors as each State's relative proportion of population of certain age groups considered at risk for mental illness, each State's taxable resources, and the comparative costs in each State of providing mental health services.

Title II authorizes appropriations of $1.5 billion for FY1993 and such sums as may be necessary for FY1994 for the Block Grant for Prevention and Treatment of Substance Abuse. The allotment formula uses similar factors as with the mental health block grant -- populations at risk for substance abuse, taxable resources, and cost of providing substance abuse services. Under the substance abuse block grant, States will

have to set aside 5% in FY1993 and FY1994 to increase services to pregnant women and women with dependent children. In addition, States will have to assure that entities receiving funds under the block grant for substance abuse treatment make available services for tuberculosis treatment and referral. States with high incidence of HIV infection will have to set aside block grant funds for early intervention services to persons receiving substance abuse treatment.

Title II also authorizes a new program of grants to help States with insufficient substance abuse treatment capacity expand such capacity.

Title III of the Act authorizes a Model Comprehensive Program for Treatment of Substance Abuse in the National Capital Area. Title IV authorizes a programs of Grants for Services for Children of Substance Abusers. Title V authorizes Grants for Home Visiting Services for At-Risk Families to improve maternal, infant, and child health. Title VI authorizes Grants for Trauma Centers Operating in Areas Severely Affected by Drug-Related Violence that have incurred substantial uncompensated costs in providing trauma care related to violence arising from drug trafficking.

Title VII authorizes a number of studies and reports, as follows: a study the Institute of Medicine on the development of anti-addiction medicine, addressing such issues as the role of the private sector and the process of Food and Drug Administration approval; a study of the provision of mental health services in correctional facilities; a study of the barriers to insurance coverage of treatment for mental illness and substance abuse; a study on Fetal Alcohol Effect and Fetal Alcohol Syndrome; a study by the National Academy of Sciences on needle exchange and bleach distribution programs to reduce the spread of HIV infection among intravenous drug abusers; a report on the block grant allotment formula; and a report by SAMHSA on health insurance coverage issues and treatment effectiveness for substance abuse and mental illness.

Major Issues

The debate over the ADMS block grant and related programs has featured the consideration of several issues. These include the revision of the allocation formula for the block, the question of whether to split the block grant into two separate programs, the proposal to transfer research functions of ADAMHA to NIH, the issue of set-asides under the block grant, and the effectiveness of prevention and treatment approaches.

Revision of the Block Grant Allocation Formula

Since the creation of the ADMS block grant in 1981, the formula under which funds from the block are allocated among the States has been an issue of discussion and concern. When the block grant was established, the allocation formula was based on historical funding proportions from the categorical grant programs for substance abuse and mental health which the block grant replaced. Funds were allocated to the States based on their allocations in certain specific years for the these programs: FY1980 for funds allocated for the alcohol and drug abuse programs, and FY1981 (prior to a rescission) for the mental health programs. The conference report for the 1981 legislation stated that the conferees anticipated that this two-part formula would result

in national allocations for mental health and substance abuse programs which were approximately equal to each other.

This allocation formula caused complaints of inequity almost immediately. The laws authorizing the previous project grants had not established priorities for awarding grants. Under the Community Mental Health Centers (CMHC) program, one of the programs replaced by the block grant, for example, grants had been awarded directly to CMHC applicants by the Department of Health, Education, and Welfare, now the Department of Health and Human Services. States were not involved in the grant process and State-by-State proportional funding was not considered. The CMHC program was based on an 8-year funding cycle, under which a grantee would receive grants for an 8-year period, after which Federal support would end. By 1981, when the ADMS block grant was created, those States in which CMHCs had applied for and received grant funds early in the program's history, because of the funding cycle, would have been receiving less under the program in comparison to those States which had begun participating in the CMHC program in the early or mid-1970s. A formula, therefore, using FY1981 as a bench mark for allocating State allotments might appear to penalize those States in which applicants had been aggressive early in pursuing funds to support community mental health services.

The 1984 amendments to the block grant, P.L. 98-509, revised the allocation formula to reflect the relative populations and per capita incomes of each State. Conferees on this bill expressed the belief that population and per capita income were "a more reliable and equitable means" of allocating block grant funds than the original formula. The 1984 amendments also required the Department to enter into an agreement with a nongovernmental entity to study the allocation formula. The Department contracted with the University of California, San Francisco, to conduct such a study, and its 1986 report concluded that the original formula was inequitable, and recommended that the formula be refined to include need indicators based on age and gender of the population at risk, and on program factors, and that a State fiscal capacity measure be maintained and refined within the formula.

The 1988 legislation reauthorizing the block grant established a new formula to allocate grant funds to the States. The new formula was based on each State's proportion of populations at risk, with particular focus on urban populations based on the rationale that substance abuse, especially illicit drug use, occurs more often in urban areas than in other areas, and on certain age groups at risk for substance abuse and mental illness. Each State receives a minimum allotment of the lesser of $7 million or 105% of the total of allotments received in FY1988 for the ADMS block grant and the substance abuse treatment grants to the States.

Objections arose to the new formula almost immediately after its 1988 enactment, primarily because of the preference it gave to States with large urbanized areas. The argument against this preference was that, although drug abuse may occur more often in urban than rural areas, it does not occur to the extent that the preference in the formula indicates. Small States and States with predominantly rural populations called for the removal of the urban weight from the formula, but attempts to change the formula during the 101st Congress were unsuccessful. S. 1306 as passed by Congress and signed into law as P.L. 102-321 removes the urban weight in the formula to eliminate the imbalance in allocations to small States and States with rural populations. It uses such factors as populations at risk, State taxable resources, and

comparative costs of providing services in the formulas for the new separate block grants.

Separate Block Grants for Substance Abuse and Mental Health

When the ADMS block grant was created in 1981, the State allocation formula was devised to assure that funds appropriated for the program were split evenly nationwide between substance abuse and mental health services. With the emergence, starting in the mid-1980s, of a national consensus on the dangers of substance abuse, especially drug abuse, and the enactment of omnibus drug abuse legislation to increase support for a "War on Drugs," the balance in the funding under the block grant began to disappear. The enactment of a new program focused solely on funding for substance abuse services by Anti-Drug Abuse Act of 1986, and then the revision of the allocation formula by the 1988 Anti-Drug Abuse Act added factors into the formula that in effect removed the 50/50 balance between substance abuse and mental health in the nationwide distribution of block grant appropriations, tipping the balance heavily in favor of substance abuse.

Table 2 shows the history of the allocation of block grant funds between substance abuse and mental health services from FY1982 to FY1991. Table 2 shows that, although the intent of the original formula for the block grant was for an equal distribution of funds between mental health and substance abuse, the allocation for mental health between FY1982 and FY1988 ranged from 47.7% to 49.2% and never achieved 50%. In the past three years, the allocation for substance abuse services has jumped to over 79%. Over the 10-year history of the block grant, the allocation of funds for mental health services has increased from $204.1 million to $250.5 million, while the substance abuse allocation has nearly quadrupled from $224 million to $954.7 million.

As the gap between funding levels for the two types of disorders began to grow in the late 1980s, some in the mental health and related fields began to express concern that the problems of mentally ill persons and the way they were addressed in a major Federal program were beginning to be overshadowed by the problems of drug abuse. Some commentators noted that the 1988 revision in the block grant formula that targeted urban area drug use should not be used for allocating mental health funds as well, and that mental health programs should not have to compete with substance abuse programs for program funding.

Some mental health care professionals and policymakers oppose the separation of mental health from the block grant. They note the incidence of comorbidity -- individuals with both mental illness and substance abuse problems -- and point out the possible difficulty of coordination of services for such patients if the programs were split. In many States, substance abuse and mental health programs are administered by the same State agency.

Legislation passed by the 102d Congress and signed into law as P.L. 102-321 establishes two separate block grants -- the Block Grant for Community Mental Health Services and the Block Grant for Prevention and Treatment of Substance Abuse.

TABLE 2. Alcohol, Drug Abuse, and Mental Health Services Block Grant Allocation of Appropriations for Substance Abuse and Mental Health, FY1982-91
(dollars in millions)

Fiscal year	Appropriation available for allocation to States	Substance abuse allocation (percentage)	Mental health allocation (percentage)
1982	$ 428.1	$224.0 (52.3%)	$204.1 (47.7%)
1983	468.0	237.6 (50.8%)	230.4 (49.2%)
1984	462.0	234.5 (50.8%)	227.5 (49.2%)
1985	490.0	250.6 (51.1%)	239.4 (48.9%)
1986	468.9	238.5 (50.1%)	230.4 (49.1%)
1987	508.6	260.7 (51.2%)	248.1 (48.8%)
1988	487.3	249.2 (51.1%)	238.1 (48.9%)
1989	765.3	518.7 (67.8%)	246.6 (32.2%)
1990	1,133.2	895.6 (79%)	237.6 (21%)
1991	1,205.2	954.7 (79%)	250.5 (21%)
1992	1,292.0	1,031.1 (79.8%)	260.9 (20.2%)

Source: Division for State assistance, OTI, ADAMHA, DHHS.

Transfer of Research Functions from ADAMHA to NIH

Before the creation of the ADMS block grant in 1981, ADAMHA consisted of three institutes, NIAAA, NIDA, and NIMH, each with its own services programs and research activities. After 1981, the block grant was administered first by the office of the Administrator of ADAMHA and then by OTI; the three institutes lost their services functions and became primarily research institutes. At the present time, ADAMHA consists of five separate entities: the three institutes, which although they are primarily research entities, conduct some service demonstration projects; and OSAP and OTI, which administer prevention and treatment services programs, although they also conduct research demonstration activities to evaluate the outcomes of their programs.

A debate has developed over the years as to whether this dual mission for ADAMHA -- services and research -- is a feasible one. Those in the research field have noted a feeling of being overshadowed within the agency by its services function. Many researchers in the area of substance abuse and mental illness have expressed a wish for a transfer of ADAMHA's research activities to NIH where they could enjoy the prominence that would derive from the association with that research agency. Supporters of such a transfer feel that it would serve a symbolic function and help to remove some of the stigma attached to substance abuse and mental illness as diseases.

Other commentators in the field are concerned that the separation of the two functions will make more difficult the transfer of what is learned in research to the provision of treatment services to mentally ill persons and substance abusers. The proposed transfer is a particular concern with relation to ADAMHA's current services-related research and demonstration activities. Questions have arisen as to whether, after a transfer of the institutes to NIH, such activities should be carried out and administered through NIH or through the services-oriented agency that remains.

P.L. 102-321 provides for the transfer of the three ADAMHA research institutes to NIH. It renames ADAMHA as the Substance Abuse and Mental Health Services Administration (SAMHSA).

Set-Asides and Other State Requirements

Another area of concern and discussion regarding the ADMS block grant over the years has been the issue of set-asides -- percentage restrictions or requirements that govern expenditure of funds by States under the block grant. The 1981 legislation creating the block required, for instance, that each State use at least 35% of the substance abuse portion of its block grant allocation for alcohol abuse activities and 35% for drug abuse activities, and that each State use at least 20% of its substance abuse allocation for prevention and early intervention activities designed to discourage the abuse of alcohol and drugs. Later amendments to the authority in succeeding Congresses included additional set-aside requirements pertaining to alcohol and drug abuse services for women and mental health services for underserved areas and for underserved populations, with special emphasis on new mental health services for severely disturbed children and adolescents.

The 1988 amendments to the block grant authority added new earmarks and set-asides for the block grant program. For instance, a State must use block grant funds appropriated in the 1988 Anti-Drug Abuse Amendments for substance abuse treatment only, and must spend at least 50% of those funds for programs of prevention and treatment of intravenous (IV) drug abuse, with priority to programs for individuals infected with the AIDS virus, and related activities. States are required to use not less than 10% of block grant funds for programs and services designed for women, especially pregnant women and women with dependent children.

The 1988 block grant reauthorization also included set-aside requirements for the mental health part of the block grant emphasizing the support of new mental health services programs as well as services for children and adolescents. Under these provisions, States are required to use at least 55% of block grant funds allocated for mental health activities to develop and provide community mental health services and programs that were not available on Oct. 1, 1988, and can provide funds for these new services only for a limited period of time. At least 10% of the mental health allocation of a State's block grant allotment must be used to provide services and programs for seriously emotionally disturbed children and adolescents.

Those who oppose the requirement of set-asides in block grants argue that such provisions act against the purpose of block grants by limiting flexibility of States to administer these programs in response to their own specific needs and problems. States without a significant problem in IV drug abuse, for example, object to the provision in

the 1988 amendments requiring them to use 50% of their substance abuse allocations under the block grant for IV drug use prevention and treatment. Those in favor of set-asides argue that such provisions act to stimulate new and expanded services in areas, such as substance abuse services for women, that would not be addressed without the specific authority that the set-aside provides.

There are questions as to whether set-asides accomplish what they are intended to do. A May 1991 report from the General Accounting Office (GAO) reviewed how the block grant set-aside for women addressed the treatment needs of drug-abusing women. GAO found a large gap between the numbers of drug-abusing pregnant women and mothers with young children and the availability of treatment centers to meet their needs. The report also found that Congress lacks a clear understanding of how the women's set-aside is used or what impact it has on the treatment of this population because the Department has not clearly specified to States what information must be provided.

Program Effectiveness

As the Congress authorizes and funds programs to support substance abuse prevention and treatment services, there is continued discussion about the effectiveness of such services. There has always been such concern about program effectiveness. Twenty years ago, drug abuse treatment programs were aimed primarily at the older heroin addict and alcohol abuse programs were aimed at the adult alcoholic. In recent years, the emphasis has shifted to a younger population of substance abusers, who use a variety of non-opiate substances, such as marijuana, cocaine, alcohol, or a combination of these and other substances, but the debate about the effectiveness of various treatment approaches has continued.

A variety of treatment approaches are available, residential and nonresidential. Some specialized residential treatment programs, such as therapeutic communities, have been effective with certain types of drug and alcohol abusers. Many of these programs are extremely expensive and require an extensive commitment of time, and therefore are often not a viable option for lower or middle income persons, who cannot afford the time or money. The development of a variety of outpatient treatment programs has provided alternatives. Outpatient programs utilize less intensive counseling and employ different approaches, such as psychotherapy, behavior modification, family therapy, and the use of pharmacological products, such as antidepressants.

Evaluations of treatment modes indicate that a variety of existing approaches to treatment have been effective in achieving reductions in drug and alcohol use and associated problem behaviors. There is little evidence that any one type of treatment is superior to others. Characteristics of the patients, such as desire to enter treatment, stable family or other relationship, and existence of employment after treatment, as well as length of time spent in treatment, are also important factors in the effective outcome of treatment.

The 1988 Anti-Drug Abuse Amendments legislation authorized services research, through both NIAAA and NIDA, to evaluate the quality, appropriateness, and costs of various forms of alcohol and drug abuse treatment programs. The President's initial National Drug Control Strategy, published in September 1989, called for accountability among State and local treatment programs for effectiveness, including the enactment

of amendments to the Act requiring States, as a condition for receipt of Federal funds for drug treatment, to develop and implement Statewide drug treatment plans. Such a requirement for State drug treatment plans has been included in legislation that was considered but not enacted by the Congress in recent years.

LEGISLATION

H.R. 3698 (Waxman)

Community Mental Health and Substance Abuse Services Improvement Act of 1991. Amends Title XIX of the PHS Act to establish a Mental Health Block Grant and a Substance Abuse Block Grant. Amends Title V of the Act related to research in mental illness, alcohol abuse and alcoholism, and drug abuse, and to substance abuse prevention. Introduced Nov. 1, 1991; referred to Committee on Energy and Commerce. Reported Mar. 24, 1992 (H.Rept. 102-464), and passed by House under suspension of rules. The House then passed S. 1306 after amending it to contain the language of H.R. 3698 as passed by the House.

P.L. 102-321, S. 1306

Alcohol, Drug Abuse, and Mental Health Reorganization Act of 1991. Restructures ADAMHA into a services-oriented agency, transferring the National Institutes on Alcohol Abuse and Alcoholism, Drug Abuse, and Mental Health to NIH. Also amends and extends the authority for the ADMS block grant, including a revision of the allocation formula. Introduced June 17, 1991; referred to Committee on Labor and Human Resources. Reported July 30, 1991 (S.Rept. no 102-131). Passed by Senate on Aug. 2, 1991. Passed by House Mar. 24, 1992, after substituting the language of H.R. 3698 as passed by the House. Conference agreement reported May 14 (H.Rept. 102-522). On May 19, the House, under suspension of rules, failed to agree on the conference report. On May 28, the House, under regular order, voted to recommit the bill to the conference committee for reconsideration. Second conference agreement reported June 3 (H.Rept. 102-546). Passed by the Senate on June 9, and by the House on July 1. Signed into law July 10, 1992.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. Senate. Committee on Labor and Human Resources. ADAMHA Reorganization Act of 1991. Report to accompany S. 1306, 102d Congress, 1st session. July 30, 1991. Senate Report no. 102-131.

FOR ADDITIONAL READING

U.S. General Accounting Office. Proposed formulas for substance abuse, mental health provide more equity. Briefing report to the Chairman, House Committee on Energy and Commerce Subcommittee on Health and the Environment. Washington, July 1987. GAO/HRD-87-109BR

----- ADMS block grant: women's set-aside does not assure drug treatment for pregnant women. Report to the Chairman, Subcommittee on Health and the Environment. Washington, May 1991. GAO/HRD-91-80.

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CRS Issue Brief 87013

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CRS Report 90-412 EPW

DEPARTMENT OF HEALTH & HUMAN SERVICES

A fax message from:
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Date: 4/8/93 Total number of pages sent: 13

Comments:

"Here's the draft release on teenage drug use survey and Q's and A's. Date for scheduled release is 4/13/93 but Senator Biden has requested advance copy as has apparently been past practice."

Avis LaVelle

HHS NEWS

DRAFT #70

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: Anne Verano
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HHS Secretary Donna E. Shalala today announced that the states of New York, Massachusetts, South Carolina, Maryland and Washington will conduct Medicaid demonstration projects to test methods for reaching and treating pregnant drug abusers and their children.

More than 2,000 women--at least 300 in each state--will receive care during the three year, $6 million demonstration.

"We are seeking the most effective strategies for bringing these women into appropriate care and preventing tragic consequences for them and their infants," Secretary Shalala said.

The projects, which will be administered by the Health Care Financing Administration, stem from surveys of urban hospitals showing 100,000 babies born each year to drug-abusing mothers.

The states will conduct outreach programs to find pregnant, Medicaid-eligible drug abusers, providing them with prenatal care, drug treatment and counseling, and other services.

"Healthier babies mean lower Medicaid costs," said William Toby, Jr., acting administrator of HCFA. "We believe this demonstration will result in fewer infants spending the first weeks of life in costly intensive care units, fewer infants requiring medical treatment in the months and years ahead, and Medicaid savings to the states and federal

-More-

government of $1 million."

Low birth weight and other health problems affect many of these infants, and drug dependency frequently limits the ability of their mothers to care for them.

"These projects are in keeping with the Clinton Administration's commitment to allow states the flexibility to initiate programs that serve their specific needs," Toby said.

The selected states presented strong prenatal care and substance abuse treatment systems, research and data management capability, and other innovative strategies, including creative methods of outreach.

Women entering the program may also receive ancillary services, such as nutrition counseling, parenting education, and transportation to service sites.

Case management--the assignment of a qualified individual to plan and coordinate all of the services needed by a patient--is a feature of the demonstration project in each state.

Massachusetts, New York, Washington and South Carolina will treat some women in residential substance abuse treatment facilities.

# # #

Editor's Note: HCFA, an agency of the U.S. Department of Health and Human Services, directs the Medicare and Medicaid programs, which help pay the medical bills of more than 67 million Americans. HCFA's estimated fiscal year 1993 expenditures are almost $230 billion.

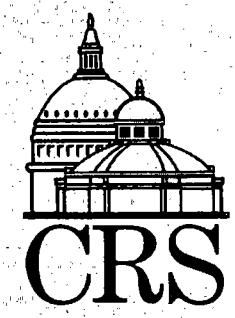
Order Code IB88009

CRS Issue Brief

Alcohol, Drug Abuse, and Mental Health Block Grant and Related Programs

Updated November 16, 1992
(Archived)

by
Edward Klebe
Education and Public Welfare Division



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CONTENTS

Alcohol, Drug Abuse, and Mental Health Block Grant and Related Programs

SUMMARY

Title XIX of the Public Health Service (PHS) Act authorizes the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, which provides grants to States for: (1) prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse; and (2) support to community mental health centers for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations. The block grant is administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services.

Title V of the PHS Act authorizes substance abuse prevention activities through ADAMHA's Office of Substance Abuse Prevention (OSAP). Title V also authorizes biomedical and clinical research, as well as service-related research to evaluate various forms of alcohol and drug abuse treatment programs and community-based services for the mentally ill, through ADAMHA's three research institutes -- National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA), and National Institute of Mental Health (NIMH).

A bill to amend the block grant authority, S. 1306, was passed by the 102d Congress and signed into law on July 10, 1992, as P.L. 102-321. This legislation splits the ADMS Block Grant into two discrete block grants -- one for prevention and treatment of substance abuse and the other for community mental health services. The legislation also transfers ADAMHA's three research institutes to the National Institutes of Health and replaces ADAMHA with a new services related agency -- the Substance Abuse and Mental Health Services Administration (SAMHSA). The legislation also contains provisions authorizing a model demonstration substance abuse treatment in the national capital area, a program of services for children of substance abusers, and a program of grants for trauma centers serving areas affected by drug-related violence.

The FY1992 appropriation for the block grant was $1.360 billion. The appropriation for FY1993 for the new Substance Abuse Block Grant is $1.13 billion, and for the new Mental Health Block Grant, $277.9 million. The FY1992 appropriation for OSAP was $285.1 million; the FY1993 appropriation for substance abuse prevention activities is $246.9 million. The FY1992 appropriations for research at NIAAA, NIDA, and NIMH are $152.4 million, $270 million, and $505.8 million, respectively. The FY 1993 appropriations for NIAAA, NIDA, and NIMH, part of NIH as of Oct. 1, 1992, are $177.3 million, $405.7 million, and $585.7 million, respectively.

ISSUE DEFINITION

Title XIX of the Public Health Service (PHS) Act authorizes grants to States for alcohol and drug abuse treatment and prevention activities and community mental health services. Title V of the PHS Act authorizes related substance abuse and mental health programs and activities in the areas of prevention and biomedical, clinical, and services-related research. These activities were administered, until October 1, 1993, by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services. A bill passed by the Congress and signed into law on July 10, 1992, among other things: splits the block grant into two separate programs, one for substance abuse services and the other focusing on mental health services; change the block grant's allocation formula; and transfer research and related activities from ADAMHA to the National Institutes of Health, leaving ADAMHA as a services agency renamed the Substance Abuse and Mental Health Services Administration (SAMHSA).

BACKGROUND AND ANALYSIS

The incidence of substance abuse -- the abuse of alcohol and illicit drugs -- and of mental illness have been for many years a matter of concern in the United States. Regarding substance abuse, the most recent national survey, the 1991 National Household Survey on Drug Abuse, indicates that 37% of the household population aged 12 and older in the U.S. reported that they had used one or more illicit drugs in their lifetimes, 12,4% had used illicit drugs in the past year, and 6.2% had used them in the last month. Eighty-five percent of the household population had ever used alcohol, 66% had used alcohol in the past year, and 51% had used it in the past month. The most commonly used illicit drug was marijuana, and the next most commonly used drugs were prescription-type psychotherapeutic drugs and cocaine. Estimates indicate that nearly 18 million persons aged 18 and older have problems related to alcohol abuse and alcoholism. More than 57% of a national survey of high school seniors in 1990 reported having used alcohol in the previous 30 days and 32% reported having five drinks or more in the two weeks before the survey.

The National Institute of Mental Health (NIMH) estimates that more than 1% of the adult population of the United States, 2.8 million persons, have serious mental illnesses, such as schizophrenia, severe forms of depression, psychosis, dementia, and others. Because of these disorders, many of these individuals are unable to complete their education, maintain employment, or otherwise lead productive lives.

Throughout the last 25 years, the Congress has enacted legislation to create and support a variety of Federal programs to support research into the causes and treatment of substance abuse and mental illness and to establish and support programs of prevention and treatment. These programs are administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services.

Program Description

Alcohol, Drug Abuse, and Mental Health Services Block Grant

Title XIX of the Public Health Service (PHS) Act, until the July 1992 enactment of P.L. 102-321, described below, authorizes the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant. As established by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Title XIX provides grants to States for the following,

-- Prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse.

-- Grants to community mental health centers for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations.

The block grant was administered by the Office for Treatment Improvement (OTI), of ADAMHA, which performed certain policy oversight and coordination activities related to the block, and, in addition, was responsible for assessing State compliance with legislative provisions for the block by reviewing State applications, annual reports and audits, conducting compliance reviews and investigations, and processing complaints. These responsibilities are currently carried out by the Center for Substance Abuse Treatment and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, authorized by P.L. 102-321.

Office of Substance Abuse Prevention

Until amended by P.L. 102-321, Title V of the PHS Act authorized the establishment in ADAMHA of an Office of Substance Abuse Prevention (OSAP), which carries out a variety of substance abuse prevention activities, including the operation of a Clearinghouse on Alcohol and Drug Abuse Information, a program of Model Projects for High Risk Youth, as well as a program of Model Projects for Pregnant and Postpartum Women and Their Infants. OSAP also administered a program of grants for drug abuse demonstration projects of national significance, with $10 million of the amount appropriated to be made available for projects to (1) determine the feasibility and efficacy of programs providing drug abuse treatment and vocational training in exchange for public service; (2) conduct outreach activities to intravenous drug abusers to prevent exposure to, and transmission of, the etiologic agent for AIDS and to encourage intravenous drug abusers to seek treatment; and (3) provide drug abuse treatment services for pregnant and postpartum women, and their infants.

ADAMHA Research

Prior to the enactment of P.L. 102-321, Title V also authorized ADAMHA, through the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and NIMH, to carry out and support basic and clinical, as well as service-related research. This included support for research to evaluate the quality, appropriateness, and costs of various forms of alcohol and drug abuse treatment programs. Title V also supported service research on community-based mental health

treatment programs and services, through NIMH, including evaluation of methods of providing community-based services for the mentally ill; and of the quality, appropriateness, and costs of different methods of treatment.

Appropriations

The FY1992 appropriation for the ADMS block grant was $1.360 billion, $1.292 billion of which was available for allocation to the States. The President's FY1993 budget proposal requested an identical $1.360 billion for the block grant. The FY1992 appropriation for OSAP was $276.3 million. The Administration's budget request for OSAP for FY1993 was $305.5 million. The FY1992 appropriations for research are $152.4 million at NIAAA, $270.0 million at NIDA, and $505.8 million at NIMH. The FY1993 appropriation requests for research at NIAAA, NIDA, and NIMH were $160.2 million, $284.6 million, and $536.8 million respectively. The FY1993 appropriation for the Departments of Labor/HHS/Education provides appropriations for these programs as amended by P.L. 102-321, as follows: $1.13 billion for the new substance abuse block grant, $277.9 million for the new mental health block grant, $246.9 million for substance abuse prevention programs; $177.3 million for NIAAA, $405.7 million for NIDA, and $585.7 million for NIMH.

TABLE 1. Appropriations for Selected Programs of Alcohol, Drug Abuse, and Mental Health Administration, FY1991 -- FY1993
(dollars in millions)

Program	FY1991 Approp.	FY1992 Approp.	FY1993 Approp.
ADMS Block Grant	$1,268.7	$1,360.0	--
Sub. Abuse Block Grant	N/A	N/A	$1,130.5
MH Block Grant	N/A	N/A	$277.9
OSAP	$271.5	$276.3	$246.9
Alcohol Abuse Research	$138.8	$152.4	$177.3
Drug Abuse Research	$257.9	$270.0	$405.7
Mental Health Research	$455.5	$505.8	$585.7

Legislation in the 102d Congress

Legislation was considered in both the House and the Senate during the first session of the 102d Congress to amend and extend the ADMS Block Grant, but final action was not taken. S. 1306, the ADAMHA Reorganization Act, passed by the Senate on Aug. 2, 1991, amended the block grant authority and, in addition, restructured the agency which administers it. The Senate bill extended the block grant authority through FY1994, and amended the block grant allocation formula to reduce the current imbalance between urban and rural States in the allocation of funds. The Senate bill also provided for the transfer of the three ADAMHA research institutes to the National Institutes on Health. S. 1306 as originally passed by the Senate restructured ADAMHA as a services-oriented agency renamed the Alcohol, Drug Abuse, and Mental Health Services Administration (ADAMHSA), consisting of the Office of Treatment Improvement (OTI), the Office for Substance Abuse Prevention (OSAP), and a new Office for Mental Health Services (OMHS).

The House early in 1992 passed legislation dividing the ADMS block grant into two blocks -- a mental health services block grant and a substance abuse services block grant. The previous year, on May 13, 1991, Representative Waxman had introduced H.R. 2311, the Community Mental Health Services Improvement Act. H.R. 2311, which established a new Community Mental Health Services Block Grant, was replaced, on June 28, by a clean bill, H.R. 2803. On November 1, Representative Waxman then introduced a new bill, H.R. 3698, the Community Mental Health and Substance Abuse Services Improvement Act of 1991. H.R. 3698 was reported to the House on Mar. 24, 1992, and passed under suspension of the rules on the same day. The House then passed S. 1306 after substituting the language of H.R. 3698. As passed by the House, the bill established separate block grants for community mental health services and substance abuse services and authorized a program of demonstration grants to improve treatment of severely disturbed children and adolescents. It also established a new Substance Abuse Treatment Capacity Expansion Program and reauthorized existing substance abuse treatment project grant programs, including programs aimed at high-risk youth and at pregnant and postpartum women.

On May 14, 1992, the conference committee on S. 1306 reported agreement on the bill (H.Rept. 102-522). The conference agreement transfers the three research institutes to NIH and establishes a new services agency to replace ADAMHA. The new agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), consists of three centers -- the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. The conference agreement also splits the block grant into two discrete block grants, one for community mental health services and one for substance abuse treatment and prevention services. The allocation formulas for the two new block grants are modified to reduce the urban weight in the current block grant formula.

The House considered the conference agreement under suspension of rules on May 19 and failed to pass it by the required three-fourths majority. On May 28, the House, under regular order, voted to recommit the bill to the conference committee for reconsideration. The major objections to the bill in the House were the implementation of the allocation formulas for the block grants, under which several States would lose part of their FY1992 allocations under the block, and the removal, in the conference agreement, of a provision in current law prohibiting States from using their block grant

allocations for programs promoting needle exchange and distribution of bleach as a method of reducing HIV infection among intravenous drug abusers.

A second conference agreement on S. 1306, reported on June 3 (H.Rept. 102-546), was the same as the first one, except that, instead of removing the prohibition of States rom using block grant funds for needle exchange programs, it prohibited such programs unless the Surgeon General determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

The Senate passed the conference agreement on June 9; the House passed it on July 1. The President signed S. 1306 into law on July 10 as P.L. 102-321.

Summary of P.L. 102-321, the ADAMHA Reorganization Act

Title I of the Act establishes the Substance Abuse and Mental Health Services Administration (SAMHSA) to replace ADAMHA. This new agency consists of three subagencies. The first of these is the Center for Substance Abuse Treatment (CSAT), which administers the following programs: the Block Grant for Prevention and Treatment of Substance Abuse authorized in Title II of the Act; the Residential and Outpatient Treatment for Pregnant and Postpartum Women; the Demonstration Projects of National Significance for Treatment Improvement; the Grants for Substance Abuse Treatment in State and Local Criminal Justice Systems; and the Grants for Training in Provision of Treatment Services.

The second subagency of SAMHSA is the Center for Substance Abuse Prevention (CSAP), which administers such prevention activities as Community Prevention Programs; and the Prevention, Treatment, and Rehabilitation Programs for High-Risk Youth. The Center for Mental Health Services (CMHS) administers programs and activities for the promotion of mental health, and the prevention and treatment of mental illness: the Block Grant for Community Mental Health Services authorized in title II of the Act; Demonstration Projects related to services for seriously mentally ill individuals and children and adolescents with serious emotional and mental disturbances; Demonstration Projects for counseling and mental health services for individuals and families of individuals testing positive for AIDS; and Grants for Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances.

Title I of the Act transfers the three research institutes to the National Institutes of Health. It also establishes other responsibilities for these institutes related to their basic research missions. For instance, Title I establishes within each of the three institutes the position of Associate Director for Prevention to focus on prevention issues. It also establishes within each of NIDA and NIMH an Office on AIDS to coordinate AIDS research in such areas as transmission via drug abuse and transmission via sexual behavior, respectively. The Act establishes a Medications Development Program in NIDA to promote research in the development and use of medications to treat drug addiction. Within NIMH, the Act establishes an Office of Rural Mental Health Research.

Title II of P.L. 102-321 provides for the establishment of separate block grants for mental health services and substance abuse services. It authorizes appropriations of

$450 million for FY1993 and such sums as may be necessary for FY1994 for the Block Grant for Community Mental Health Services. Funds under this block grant are allocated to the States by a formula utilizing such factors as each State's relative proportion of population of certain age groups considered at risk for mental illness, each State's taxable resources, and the comparative costs in each State of providing mental health services.

Title II authorizes appropriations of $1.5 billion for FY1993 and such sums as may be necessary for FY1994 for the Block Grant for Prevention and Treatment of Substance Abuse. The allotment formula uses similar factors as with the mental health block grant -- populations at risk for substance abuse, taxable resources, and cost of providing substance abuse services. Under the substance abuse block grant, States will have to set aside 5% in FY1993 and FY1994 to increase services to pregnant women and women with dependent children. In addition, States will have to assure that entities receiving funds under the block grant for substance abuse treatment make available services for tuberculosis treatment and referral. States with high incidence of HIV infection will have to set aside block grant funds for early intervention services to persons receiving substance abuse treatment.

Title II also authorizes a new program of grants to help States with insufficient substance abuse treatment capacity expand such capacity.

Title III of the Act authorizes a Model Comprehensive Program for Treatment of Substance Abuse in the National Capital Area. Title IV authorizes a programs of Grants for Services for Children of Substance Abusers. Title V authorizes Grants for Home Visiting Services for At-Risk Families to improve maternal, infant, and child health. Title VI authorizes Grants for Trauma Centers Operating in Areas Severely Affected by Drug-Related Violence that have incurred substantial uncompensated costs in providing trauma care related to violence arising from drug trafficking.

Title VII authorizes a number of studies and reports, as follows: a study the Institute of Medicine on the development of anti-addiction medicine, addressing such issues as the role of the private sector and the process of Food and Drug Administration approval; a study of the provision of mental health services in correctional facilities; a study of the barriers to insurance coverage of treatment for mental illness and substance abuse; a study on Fetal Alcohol Effect and Fetal Alcohol Syndrome; a study by the National Academy of Sciences on needle exchange and bleach distribution programs to reduce the spread of HIV infection among intravenous drug abusers; a report on the block grant allotment formula; and a report by SAMHSA on health insurance coverage issues and treatment effectiveness for substance abuse and mental illness.

Major Issues

The debate over the ADMS block grant and related programs featured the consideration of several issues. These include the revision of the allocation formula for the block, the question of whether to split the block grant into two separate programs, the proposal to transfer research functions of ADAMHA to NIH, the issue of set-asides under the block grant, and the effectiveness of prevention and treatment approaches.

Revision of the Block Grant Allocation Formula

Since the creation of the ADMS block grant in 1981, the formula under which funds from the block are allocated among the States has been an issue of discussion and concern. When the block grant was established, the allocation formula was based on historical funding proportions from the categorical grant programs for substance abuse and mental health which the block grant replaced. Funds were allocated to the States based on their allocations in certain specific years for the these programs: FY1980 for funds allocated for the alcohol and drug abuse programs, and FY1981 (prior to a rescission) for the mental health programs. The conference report for the 1981 legislation stated that the conferees anticipated that this two-part formula would result in national allocations for mental health and substance abuse programs which were approximately equal to each other.

This allocation formula caused complaints of inequity almost immediately. The laws authorizing the previous project grants had not established priorities for awarding grants. Under the Community Mental Health Centers (CMHC) program, one of the programs replaced by the block grant, for example, grants had been awarded directly to CMHC applicants by the Department of Health, Education, and Welfare, now the Department of Health and Human Services. States were not involved in the grant process and State-by-State proportional funding was not considered. The CMHC program was based on an 8-year funding cycle, under which a grantee would receive grants for an 8-year period, after which Federal support would end. By 1981, when the ADMS block grant was created, those States in which CMHCs had applied for and received grant funds early in the program's history, because of the funding cycle, would have been receiving less under the program in comparison to those States which had begun participating in the CMHC program in the early or mid-1970s. A formula, therefore, using FY1981 as a bench mark for allocating State allotments might appear to penalize those States in which applicants had been aggressive early in pursuing funds to support community mental health services.

The 1984 amendments to the block grant, P.L. 98-509, revised the allocation formula to reflect the relative populations and per capita incomes of each State. Conferees on this bill expressed the belief that population and per capita income were "a more reliable and equitable means" of allocating block grant funds than the original formula. The 1984 amendments also required the Department to enter into an agreement with a nongovernmental entity to study the allocation formula. The Department contracted with the University of California, San Francisco, to conduct such a study, and its 1986 report concluded that the original formula was inequitable, and recommended that the formula be refined to include need indicators based on age and gender of the population at risk, and on program factors, and that a State fiscal capacity measure be maintained and refined within the formula.

The 1988 legislation reauthorizing the block grant established a new formula to allocate grant funds to the States. The new formula was based on each State's proportion of populations at risk, with particular focus on urban populations based on the rationale that substance abuse, especially illicit drug use, occurs more often in urban areas than in other areas, and on certain age groups at risk for substance abuse and mental illness. Each State receives a minimum allotment of the lesser of $7 million or 105% of the total of allotments received in FY1988 for the ADMS block grant and the substance abuse treatment grants to the States.

Objections arose to the new formula almost immediately after its 1988 enactment, primarily because of the preference it gave to States with large urbanized areas. The argument against this preference was that, although drug abuse may occur more often in urban than rural areas, it does not occur to the extent that the preference in the formula indicates. Small States and States with predominantly rural populations called for the removal of the urban weight from the formula, but attempts to change the formula during the 101st Congress were unsuccessful. S. 1306 as passed by Congress and signed into law as P.L. 102-321 removes the urban weight in the formula to eliminate the imbalance in allocations to small States and States with rural populations. It uses such factors as populations at risk, State taxable resources, and comparative costs of providing services in the formulas for the new separate block grants.

Separate Block Grants for Substance Abuse and Mental Health

When the ADMS block grant was created in 1981, the State allocation formula was devised to assure that funds appropriated for the program were split evenly nationwide between substance abuse and mental health services. With the emergence, starting in the mid-1980s, of a national consensus on the dangers of substance abuse, especially drug abuse, and the enactment of omnibus drug abuse legislation to increase support for a "War on Drugs," the balance in the funding under the block grant began to disappear. The enactment of a new program focused solely on funding for substance abuse services by Anti-Drug Abuse Act of 1986, and then the revision of the allocation formula by the 1988 Anti-Drug Abuse Act added factors into the formula that in effect removed the 50/50 balance between substance abuse and mental health in the nationwide distribution of block grant appropriations, tipping the balance heavily in favor of substance abuse.

Table 2 shows the history of the allocation of block grant funds between substance abuse and mental health services from FY1982 to FY1991. Table 2 shows that, although the intent of the original formula for the block grant was for an equal distribution of funds between mental health and substance abuse, the allocation for mental health between FY1982 and FY1988 ranged from 47.7% to 49.2% and never achieved 50%. In the past three years, the allocation for substance abuse services has jumped to over 79%. Over the 10-year history of the block grant, the allocation of funds for mental health services has increased from $204.1 million to $250.5 million, while the substance abuse allocation has nearly quadrupled from $224 million to $954.7 million.

As the gap between funding levels for the two types of disorders began to grow in the late 1980s, some in the mental health and related fields began to express concern that the problems of mentally ill persons and the way they were addressed in a major Federal program were beginning to be overshadowed by the problems of drug abuse. Some commentators noted that the 1988 revision in the block grant formula that targeted urban area drug use should not be used for allocating mental health funds as well, and that mental health programs should not have to compete with substance abuse programs for program funding.

Some mental health care professionals and policymakers oppose the separation of mental health from the block grant. They note the incidence of comorbidity -- individuals with both mental illness and substance abuse problems -- and point out the

possible difficulty of coordination of services for such patients if the programs were split. In many States, substance abuse and mental health programs are administered by the same State agency.

Legislation passed by the 102d Congress and signed into law as P.L. 102-321 establishes two separate block grants -- the Block Grant for Community Mental Health Services and the Block Grant for Prevention and Treatment of Substance Abuse.

TABLE 2. Alcohol, Drug Abuse, and Mental Health Services Block Grant Allocation of Appropriations for Substance Abuse and Mental Health, FY1982-91
(dollars in millions)

Fiscal year	Appropriation available for allocation to States	Substance abuse allocation (percentage)	Mental health allocation (percentage)
1982	$ 428.1	$224.0 (52.3%)	$204.1 (47.7%)
1983	468.0	237.6 (50.8%)	230.4 (49.2%)
1984	462.0	234.5 (50.8%)	227.5 (49.2%)
1985	490.0	250.6 (51.1%)	239.4 (48.9%)
1986	468.9	238.5 (50.1%)	230.4 (49.1%)
1987	508.6	260.7 (51.2%)	248.1 (48.8%)
1988	487.3	249.2 (51.1%)	238.1 (48.9%)
1989	765.3	518.7 (67.8%)	246.6 (32.2%)
1990	1,133.2	895.6 (79%)	237.6 (21%)
1991	1,205.2	954.7 (79%)	250.5 (21%)
1992	1,292.0	1,031.1 (79.8%)	260.9 (20.2%)

Source: Division for State assistance, OTI, ADAMHA, DHHS.

Transfer of Research Functions from ADAMHA to NIH

Before the creation of the ADMS block grant in 1981, ADAMHA consisted of three institutes, NIAAA, NIDA, and NIMH, each with its own services programs and research activities. After 1981, the block grant was administered first by the office of the Administrator of ADAMHA and then by OTI; the three institutes lost their services functions and became primarily research institutes. At the present time, ADAMHA consists of five separate entities: the three institutes, which although they are primarily research entities, conduct some service demonstration projects; and OSAP and OTI, which administer prevention and treatment services programs, although they also conduct research demonstration activities to evaluate the outcomes of their programs.

A debate has developed over the years as to whether this dual mission for ADAMHA -- services and research -- is a feasible one. Those in the research field have noted a feeling of being overshadowed within the agency by its services function. Many researchers in the area of substance abuse and mental illness have expressed a wish for a transfer of ADAMHA's research activities to NIH where they could enjoy the prominence that would derive from the association with that research agency. Supporters of such a transfer feel that it would serve a symbolic function and help to remove some of the stigma attached to substance abuse and mental illness as diseases.

Other commentators in the field are concerned that the separation of the two functions will make more difficult the transfer of what is learned in research to the provision of treatment services to mentally ill persons and substance abusers. The proposed transfer is a particular concern with relation to ADAMHA's current services-related research and demonstration activities. Questions have arisen as to whether, after a transfer of the institutes to NIH, such activities should be carried out and administered through NIH or through the services-oriented agency that remains.

P.L. 102-321 provides for the transfer of the three ADAMHA research institutes to NIH. It renames ADAMHA as the Substance Abuse and Mental Health Services Administration (SAMHSA).

Set-Asides and Other State Requirements

Another area of concern and discussion regarding the ADMS block grant over the years has been the issue of set-asides -- percentage restrictions or requirements that govern expenditure of funds by States under the block grant. The 1981 legislation creating the block required, for instance, that each State use at least 35% of the substance abuse portion of its block grant allocation for alcohol abuse activities and 35% for drug abuse activities, and that each State use at least 20% of its substance abuse allocation for prevention and early intervention activities designed to discourage the abuse of alcohol and drugs. Later amendments to the authority in succeeding Congresses included additional set-aside requirements pertaining to alcohol and drug abuse services for women and mental health services for underserved areas and for underserved populations, with special emphasis on new mental health services for severely disturbed children and adolescents.

The 1988 amendments to the block grant authority added new earmarks and set-asides for the block grant program. For instance, a State must use block grant funds appropriated in the 1988 Anti-Drug Abuse Amendments for substance abuse treatment only, and must spend at least 50% of those funds for programs of prevention and treatment of intravenous (IV) drug abuse, with priority to programs for individuals infected with the AIDS virus, and related activities. States are required to use not less than 10% of block grant funds for programs and services designed for women, especially pregnant women and women with dependent children.

The 1988 block grant reauthorization also included set-aside requirements for the mental health part of the block grant emphasizing the support of new mental health services programs as well as services for children and adolescents. Under these provisions, States are required to use at least 55% of block grant funds allocated for mental health activities to develop and provide community mental health services and programs that were not available on Oct. 1, 1988, and can provide funds for these new

services only for a limited period of time. At least 10% of the mental health allocation of a State's block grant allotment must be used to provide services and programs for seriously emotionally disturbed children and adolescents.

Those who oppose the requirement of set-asides in block grants argue that such provisions act against the purpose of block grants by limiting flexibility of States to administer these programs in response to their own specific needs and problems. States without a significant problem in IV drug abuse, for example, object to the provision in the 1988 amendments requiring them to use 50% of their substance abuse allocations under the block grant for IV drug use prevention and treatment. Those in favor of set-asides argue that such provisions act to stimulate new and expanded services in areas, such as substance abuse services for women, that would not be addressed without the specific authority that the set-aside provides.

There are questions as to whether set-asides accomplish what they are intended to do. A May 1991 report from the General Accounting Office (GAO) reviewed how the block grant set-aside for women addressed the treatment needs of drug-abusing women. GAO found a large gap between the numbers of drug-abusing pregnant women and mothers with young children and the availability of treatment centers to meet their needs. The report also found that Congress lacks a clear understanding of how the women's set-aside is used or what impact it has on the treatment of this population because the Department has not clearly specified to States what information must be provided.

Program Effectiveness

As the Congress authorizes and funds programs to support substance abuse prevention and treatment services, there is continued discussion about the effectiveness of such services. There has always been such concern about program effectiveness. Twenty years ago, drug abuse treatment programs were aimed primarily at the older heroin addict and alcohol abuse programs were aimed at the adult alcoholic. In recent years, the emphasis has shifted to a younger population of substance abusers, who use a variety of non-opiate substances, such as marijuana, cocaine, alcohol, or a combination of these and other substances, but the debate about the effectiveness of various treatment approaches has continued.

A variety of treatment approaches are available, residential and nonresidential. Some specialized residential treatment programs, such as therapeutic communities, have been effective with certain types of drug and alcohol abusers. Many of these programs are extremely expensive and require an extensive commitment of time, and therefore are often not a viable option for lower or middle income persons, who cannot afford the time or money. The development of a variety of outpatient treatment programs has provided alternatives. Outpatient programs utilize less intensive counseling and employ different approaches, such as psychotherapy, behavior modification, family therapy, and the use of pharmacological products, such as antidepressants.

Evaluations of treatment modes indicate that a variety of existing approaches to treatment have been effective in achieving reductions in drug and alcohol use and associated problem behaviors. There is little evidence that any one type of treatment is superior to others. Characteristics of the patients, such as desire to enter treatment, stable family or other relationship, and existence of employment after treatment, as well

as length of time spent in treatment, are also important factors in the effective outcome of treatment.

The 1988 Anti-Drug Abuse Amendments legislation authorized services research, through both NIAAA and NIDA, to evaluate the quality, appropriateness, and costs of various forms of alcohol and drug abuse treatment programs. The President's initial National Drug Control Strategy, published in September 1989, called for accountability among State and local treatment programs for effectiveness, including the enactment of amendments to the Act requiring States, as a condition for receipt of Federal funds for drug treatment, to develop and implement Statewide drug treatment plans. Such a requirement for State drug treatment plans has been included in legislation that was considered but not enacted by the Congress in recent years.

LEGISLATION

P.L. 102-321, S. 1306

Alcohol, Drug Abuse, and Mental Health Reorganization Act of 1991. Restructures ADAMHA into a services-oriented agency, transferring the National Institutes on Alcohol Abuse and Alcoholism, Drug Abuse, and Mental Health to NIH. Also amends and extends the authority for the ADMS block grant, including a revision of the allocation formula. Introduced June 17, 1991; referred to Committee on Labor and Human Resources. Reported July 30, 1991 (S.Rept. no 102-131). Passed by Senate on Aug. 2, 1991. Passed by House Mar. 24, 1992, after substituting the language of H.R. 3698 as passed by the House. Conference agreement reported May 14 (H.Rept. 102-522). On May 19, the House, under suspension of rules, failed to agree on the conference report. On May 28, the House, under regular order, voted to recommit the bill to the conference committee for reconsideration. Second conference agreement reported June 3 (H.Rept. 102-546). Passed by the Senate on June 9, and by the House on July 1. Signed into law July 10, 1992.

H.R. 3698 (Waxman)

Community Mental Health and Substance Abuse Services Improvement Act of 1991. Amends Title XIX of the PHS Act to establish a Mental Health Block Grant and a Substance Abuse Block Grant. Amends Title V of the Act related to research in mental illness, alcohol abuse and alcoholism, and drug abuse, and to substance abuse prevention. Introduced Nov. 1, 1991; referred to Committee on Energy and Commerce. Reported Mar. 24, 1992 (H.Rept. 102-464), and passed by House under suspension of rules. The House then passed S. 1306 after amending it to contain the language of H.R. 3698 as passed by the House.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. Senate. Committee on Labor and Human Resources. ADAMHA Reorganization Act of 1991. Report to accompany S. 1306, 102d Congress, 1st session. July 30, 1991. Senate Report no. 102-131.

FOR ADDITIONAL READING

U.S. General Accounting Office. Proposed formulas for substance abuse, mental health provide more equity. Briefing report to the Chairman, House Committee on Energy and Commerce Subcommittee on Health and the Environment. Washington, July 1987. GAO/HRD-87-109BR

----- ADMS block grant: women's set-aside does not assure drug treatment for pregnant women. Report to the Chairman, Subcommittee on Health and the Environment. Washington, May 1991. GAO/HRD-91-80.

----- Drug treatment: targeting aid to States using urban population as indicator of drug use. Report to the Chairman, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Senate Committee on Appropriations. Washington, November 1990. GAO/HRD-91-17.

U.S. Library of Congress. Congressional Research Service. Drug control, by Harry Hogan. [Washington] 1987. (Updated regularly).
CRS Issue Brief 87013

----- Substance abuse treatment, prevention, and education, by Edward R. Klebe. [Washington] 1990. 20 p.
CRS Report 90-412 EPW

90-412 EPW

CRS Report for Congress

Substance Abuse Treatment, Prevention, and Education

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August 21, 1990

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SUBSTANCE ABUSE TREATMENT, PREVENTION, AND EDUCATION

SUMMARY

Substance abuse has been for many years a matter of concern in the United States and a threat both to individuals and to society as a whole. A 1988 survey of the national household population aged 12 and over found that 7.3 percent of this population, or 14.5 million persons, reported having used such illicit drugs as marijuana, cocaine, and others during the previous 30 days. In addition, an estimated 18 million Americans age 18 and older currently experience problems as a result of alcohol abuse or alcoholism.

Throughout the past 25 years, the Congress has enacted legislation creating and supporting a variety of Federal programs to prevent and treat drug and alcohol abuse and to educate the public, particularly children in schools, about the dangers of substance abuse. The two Federal agencies with the major responsibilities for substance abuse treatment, prevention, and education programs are the Department of Health and Human Services (DHHS) and the Department of Education (ED). The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of DHHS administers the Alcohol, Drug Abuse, and Mental Health Services Block Grant, which allocates funds to States--$1.2 billion in FY 1990--for treatment and prevention programs, and supports other prevention, research, and demonstration activities. The Drug-Free Schools and Communities Act administered by ED provides funding support--$539 million in FY 1990--for State and local school- and community-based substance abuse education activities. It also supports school personnel training and a variety of national programs, including development and dissemination of curricula and other educational materials.

Treatment services for alcohol and drug abuse are provided in a variety of settings and modalities, both inpatient and outpatient. Research into the effectiveness of substance abuse treatment has found at least limited effectiveness for most if not all types and settings of treatment, but has been inconclusive in proving that any particular form of treatment is more effective than another, or in enabling anyone to predict the most appropriate form of treatment for a specific patient at any particular time.

Theories and techniques on substance abuse prevention and education have changed over the years. The assumption that increased knowledge about drugs and alcohol and the consequences of their use would be an effective deterrent dominated the provision of prevention and education services, until evaluations seemed to indicate that increased knowledge had little impact on actual drug or alcohol use. Recent approaches to substance abuse education and prevention include a more comprehensive approach focusing on--(1) establishment and enforcement of rules concerning drug and alcohol possession and use on school grounds; (2) intervention with students already involved with substance abuse; and (3) a prevention component combining a presentation of accurate information about drugs and their use in conjunction with a focus on the personal and social pressures and motivations that tempt young people to use drugs and alcohol.

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SUBSTANCE ABUSE TREATMENT, PREVENTION, AND EDUCATION

Substance abuse has been for many years a matter of concern in the United States. The abuse of drugs and alcohol is seen as a threat both to individuals and to society as a whole.[1] The most recent national survey indicates that 28 million persons in the 1988 household population in the U.S. had used an illicit drug during the previous year and 14.5 million had used such drugs in the preceding 30 days. In addition, estimates indicate that nearly 18 million persons age 18 and older have problems related to alcoholism or alcohol abuse. Nearly 64 percent of the high school senior class of 1988 reported using alcohol in the previous 30 days and 35 percent reported having 5 drinks or more in the 2 weeks before the survey.

Throughout the past 25 years, the Congress, in response to its perception of a need in this area, has enacted legislation creating and supporting a variety of Federal programs to prevent and treat drug and alcohol abuse and to educate the public, particularly children in schools, about the dangers of substance abuse.

The following report discusses recent estimates of the extent of the substance abuse problem in the United States, the history of Federal legislation and programs to support substance abuse treatment, prevention,

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[1]This report uses the term "substance abuse" to mean the use and abuse of both illicit drugs and alcohol. Federally-supported substance abuse prevention and education programs and activities, which focus primarily on children and youth, operate on the belief that any alcohol use by persons under the age of 21 constitutes "alcohol abuse," and are aimed primarily at preventing such use as well as the use of illicit drugs. The Office of Substance Abuse Prevention of the Department of Health and Human Services, for example, has recently begun to substitute the term "alcohol and other drug use" for "substance abuse" in its literature. Treatment programs and activities sometimes deal with these substances separately, as in the case of methadone treatment for heroin addiction, as well as such organizations as Alcoholics Anonymous and Narcotics Anonymous. Many treatment programs, however, provide treatment services for all kinds of substance abuse in the same setting. This is increasingly the case for persons who abuse more than one substance. Most of the research into the effectiveness of treatment focuses on either alcohol abuse treatment or treatment for drug abuse, and will be discussed separately later in the report.

and education,[2] and the types of such activities that are currently in use, as well as what is known about their effectiveness.

SUBSTANCE ABUSE IN THE U.S.--EXTENT OF THE PROBLEM

Estimates of the extent of drug and alcohol abuse in the United States vary, but it seems clear that millions of persons in this country abuse such substances each year to varying degrees. In addition, although substance abuse trends in recent years appear to be on the decline, the fact remains that a significant proportion of our population is using illicit drugs and alcohol to excess and make up a substantial population at risk for treatment and rehabilitation services.

The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Department of Health and Human Services (DHHS) finances and publishes several national surveys that measure the extent of substance abuse in the United States. The 1988 **National Household Survey on Drug Abuse**, for instance, is the ninth in a series of national surveys first carried out in 1971 to measure the prevalence of drug use among the American household population aged 12 and over. The 1988 National Household Survey found that 7.3 percent of the household population age 12 and over (14.5 million persons) were "current" users of such illicit drugs as marijuana, cocaine, and others, i.e., they admitted to using such drugs in the 30 days before the survey was conducted. This was a decrease in 37 percent from the 23 million current users in the 1985 study. Users of any illicit drug "within the last year" declined from 37 million in 1985 to 28 million in 1988 (14.1 percent of the population group), a drop of almost 25 percent. The number of "current" users of cocaine fell by 50 percent, from 5.8 million in 1985 to 2.9 million (1.5 percent of the population group) in 1988, and those who used cocaine "within the past year" fell by a third, from 12 million to 8 million (4.1 percent of the population group).[3]

The 1988 Household Survey, however, did find continued intense use of cocaine within the cocaine user population: an estimated 862,000 used cocaine once a week or more, compared with 647,000 in 1985. A study conducted by Mark Kleiman of Harvard University's Kennedy School of Government for

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[2]The terms substance abuse *prevention* and *education* are used interchangeably to refer to activities designed to reduce the extent of substance use and to prevent alcohol- and drug-related problems. In this report, the term *prevention* will refer to such activities carried out and supported by the Alcohol, Drug Abuse, and Mental Health Administration of the U.S. Department of Health and Human Services and *education* will be used to refer to school- and community-based substance abuse activities carried out or supported by the U.S. Department of Education.

[3]National Institute on Drug Abuse. *National Household Survey on Drug Abuse. Population Estimates 1988*. Washington, U.S. Govt. Print. Off., 1989.

the Senate Judiciary Committee in 1990, however, found the ADAMHA survey finding of "hard-core" cocaine users to be a significant underestimate. This survey estimates that there are currently about 2.2 million "hard-core" cocaine users, those who use cocaine on a weekly basis.[4]

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) of ADAMHA estimates that 10.5 million adults 18 years old and older currently exhibit some symptoms of alcoholism or alcohol dependence and an additional 7.2 million abuse alcohol, but do not yet show symptoms of dependence.[5] The problems may include such symptoms of dependence as loss of memory, inability to stop drinking until intoxication, inability to cut down on drinking, binge drinking, and withdrawal symptoms.

ADAMHA also sponsors a nationwide survey of young people entitled *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*. Better known as the **High School Senior Survey**, it has reported, annually since 1975, on the drug use and related attitudes of a representative national sample of high school seniors. The 1989 High School Senior Survey shows decreases in alcohol and drug use similar to those reported by the Household Survey. Use of marijuana, the illicit drug most frequently used by high school seniors, has declined markedly over the past decade. In 1979, half of all seniors reported some marijuana use in the year prior to the survey; in 1989, only 30 percent reported such use. In 1979, 36.5 percent of all high school seniors reported marijuana use in the prior 30 days; by 1989, only 16.7 percent reported marijuana use in the previous month. Similar trends were reported for other drug use--use of cocaine in the 30 days prior to the survey fell from a peak of 6.7 percent in 1985 to 2.8 percent in 1989. Use of alcohol also declined among this population, although alcohol use remains high. Sixty percent of the class of 1989 reported using alcohol in the previous 30 days; 33 percent reported having 5 drinks or more in a row in the last 2 weeks before the survey.[6]

These surveys have certain limitations in measuring national alcohol and drug use in that they leave out some populations which could represent extensive drug and alcohol use. The National Household Survey, for instance, includes no information on alcohol and drug use by persons not living in households, such as the homeless, military personnel living on base, and those

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[4]U.S. Congress. Senate. Committee on the Judiciary. *Hard-Core Cocaine Addicts: Measuring--and Fighting--the Epidemic*. Senate Print 101-6, May 10, 1990. Washington, U.S. Govt. Print. Off., 1990.

[5]National Institute on Alcohol Abuse and Alcoholism. *Seventh Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services*. Washington, January 1990.

[6]University of Michigan Institute for Social Research. Press release on 1989 National High School Senior Survey. Feb. 13, 1990.

in dormitories, hospitals, and jails. The High School Senior Survey includes no information on the alcohol and drug use of the dropout population of the high school senior age group. Despite these limitations, the various national surveys of alcohol and drug use are helpful in examining current trends in such use.

LEGISLATION ON SUBSTANCE ABUSE PREVENTION AND TREATMENT

Interest by the Congress and the Federal Government in alcohol and drug abuse is, of course, not new. Reports of epidemics in drug abuse, primarily heroin, in the late 1960s and early 1970s led to the enactment of a series of bills to provide Federal program support to deal with drugs and alcohol. The initial effort to support treatment and rehabilitation services for persons who abuse alcohol and drugs came in 1968 with the enactment of the Alcoholic and Narcotic Rehabilitation Act (P.L. 90-574). This legislation authorized special grants for construction and staffing support within the community mental health centers program to provide incentives for localities to initiate and develop new services for alcoholics and alcohol and drug abusers.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616) and the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) established separate project grants and formula grants to the States to support State and local programs in treatment and rehabilitation of alcohol abuse and drug abuse, respectively. They also established the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) to administer the respective grants programs and related activities in research, training, prevention, and public information. In 1974, the two institutes were combined with the National Institute for Mental Health under ADAMHA, the lead agency in the Public Health Service (PHS) of the DHHS for substance abuse and mental health activities.

The Alcohol, Drug Abuse, and Mental Health Services Block Grant

The separate alcohol abuse and drug abuse project and formula grant programs continued through the 1970s until 1981, when they were consolidated in a single block grant under title XIX of the Public Health Service Act, the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). P.L. 97-35 authorized appropriations for FY 1982 through FY 1984 for grants to States to be used for--

(1) prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse; and

(2) grants to community mental health centers for the provision of mental health services, including services for the chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations.

The ADMS block grant authority was amended and extended through FY 1987 in 1984 by P.L. 98-509, and further amended in 1985 by P.L. 99-117. The Anti-Drug Abuse Act of 1986 (P.L. 99-570) authorized additional appropriations for the block grant for FY 1987, and, in addition, established new authorities for FY 1987 for alcohol and drug abuse treatment and prevention activities. The Anti-Drug Abuse Act of 1988 (P.L. 100-690) made further changes in the block grant authority.

As originally authorized, block grant funds were allocated to the States by a formula based on their allocations for certain years under the previous categorical programs. This method resulted in national allocations for mental health and substance abuse programs which were approximately equal to each other.

The law authorizing the ADMS block grant required States to distribute block grant allotments between mental health and substance abuse services in the same proportion that Federal funds were awarded to support such services in the State in the years the allocation formula was based on. Under the original block grant authority, 95 percent of the State's allotment in FY 1983, and 85 percent of the State's allotment in FY 1984, had to be obligated in this manner. The 1988 amendments made permanent a percentage of 90 percent that States have to allocate in this manner; States may exercise discretion over the remaining 10 percent.

States are required to distribute their allotments for drug abuse and alcoholism services in a certain way: of funds received by a State for substance abuse services, at least 35 percent must be used for alcoholism and alcohol abuse services and at least 35 percent for drug abuse services. In addition, of funds allotted to a State for substance abuse services, at least 20 percent must be used for prevention and early intervention programs.

The 1984 amendments established, and the 1985 amendments modified, two new set-aside provisions requiring States to allocate specific portions of their block grant allotments for program activities for alcohol and drug abuse services for women, and comprehensive community mental health services for underserved areas or populations, with special emphasis on services for severely disturbed children and adolescents.

The Anti-Drug Abuse Act of 1986 (P.L. 99-570) authorized, and the continuing appropriations act for FY 1987 (P.L. 99-591) appropriated funds for several new program activities in ADAMHA related to substance abuse treatment and prevention. The 1986 Act authorized a new program of grants to States to enhance ongoing alcohol and drug treatment and rehabilitation

programs (ADTR Grants), with funds allocated to States on the basis of population and need. The 1986 Act also authorized, in title V of the PHS Act, the creation of an Office of Substance Abuse Prevention (OSAP) within ADAMHA to carry out substance abuse prevention activities, including a program of demonstration project grants for substance abuse prevention, treatment, and rehabilitation among high-risk youth.

In 1988, the Congress passed another omnibus drug abuse control bill, the Anti-Drug Abuse Act of 1988 (P.L. 100-690). Among other things, this legislation revised and extended the authority for the ADMS Block Grant, at an authorization level of $1.5 billion for FY 1989 and such sums as may be necessary for FY 1990 and FY 1991. It also revised the method for allotment of ADMS block grant funds to the States to a formula based on each State's population of age groups at greatest risk for substance abuse and mental illness and on total taxable resources of each State.

The 1988 Act requires States, starting in FY 1990, to agree to use at least 50 percent of their drug abuse treatment allotments under this block grant for intravenous (IV) drug abuse treatment programs as follows: (1) IV drug abuse treatment programs with priority to programs which treat individuals infected with the etiologic agent for AIDS; (2) training of drug abuse counselors and other health care providers in providing such treatment; and (3) outreach activities to encourage individuals in need of drug abuse treatment to undergo such treatment. A State may receive a waiver of these requirements if the Secretary determines that the incidence of intravenous drug abuse in the State warrants it. States may not use such funds for any IV treatment program which distributes sterile needles or bleach to cleanse needles or to carry out testing for AIDS unless testing is accompanied by appropriate counseling.

The 1988 legislation also requires an intravenous drug abuse treatment program receiving funds under the block grant to notify the State when it reaches 90 percent of its capacity to admit individuals to the program, and requires each State, when so notified, to ensure that, to the maximum extent practicable, each individual who requests and is in need of such treatment is admitted to a program within 7 days of such request. It also authorized the appropriation of $100 million to be available until expended, for grants to reduce the waiting lists of public and nonprofit private programs providing drug abuse treatment services.

The 1988 Act amended block grant authority to permit the use of block grant funds for the construction of substance abuse treatment facilities. It required a State to use at least 10 percent of its allotment under the block grant for programs and services designed for women (especially pregnant women and women with dependent children) and demonstration projects to provide residential treatment services to pregnant women. It also required each State, in order to receive block grant funds, to establish a revolving loan fund to make loans for establishing group homes for recovering substance abusers.

The Anti-Drug Abuse Act of 1988 extended authority for the OSAP and its programs, such as the Clearinghouse on Alcohol and Drug Abuse Information, the Model Projects for High Risk Youth, and Model Projects for Pregnant and Postpartum Women and Their Infants. It required that $5 million of each year's appropriation for OSAP be made available for programs to train drug abuse counselors and other health personnel in drug abuse education, prevention, intervention, diagnosis, and treatment.

It authorized grants for drug abuse demonstration projects of national significance, with $10 million of the amount appropriated to be made available for projects to (1) determine the feasibility and efficacy of programs providing drug abuse treatment and vocational training in exchange for public service; (2) conduct outreach activities to IV drug abusers to prevent exposure to, and transmission of the etiologic agent for AIDS and to encourage IV drug abusers to seek treatment; and (3) provide drug abuse treatment services for pregnant and postpartum women, and their infants.

The 1988 Act authorized research, through NIAAA and NIDA, to evaluate the quality, appropriateness, and costs of various forms of alcohol and drug abuse treatment programs. It also required the Secretary to collect and publish data each year on incidence and prevalence of various forms of mental illness and substance abuse nationally and in selected major metropolitan areas.

TABLE 1. Alcohol, Drug Abuse, and Mental Health Services Block Grant--Authorizations and Appropriations, FY 1982-FY 1991
(dollars in thousands)

Fiscal year	Authorization	Appropriation
1982	$491,000	$428,095
1983	511,000	467,972[a]
1984	532,000	462,000
1985	515,000	490,000
1986	545,000	468,930[b]
1987	760,365	671,860[c]
1988	d	643,217
1989	1,500,000	805,594
1990	1,500,000	1,192,851[e]
1991 budget request	1,500,000	1,292,775

[a]Includes regular appropriation of $437.972 million plus a supplemental appropriation of $30 million by P.L. 98-8 to be used for alcohol and drug abuse problems related to unemployment.

[b]Represents post-sequestration under Gramm-Rudman-Hollings from an appropriation of $490 million.

[c]Includes appropriation of $495 million plus $13.8 million authorizedby P.L. 90-570 and appropriated by the FY 1987 continuing resolution, P.L. 99-590, for the ADMS block grant and $163 million for ADTR grants to States.

[d]Legislation to reauthorize the program in FY 1988 was not enacted, but the appropriation of funds for FY 1988 through the continuing resolution P.L. 100-202, served as de facto authorization for the year. The total appropriation includes $487.3 million for the ADMS block and $155.9 million for ADTR grants to States.

[e]After sequestration.

The Drug-Free Schools and Communities Act

The 1986 and 1988 Anti-Drug Abuse Acts (P.L. 99-570 and P.L. 100-690), in addition to amending and extending substance abuse treatment and prevention authorities under the PHS Act, also authorized a program of support for substance abuse education activities through the Department of Education. The Drug-Free Schools and Communities Act was originally established by the 1986 Anti-Drug Abuse Act and subsequently amended and reenacted as title V of the Elementary and Secondary Education Act of 1965 (ESEA) by the Hawkins/Stafford Elementary and Secondary School Improvement Amendments of 1988 (P.L. 100-297). The authority was further amended by the 1988 Anti-Drug Abuse Act and by the Drug-Free Schools and Communities Act Amendments of 1989 (P.L. 101-226).

The Drug-Free Schools and Communities authority funds a variety of programs to support substance abuse education activities in schools and in the community. The major activity of the authority is a program of formula grants to the States. Under the original authority, funds were allocated to States solely on the basis of the number of school-aged children in each State. Under a provision in the 1989 amendments, part of the funds are now allocated on the basis of the amount of funds received by each State under the authority for programs for the disadvantaged in part A of chapter 1 of title I of ESEA.

Each State's allocation under the Drug-Free Schools Act is divided between the State educational agency (70 percent) and the Office of the Governor (30 percent). Of the funds available to the State agency, 10 percent may be used by the agency for: training programs; the development, identification, dissemination, and evaluation of curricular materials; demonstration projects; special assistance to economically disadvantaged areas; technical assistance; and State administration. The remaining 90 percent must be allotted to local and intermediate educational agencies based on school-age population. These local schools and school districts may use their allotments for: the development and acquisition of curricular materials; school-based prevention programs; family-based prevention programs; counseling programs for students and parents; outreach activities for school dropouts; referral programs; training programs for teachers, school personnel, community leaders; and law-enforcement personnel; public education programs; efforts to enhance the identification and discipline of drug and alcohol abusers; special programs for student athletes; and model alternative schools that address the special needs of students with drug problems. Local educational agencies are required to assure the equitable participation of students in private nonprofit schools.

Of funds available under the formula allocation to the Office of the Governor, up to 50 percent may be used for awards to parent groups, community action agencies, community-based organizations, and other public and private nonprofit agencies for local drug and alcohol abuse prevention programs; training for teachers, parents, and law-enforcement officials;

distribution of training materials; technical assistance to local programs; intra-state drug and alcohol abuse education and prevention centers; coordination of community efforts; and the establishment and maintenance of drug-free zones for schools within the State. At least 50 percent of the Governor's funds is reserved for awards to public and private nonprofit entities for innovative, community-based programs for high-risk youth, including juveniles in State detention facilities.

The Drug-Free Schools and Communities Act also provides support for school personnel training, emergency grants, and national programs. The personnel training effort is a competitive project grant program to establish, expand, or enhance the training of teachers, administrators, guidance counselors, and other school personnel concerning drug and alcohol abuse education and prevention. The Emergency Grants program, established by the 1989 amendments, provides funds to school districts that demonstrate significant need for additional assistance in combating drug and alcohol abuse. To be eligible for such funds, a school district must have a significant number or concentration of disadvantaged children and have a significant drug and alcohol problem, as indicated by the fact that it serves an area with a large number of youth drug- or alcohol-related arrests or convictions, large numbers or high percentage of youth drug- or alcohol-related referrals for treatment and rehabilitation, and demonstrates other indicators of drug and alcohol problems.

National programs under the Drug-Free Schools and Communities Act provide funds for a variety of programs designed to combat drug abuse in schools and communities. These programs, administered by the Office of the Secretary, include grants to institutions of higher education, programs for Indian youths and for Hawaiian natives, regional centers, and Federal activities.

Grants to institutions of higher education are used for programs of drug education for students enrolled in such institutions, including referral for rehabilitation, and for the development of demonstration programs in drug abuse education and prevention for use in elementary and secondary schools. The Regional Centers program funds five centers across the Nation which train school teams to assess and respond to substance abuse problems in their schools, help local educational agencies and institutions of higher education to develop substance abuse prevention training programs for teachers and school personnel, evaluate programs and strategies for effectiveness and disseminate information about successful programs; and assist State educational agencies in coordinating and strengthening alcohol and drug abuse prevention policies and programs in schools.

The National program funds under the Drug-Free Schools Act which are allocated to Federal activities are used for such activities as the development and dissemination of curriculum materials and other publications. Recent publications include *What Works: Schools Without Drugs*, *Growing Up Drug Free: A Parent's Guide to Prevention*, and *Learning to Live Drug Free: A*

Curriculum Model for Prevention. Other Federal activities carried out by the Office of the Secretary under the national programs authority include providing technical assistance to State and local educational agencies in selecting and implementing curricula, approaches, and programs; recognizing successful programs with awards; and evaluating programs funded under the Act.

TABLE 2. Drug-Free Schools and Communities Act--Authorizations and Appropriations, FY 1987-FY 1991
(dollars in thousands)

Fiscal Year	Authorization	Appropriation
1987	$200,000	$200,000
1988	250,000	229,776
1989	366,000[a]	354,500[b]
1990	Indefinite[c]	539,200[d]
1991 Budget Request	Indefinite[e]	593,300[f]

[a]Includes $350 million for the Grants to States and National Programs and $16 million for Teacher Training grants.

[b]Includes $347.5 million for Grants to States and National Programs and $7 million for Teacher Training.

[c]Such sums as may be necessary for Grants to States and National Programs and $20 million for Teacher Training.

[d]Includes $524.6 million for Grants to States and National Programs and $14.6 million for Teacher Training.

[e]Such sums as may be necessary for Grants to States and National Programs and $35 million for Teacher Training.

[f]Includes $578.7 million for Grants to States and National Programs and $14.6 million for Teacher Training.

SUBSTANCE ABUSE TREATMENT SERVICES

Types of Treatment Services

Treatment services for alcohol and drug abuse are provided in a variety of settings and modalities. Some forms of treatment are aimed at drug

abusers only, such as in the case of methadone maintenance for heroin addicts, others for alcohol abuse only, such as treatment involving the use of the sensitizing drug disulfiram (Antabuse). Aside from such exceptions, however, similar modalities of treatment are used for both alcohol or drug abuse, and often in the same setting. Such treatment often starts with a short-term program of detoxification, which can be provided on an inpatient basis in a hospital or other residential facility or in an outpatient program. Although many substance abusers do not receive any treatment services beyond it, detoxification is not a treatment for the substance abuse dependence as such, but is used, most often with alcohol abuse and heroin addiction, to clear the client's system of the physical remnants of the drug or alcohol. For those who choose to proceed to further care following detoxification, a variety of program modalities are available to prevent relapse and help clients remain alcohol- or drug-free.

Treatment can be provided on an inpatient basis, in such settings as detoxification and rehabilitation units in general hospitals, treatment units in public and private psychiatric hospitals, and free-standing treatment facilities. Substance abuse treatment can also be provided in an outpatient setting, in the office of a private physician or other treatment professional, in treatment units of community facilities such as community mental health center or hospital, or in free-standing outpatient substance abuse treatment facilities.

Treatment modalities in inpatient and outpatient settings include medical approaches, psychological approaches, and social-cultural approaches, or a combination of them, in providing care. The medical approach uses medications such as antidepressants, sensitizing agents such as disulfiram, and other medications to assist the patient in remaining drug-free. Psychological approaches to treatment use aversion therapy and other behavioral and nonbehavioral techniques. Social-cultural approaches to treatment focus on changing the social environment in which the drug or alcohol abuser functions. An example of this is the approach used by such groups as Alcoholics Anonymous and Narcotics Anonymous, which try to establish a whole new culture for the alcoholic or drug addict. It is not at all unusual for a drug or alcohol abuser to go through many different types and settings of treatment before achieving long-term success in becoming alcohol- or drug-free.

Most treatment for drug abuse in recent years has focused on three different modalities of treatment--methadone maintenance for opiate addiction, and therapeutic communities and outpatient drug-free programs for all types of drug abuse. Methadone maintenance is a treatment, usually outpatient, designed to help persons addicted to heroin and other opium-derivative drugs. It combines the daily administration of methadone, a synthetic opiate product that is administered orally and controls the craving for heroin in the addict, with intensive counseling and other social and medical services.

The residential drug-free program approach, includes the therapeutic community approach, the models for which were the Synanon program in California and Daytop Village in New York in the late 1950s and early 1960s.

Therapeutic communities are full-time, drug-free residential programs which provide a highly-structured, nonpermissive program of treatment. Therapy in a therapeutic community is generally a long-term proposition, often extending beyond a year in duration. Treatment features peer support and confrontation, individual and group counseling, and educational and job training when appropriate.

Outpatient drug-free programs vary widely in duration, goals, and content, but have in common that they do not use medication in treatment, they use counseling as the major form of therapy, and as outpatient programs they allow clients to live at home during the course of treatment. These outpatient programs began as a response to a need for community-based crisis centers for addicts. Many outpatient programs operate largely as drop-in "crisis" centers, while others are more structured. As with the therapeutic community, outpatient drug-free programs make extensive use of former addicts as staff counselors and therapists.

Treatment Statistics

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has for the past 3 years, under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) of ADAMHA, compiled and published fiscal, client, and other service data related to substance abuse treatment activities in the States. These data apply to only those treatment units and programs in the States "that received at least some funds administered by the State Alcohol/Drug Agency."

In FY 1988, the most recent year for which data are published, the NASADAD study reported on 6,926 alcohol and/or drug treatment units which received funds administered by State alcohol and drug abuse agencies. Of the total, 1,806 were identified as alcohol units, 1,614 as drug units, and the remaining 3,506 as combined alcohol/drug units. These units in FY 1988 reported 1.2 million admissions for alcoholism and alcohol abuse treatment and 518,000 for drug abuse and dependency treatment.

Of the admissions for alcoholism and alcohol abuse treatment, 392,000 were for detoxification (79,000 in a hospital setting and 313,000 in a nonhospital setting), 182,000 were for longer term rehabilitation or residential care (19,000 in a hospital setting and 163,000 in nonhospital setting), and 549,000 were for outpatient care (33,000 in a hospital setting and 516,000 in a nonhospital setting). Of the more than half million admissions for drug treatment, nearly 96,000 were for detoxification (13,000 in a hospital setting, 47,000 in other residential settings, and 36,000 in an outpatient setting), 47,600 for methadone maintenance (nearly 46,000 in an outpatient program and 1,600 in a residential facility), and 357,000 in drug-free programs (7,800

in a hospital setting, 72,700 in a residential program, and 276,700 in an outpatient program).[7]

Treatment Effectiveness

Findings of research into the effectiveness of substance abuse treatment can be described as inconclusive at best. Treatment research carried out over the past two decades on various treatment settings and modalities has found at least limited effectiveness for most if not all types and settings of treatment for alcohol and drug abuse. Most treatments, apparently, can be shown to be effective in detoxifying and preventing relapses in some alcohol and drug abusers some of the time. What treatment research thus far has been unable to do is to prove that any particular form of treatment is more effective than another, or to enable anyone to predict the most appropriate treatment for a specific patient at any particular time.

Effectiveness of Alcoholism Treatment

In 1983, the U.S. Office of Technology Assessment (OTA) published a report, *The Effectiveness and Costs of Alcoholism Treatment*[8] (prepared under contract by Saxe et al, Boston University) which focused on the costs of alcoholism and alcohol abuse to the health care system and to society in general. The OTA report, in assessing the effectiveness and cost-effectiveness of the various treatment settings and modalities for alcoholism based on a review of available treatment research, concluded that "treatment is better than no treatment, but that methodological problems render it difficult to conclude that any specific treatment is more effective than any other." The report found consensus that inpatient treatment is far more expensive than other treatment options, but found no evidence to demonstrate that inpatient care for alcoholism treatment offered greater likelihood of successful treatment than outpatient care. In assessing cost-effectiveness, the OTA review found "some evidence to support the hypothesis that alcoholism treatment is cost-beneficial" in that the benefits "seem to be in excess of the costs of providing such treatment." The review, however, concluded that it was difficult from the evidence available at the time "to determine the relative effectiveness or cost-effectiveness of inpatient v. outpatient treatment."

The 1983 OTA report suggested that treatment reimbursement strategies that encouraged early outpatient treatment and continuing aftercare services on a outpatient basis would lead to better use of resources. The report, however, did not recommend curtailing the use of hospital programs because

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[7]National Association of State Alcohol and Drug Abuse Directors, Inc. *State Resources and Services Related to Alcohol and Drug Abuse Problems, Fiscal Year 1988*. Aug. 1989.

[8]U.S. Congress. Office of Technology Assessment. *The Effectiveness and Costs of Alcoholism Treatment*. Washington, U.S. Govt. Print. Off., Mar. 1983.

it was felt that there was not a sufficient supply of non-hospital based treatment programs available at that time.

In a 1988 study updating OTA's 1983 review and findings, the principal author states that in not making such a recommendation, the "hope was that encouragement of such alternatives would lead, over time, to a reduced utilization of hospitals." The 1988 study concluded that the hoped-for reduction in the use of hospital-based treatment programs had not occurred; that, in fact, there had been an increase in the use of such treatment. (Between 1980 and 1986, the number of hospital-based inpatient addiction treatment programs more than doubled, from 506 to 1,039, while outpatient programs increased only 13 percent, from 1,182 to 1,342.[9]) Further, the 1988 review confirmed the findings of the earlier report--that both inpatient and outpatient treatment have demonstrable effectiveness, but that there is "no evidence to suggest that inpatient treatment is better than outpatient treatment" and that there is a growing body of evidence to indicate that "relapse rates and other outcomes are no different as a result of inpatient v. outpatient." It concludes that "these findings have remained consistent across a variety of different approaches to treatment and across a diversity of populations. There remains little convincing evidence in favor of inpatient treatment or lengthy and intensive treatment." And because inpatient treatment programs are consistently more expensive than outpatient programs, the 1988 study further concludes is that "the clear implication of currently available data is that outpatient care is not only effective, but far more cost-effective than inpatient care."[10]

Effectiveness of Drug Abuse Treatment

Most research on drug abuse treatment until recent concern for treatment of cocaine abuse has focused on treatment for heroin addiction. Much of this research, on methadone maintenance programs and early therapeutic community programs such as Synanon, reported success in helping addicts to achieve abstinence from heroin. There was skepticism about such reports of success, due to flaws in much of the research, such as the lack of control groups.

In 1969, the first national comprehensive study of drug abuse treatment effectiveness was initiated as the Drug Abuse Reporting Program (DARP). This study looked at four major treatment modalities--methadone maintenance, therapeutic communities, outpatient drug-free programs, and

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[9]Cotton, Paul. Detox Programs Called 'Wasteful'. *Medical World News*, Dec. 26, 1988. p. 53.

[10]Saxe, Leonard and Lisa Goodman. *The Effectiveness of Outpatient v. Inpatient Treatment: Updating the OTA Report.* Working Paper, Bigel Institute for Health Policy, Brandeis University. p. 5. The preceding paragraphs use this paper as source.

detoxification. The major conclusion of the DARP research was that the most favorable results in terms of abstinence or reduced drug use and reductions in criminal activity were produced by treatment in the three major modalities, but not by detoxification only. All three produced similar positive outcomes. The DARP study appeared to show that length of treatment was the most effective predictor of success in treatment, whatever the modality--the clients who remained longer in treatment had the most favorable outcomes in terms of reduced drug use and criminal activity. The data suggested that treatments which lasted less than 90 days appeared to be of limited benefit, regardless of the type of treatment involved. Beyond 90 days, treatment outcomes improved in direct proportion to the length of time spent in treatment.[11]

A second national study of drug abuse treatment effectiveness called the Treatment Outcome Prospective Study (TOPS) was initiated in the mid-1970s. A multi-year study financed by NIDA, the project studied 10,000 drug users who entered treatment in 1979, 1980, or 1981 in 37 selected U.S. drug abuse treatment programs representing three major treatment modalities--methadone maintenance, therapeutic communities, and outpatient drug-free programs. Patients who served as study subjects were followed from the time they entered treatment, through 5 years after they left treatment.

The TOPS study addressed the impact of drug abuse treatment across the range of settings and for clients with varying degrees of dependence and associated programs.[12] The study measured the actual reduction of drug use as well as several indicators of the patients' success in building productive lives--decrease in criminal activity, excessive alcohol use, depression, and increase in employment. Generally, the study found that all of the modalities of treatment were effective in reducing drug use up to 5 years after a single course of treatment; they had a more limited measure of success in helping clients build more productive lives.

Basically, the TOPS study found that treatment resulted in substantial decreases in the abuse of both opiate drugs such as heroin and other drugs as well, but that the goal of abstinence was achieved by a relative few. Pretreatment levels of drug use declined dramatically during treatment, increased slightly immediately after treatment relative to in-treatment levels, and again declined in subsequent periods after treatment. The prevalence of

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[11]Simpson, D. Wayne. National Treatment System Evaluation Based on the Drug Abuse Reporting Program (DARP) Followup Research. In Tims, Frank M., and Jacqueline P. Ludford, eds. *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects.* Research Monograph 51, National Institute on Drug Abuse, DHHS Publication No. 84-1329.

[12]Hubbard, Robert L., et al. *Drug Abuse Treatment: A National Study of Effectiveness.* Chapel Hill, North Carolina, The University of North Carolina Press, 1989. This section of the paper uses this book as source.

regular cocaine use increased slightly 3 to 5 years after treatment, while use of most other drugs continued to decline. These trends for use held for all three treatment modalities. Time in treatment, as in the DARP study, was among the most important predictors of posttreatment drug abuse for all types of drugs, particularly for heroin abuse--the longer a client spent in treatment, the better the chances for positive outcomes. In contrast to the DARP study, however, the TOPS study found the time in treatment necessary for greater success was relatively long: 6 to 12 months. Time in treatment was a less successful predictor of reduced post-treatment drug use for cocaine abusers and multiple drug abusers.

The TOPS study also looked at the cost-effectiveness of treatment and found substantial reductions in crime-related and other costs to the Nation of drug abusers as a result of treatment. The study found that the investment of $5,000 for a year of outpatient drug-free or methadone treatment or $15,000 to $20,000 a year for residents of therapeutic communities--the average annual costs of treatments in the study--produced benefits that far outweighed the costs. The prevention of AIDS through reduction of intravenous drug use is another potential cost-related savings resulting from drug abuse treatment. The study concludes that the reduction in crime-related and other costs to society appears to be at least as large as the cost of providing treatment and that much of the expenditure is recovered during the time the abuser is in treatment. The study concludes that "...in that substantial benefits are to be gained during the treatment period in terms of reductions in criminal activity and associated costs to the nation, long-term drug abuse treatment appears to be an effective mechanism to limit the burden of drug abusers on the nation."

The TOPS study also recommends several ways in which existing treatment efforts could be substantially improved through increased outreach and recruitment to encourage more drug abusers into treatment, better patient assessment and planning to ensure that drug abusers receive the services they need, improved counseling and increased habilitation and rehabilitation and related services, and increased efforts to ensure that clients remain in treatment for the appropriate length of time to improve chances of success and receive adequate transitional and aftercare services after treatment is completed. The report also calls for more research on the difficult problems of matching different types of clients with the particular treatment modalities and settings that are most appropriate for those clients. The question of what treatment works best for what type of client is still difficult to answer and for publicly-funded treatment programs can be a crucial issue in allocating limited resources.

One major problem that some researchers have with much drug abuse treatment research, including the DARP and TOPS studies, is that they concentrate for the most part on treatment for heroin addiction. Little is known as yet on the effectiveness of treatment for cocaine abuse and polydrug use, which are becoming increasingly dominant among drug abusers in our society. TOPS study results that showed increased use of cocaine after

treatment demonstrate the difficulty of successfully treating addiction to this drug.

SUBSTANCE ABUSE PREVENTION AND EDUCATION

On the assumption that increased knowledge about drugs and alcohol and the consequences of their use would be an effective deterrent, prevention programs in general and school programs, in particular, have attempted to provide information about the legal, pharmacological, and medical aspects of such use. Evaluations of such programs, however, seem to indicate that increased knowledge had virtually no impact on substance used or on intentions to drink or to use drugs. In an effort to prevent young people from trying drugs, some information-based education programs tended to exaggerate the immediate effects of drug use. This approach contradicted what many young people knew, or thought they knew, from personal experience or observation, and created disbelief. Some studies even suggested that drug education programs using information dissemination may have led to drug experimentation and use among curious or adventurous young people.

Recent approaches to substance abuse education and prevention include more than a curriculum of study on the problem. Increasingly, schools and school districts have begun to develop a comprehensive three-part approach that goes beyond a simple unit on drug and alcohol abuse as part of a class in health education.[13] An important part of this approach is the establishment and enforcement of rules prohibiting drug and alcohol use, possession, and sale on school premises and at school functions by students and staff, along with a clear explanation of the penalties resulting from such behavior. In order for such a policy to be successful, students, staff, and parents must understand the policy and rules, and any infractions must be enforced consistently.

Another facet of a successful school substance abuse prevention program is a policy of intervention with students who are already involved with drug or alcohol use. Intervention efforts, which can include staff training, peer counseling, hiring of drug counselors, and liaisons with such local groups as medical societies and mental health agencies, generally seek to identify the student who is using drugs or alcohol, refer that student for treatment, and support the student upon his or her return to school following treatment.

The third and final part of a comprehensive substance abuse program in the school is the design and implementation of prevention strategies designed to keep students who have not begun to experiment with drugs and alcohol from ever starting. Such efforts vary from school to school, but most agree that substance abuse prevention programs should begin in kindergarten and continue through the 12th grade, delivering a consistent, increasingly

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[13]National School Boards Association. *Alcohol and Drugs in the Public Schools: Implications for School Leaders*. Apr. 1988.

comprehensive message each year. Programs combine a presentation of accurate information about drugs and their use in conjunction with a focus on the personal and social pressures and motivations that tempt young people to use drugs and alcohol. This usually includes training in assessing media messages and peer pressure. In an attempt to promote and develop social and life skills, current prevention efforts include such components as self-esteem enhancement, communication skills, relationship skills, stress management skills, use of leisure time, and problem-solving and decision-making skills. This combined approach is derived from successful anti-smoking program activities over the past 20 years.

Research into the effectiveness of substance abuse prevention strategies is limited. A 1987 Department of Education report on the nature and effectiveness of drug prevention/education programs noted that research into the effectiveness of prevention programs has traditionally measured three types of outcomes: changes in drug and alcohol knowledge, changes in attitudes, and changes in use.[14] In general, according to this report, research suggests that increases in knowledge are easy to obtain, changes in attitude are more difficult, and changes in behavior, particularly lasting changes, are rare. Although changes in knowledge and attitudes can be important precursors to changes in behavior, the ultimate test of prevention programs is evidence of reduced drug and alcohol use and related problems.

In recent years, several education/prevention efforts have been found to bring about measurable changes in knowledge, attitudes, and behavior. The STAR Project, for instance, has, since 1984, involved the entire early adolescent population of the 15 communities that constitute the Kansas City (Kansas and Missouri) metropolitan area in a trial for primary prevention of cigarette, alcohol, and marijuana. The project includes mass media programming, a school-based educational program, parent education and organization, community organization, and health policy components.[15] Researchers studying children who have gone through the program, as well as a control group, have found encouraging results. Fewer of the students who participated in the course of study were using cigarettes or marijuana 3 years later as opposed to those in the control group who had not participated. Those in the project were also apparently less likely to use alcohol than control students, but the difference was not statistically significant.

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[14]U.S. Dept. of Education, in conjunction with the U.S. Dept. of Health and Human Services. *Report to Congress and the White House on the Nature and Effectiveness of Federal, State, and Local Drug Prevention/Education Programs.* Oct. 1987.

[15]Pentz, Mary Ann et al. A Multicommunity Trial for Primary Prevention of Adolescent Drug Abuse. *Journal of the American Medical Association*, v. 261, June 9, 1989. p. 3259.

Another program reported on in 1990, Project Alert, focused on junior high students in urban, rural, and suburban communities in Oregon and California and was also aimed at preventing the use of cigarettes, alcohol, and marijuana. As with the STAR Project, the program appeared to be effective in delaying initial and current use of marijuana and cigarettes, and also appeared to be equally effective with high-risk youth in urban schools with large minority enrollments as with lower-risk youth in predominantly white, middle-class, suburban schools. The program did not help previously confirmed smokers and its effects on adolescent drinking were short-lived.[16]

Another school-based substance abuse prevention program that has shown promise in establishing student attitudes is the Project DARE (Drug Abuse Resistance Education) program, which was established by the Los Angeles Police Department and the Los Angeles Unified School District in 1983 and in the years since has spread to communities across the Nation. The DARE program uses uniformed law enforcement officers to teach a formal curriculum to elementary school students, focusing on four major areas: providing accurate information about tobacco, alcohol, and drugs; teaching students decision-making skills; showing students how to resist peer pressure; and suggesting alternatives to drug use.

Evaluation of the long-term effectiveness of the DARE approach is still in the preliminary stages, but the law enforcement and school officials in communities across the country have found the program helpful in helping students to become less accepting of drug and alcohol use and better prepared to deal with peer pressure. The program also appears to enable students to get to know police officers in a positive, nonpunitive role. The Bureau of Justice Assistance of the U.S. Department of Justice has published a Program Brief on Project DARE inviting communities to implement the program in their schools.[17] In addition, the Congress has expressed its support for the program, including authority in P.L. 101-226, for local schools to use their funds under the Drug-Free Schools and Communities Act for Project DARE-type programs using law enforcement personnel.

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[16]Ellickson, Phyllis L., and Robert M. Bell. Drug Prevention in Junior High: A Multi-Site Longitudinal Test. *Science*, v. 247, Mar. 16, 1990. p. 1299.

[17]U.S. Dept. of Justice, Bureau of Justice Assistance. *An Invitation to Project DARE: Drug Abuse Resistance Education*. June 1988.

TREATING DRUG PROBLEMS

VOLUME 1

INSTITUTE OF MEDICINE

5

The Effectiveness of Treatment

The question that people ask drug treatment experts most often and most insistently is a simple one: Does treatment really work? In the committee's judgment, and that of most experts, the available clinical experience and research data add up to a similarly short and pointed answer: It varies. This answer should be no surprise, as the question is naive. Virtually everything in Chapters 2, 3, and 4 of this report leads one to expect the effectiveness of treatment to be a complicated matter to understand and assess. Drug treatment is not a single entity but a variety of different approaches to different populations and goals. Response to treatment is not a matter of all or nothing, complete success versus total failure, but of degrees of improvement. Moreover, the setting for evaluation is not the quiet purity of a controlled laboratory experiment but the tangled complexity of real lives and programs under pressure from many directions.

The committee's strategy under the circumstances has been to put forward a line of questioning that is straightforward but somewhat more elaborate and revealing than "Does treatment really work?" These questions, which are listed below, cannot all be fully and confidently answered at present. Consequently, they must continue to be asked about each kind of treatment.

- *What are the basic concepts or modalities of treatment*? That is, what are the underlying designs or theories of treatment, what specific types of drug problems or population groups are being addressed by each

design, and what are the best results that have been obtained under ideal conditions?

- *How well does each modality work in practice*? How adequate in terms of methodology are the evaluations of real programs, and what do the best of these evaluations reveal?
- *If a modality is not working as well as might be expected, what are the reasons*? For example, is the implementation or replication of the modality flawed or incomplete? Are the wrong kinds of clients being treated? Are there unexpected side effects? Does the environment interfere with the effectiveness of the treatment?
- *Do the benefits of the treatment justify its costs*? In other words, is treatment a sound investment of scarce public and/or private resources?
- In addition to these questions about treatment as it presently exists: *How might further research help to improve treatment*?

In responding to the first of these questions, this chapter considers serially the four major types or modalities of drug treatment: outpatient methadone maintenance, residential therapeutic communities (TCs), outpatient nonmethadone (OPNM) treatment, and inpatient/outpatient chemical dependency (CD) treatment. As indicated in the brief description of these modalities in Chapter 2, each type of drug treatment has developed since the 1950s. TCs derived largely from Synanon, which began in California in 1958. Methadone maintenance developed from studies on a hospital ward in New York in 1964; CD programs grew out of hospital-based approaches to treating alcoholism in Minnesota in the 1960s. Outpatient nonmethadone treatment[1] goes back at least to psychoanalytic treatment of "toxicomania" in the 1930s, but the community mental health movement, youth crisis counseling, "drop-in centers," and "free clinics" of the 1960s adopted quite different orientations that have substantially shaped the OPNM programs seen today. Although every modality has specific roots, all have continued to evolve since their introduction.

The most extensive usable results of research on the effectiveness of

[1]Because methadone maintenance programs are virtually always conducted on an outpatient basis but are set apart by the specific reference to methadone, all other outpatient programs are conventionally lumped together as outpatient nonmethadone or outpatient drug free. In light of the frequent use of other psychotropic medications during outpatient treatment, the committee views the term "nonmethadone" as more accurate than "drug free." The lumping together of all outpatient nonmethadone treatment is testimony to the prominence and distinctive nature of methadone maintenance and the fact that the population it serves is sufficiently homogeneous and different from the populations served by other outpatient programs. It should also be noted that methadone may be used in modalities other than maintenance, which technically refers to a planned treatment duration of 180 days or longer. (Shorter periods—usually 3 weeks to 2 months—are considered methadone detoxification.) Planned methadone-to-abstinence tapers of longer than 180 days are also incorporated into some program plans.

drug treatment are from several moderately sized clinical experiments and natural or quasi-experiments and from prospective longitudinal studies involving thousands of clients. There have been two large-scale, multisite, federally sponsored studies of publicly supported programs: the 12-year follow-up of a 1969–1971 Drug Abuse Reporting Program (DARP) national admission sample cohort and the Treatment Outcome Prospective Study, or TOPS, which involved a 10,000-person national sample of 1979–1981 admissions to 41 drug treatment programs in 10 cities. The Drug Abuse Treatment Outcome Study (DATOS), a third large-scale national prospective study, is scheduled to begin in 1990.

The committee addresses the paradigmatic questions separately within each modality. Although many treatment seekers try more than one treatment modality over the course of their drug careers (they build up a "treatment career" as well), the average profiles of clients admitted to the major modalities are quite different. Both treatment seekers and treatment programs engage in a great deal of individual selection into which many factors enter. For example, programs are geographically and economically differentiated in their accessibility to various types of potential clients; methadone clinics are relatively low in cost and typically located in inner-city areas; chemical dependency units are generally expensive and found in affluent suburbs. The typical demographic and drug-taking patterns of the different modalities' populations (a reflection of who *stays* in treatment from among those who are admitted) are quite distinctive. As a result, one cannot simply compare the performance or results of each modality with the others as if their client populations were interchangeable. Moreover, because some clients move between programs and there is evidence that treatment effects may, in part, be delayed and cumulative, it is hazardous to ascribe all the effects of a treatment episode to that episode alone; adjustments must be made to take prior treatments into account.

The most extensive and scientifically best developed evidence concerns methadone maintenance. A lower although still suggestive level of evidence is available concerning therapeutic communities and outpatient nonmethadone treatment. The lowest level of evidence is available for chemical dependency. Where the evidence on treatment effectiveness approaches adequacy, its overall tendencies are clear.

- Treatment reduces the drug consumption and other criminal behavior of a substantial number of people. Clients exhibit their best behavior while actively enrolled in treatment; their behavior is often poorer following treatment than during it, although still better than before admission.
- There are large variations in effectiveness across programs, which seem to be related to the varying quality of clinical management and competence. Practices in methadone maintenance dosing are a clear instance

of this variation; there is also variance owing to differences in the characteristics of the populations being treated, such as the severity of their problems at admission.

- The length of time in treatment is a very important correlate of outcome; that is, longer treatment episodes yield better outcomes than shorter ones. Retention is presumably related to general program quality and specific client motivation to remain in treatment; however, no predictive treatment motivation test is available, and the role of treatment in facilitating motivation or averting impulsive decisions to "split" from treatment is not yet well understood.
- The benefits of treatment programs on the whole outweigh their costs, but variations in cost-benefit methodologies and results are great.

It should be noted that, except to describe the model, there are virtually no data to answer critical questions regarding independent self-help fellowship groups such as Narcotics Anonymous and Cocaine Anonymous or the Oxford Houses. Although the ideas underlying the Anonymous fellowships were incorporated at the outset into the clinical approaches[2] of TCs and CD programs and clients in these modalities are encouraged to participate in Anonymous meetings, the fellowships have shied away from involvement in formal evaluation protocols. Because drug-related Anonymous groups have been meeting in most cities longer than drug treatment programs have been present, and because they generally welcome individuals who are in treatment as well as those who are not (except that many Anonymous groups are antipathetic to individuals in methadone maintenance), they are in essence a part of the environmental baseline over which the incremental effects of the more formal treatments must be measured.

Two special topics are set slightly apart from the main lines of the chapter: the role of detoxification, which is often carried out in hospital settings, and the effects of treatment that occurs within correctional institutions. In the committee's view, it is not tenable to consider detoxification a treatment modality for the rehabilitation of drug abuse and dependence. Rather, it is a way of moderating some of the effects of overdose or withdrawal, and it may serve as a gateway to treatment. Correctional programs seem to fall largely into one of three types: they are either therapeutic communities, outpatient-type programs whose clients happen to live in prison, or drug law education programs carrying the name of treatment.

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[2]Although CD programs incorporate numerous therapeutic components in addition to Alcoholics Anonymous-type meetings, the 12 steps of the Anonymous creed are so fundamental to the CD modality that the latter has been referred to as the "professionalization of Alcoholics Anonymous." There is no scientific literature on the Oxford House approach, which combines residential proximity with the fellowship principles.

The committee considers the need and opportunity for research relevant to treatment effectiveness to be so important that this chapter presents several recommendations for research on treatment methods and services. With recent budget increases for research, there is no overall lack of resources that could be devoted to such studies. Rather, the challenges of treatment-oriented research are arduous and demand certain kinds of commitments that are altogether too easy to slight in the rush to distribute cascades of research funding to more glamorous (e.g., high-technology) research ventures.

METHADONE MAINTENANCE

What Is Methadone Maintenance?

Methadone maintenance is a treatment specifically designed for dependence on narcotic analgesics, particularly the narcotic of greatest concern in the United States, heroin.[3] The controversies surrounding methadone maintenance[4] have made it the subject of literally hundreds of studies. From these studies, including a few vitally important clinical trials, strong evidence has accumulated about the safety and effectiveness of methadone.

[3]There are three main types of narcotic analgesics: those derived from opium, such as morphine, heroin (diacetylmorphine), and codeine, and the two major synthetics, meperidine (best known as Demerol) and methadone. There are numerous congeners of each major narcotic type that have varying degrees of activity. The natural and synthetic compounds have dissimilar chemical bases but share certain critical structural properties that result in their penetrating and affecting the "endogenous opioid" neurotransmitter system in similar ways. There are significant differences, however, in how the major narcotic types are absorbed and metabolized outside the brain; these difference affect the duration and rate of their central nervous system effects.

[4]There continue to be widespread negative beliefs among the general public and some policymakers about methadone (see, for example, the results of focus group discussions reported by the Technical Assistance & Training Corporation [1989]). The drug is suspected, for example, of being unsafe even in clinically controlled usage; it is said to "rot" the bones (or the brain, or the liver) and to create lassitude or stupefaction among individuals who take it for any length of time or at any dose except a minimal one. It is also said that indefinite maintenance is "just substituting one addiction for another," so the most important clinical goal should be to "get off methadone" as soon as possible. It is thought that most of the people enrolled in methadone maintenance programs sell some or all of their daily methadone dose and use the proceeds to buy heroin and other drugs. Putting all of these beliefs together, methadone can be portrayed as an assault on the well-being of communities in which methadone maintenance clinics are located, rather than a therapeutic response to local drug problems.

This set of beliefs about methadone is based partly on shards of experience (often reported by journalists), partly on philosophical or ideological premises that may be impervious to evidence, and partly on frank skepticism about the existence of a therapeutic rationale or base of evidence underpinning methadone maintenance treatment. This section should at least be useful in addressing the last of these sources of belief.

The idea is not unfamiliar that a treatment for a chronic health disorder could involve long-term, even permanent pharmacological maintenance using a powerful drug that is nevertheless safe if properly administered. Perhaps the most obvious examples are treatments for endocrine problems: insulin for diabetes, thyroxine for thyroid deficiency. A treatment for chronic mood disorders (manic-depressive cyclothymia) using lithium chloride for long-term maintenance is a psychiatric example. Although methadone maintenance was viewed as revolutionary when it was first developed in the United States, the historical sketches in Chapter 2 and in Courtwright (1990) point toward early twentieth century instances in U.S. cities of morphine maintenance as a treatment for opiate dependence. In Great Britain, heroin maintenance was also practiced, although it has largely been replaced there by methadone maintenance. The application of maintenance concepts to the treatment of drug dependence therefore is not medically unusual. But to understand how methadone maintenance operates as a treatment for heroin dependence, three aspects must be stressed: the significance of clinically defined goals, the pharmacological basis of drug substitution, and the embedding of substitution in a broader clinical behavioral strategy.

Goals

Methadone maintenance cannot be understood apart from the correct stipulation of the major goals of treatment, primarily to reduce illicit drug consumption and other criminal behavior and secondarily to improve productive social behavior and psychological well-being. It is critical that methadone is a legally prescribed drug for the purpose of treating dependence.[5] Yet even more critical is that individuals who receive methadone maintenance treatment should reduce their use of illicit drugs and their commission of other crimes (e.g., selling drugs, stealing money, using weapons to obtain funds to support their drug consumption) ideally to zero but at least by an appreciable amount. Improved social productivity and well-being would be important further measures of the effectiveness of methadone maintenance. The goal of ending the licit dependence on methadone itself is well down the list—so that the risk of increased crime or illicit drug use weighs heavily against arbitrary limitation on the duration of methadone maintenance. Nevertheless, this goal has been given much higher priority in many programs, as discussed later in the chapter.

[5]The argument has been made that even illegally marketed methadone represents a significant public health improvement over street heroin. Although this result is theoretically plausible, an opposite result is equally plausible, and there is little evidence to support either theory. Therefore, in policy terms, street methadone sales are a negative effect.

Substitution

At the base of methadone maintenance is an empirical observation that was made before the biological reasons for it were well understood: all of the effective narcotic analgesics may be substituted for one another with adjustments in dose and route of administration. Substitution is possible because there are basic similarities in their objective and subjective effects; in particular, in dependent individuals there is parallel or cross-tolerance to elevated doses and cross-suppression of respective withdrawal effects. Key differences involve how quick, how strong, and how long-lasting these actions are; they are also apparent in the precise mixture of effects for each drug.

Cross-dependence is particularly important in detoxification. Most drugs of widespread abuse and dependence (heroin, cocaine, alcohol) act quickly and dramatically and wear off in a matter of hours. By the same token, the associated primary withdrawal syndromes tend to be striking but short; there is usually, however, a somewhat more protracted but less dramatic phase of sustained withdrawal symptoms such as sleep disturbance, agitation, or mild depression. The general approach to detoxification is to moderate the more severe symptoms, often by substituting a long-acting drug, which can then be tapered down to zero, leaving only the lesser symptoms.

Methadone may be prescribed not for maintenance purposes but for a shorter period—three weeks was once standard, although the period may legally extend up to six months—to moderate withdrawal symptoms. Detoxification generally begins with an escalating dosage to reach a point such that the patient stops using other opiates and withdrawal symptoms are not evident. Then the methadone dose is tapered down to zero. Individual responses vary, but usually this method does not completely suppress withdrawal symptoms during and after the tapering period; rather, it keeps them mild for a time—until the tapering procedure does not provide enough methadone to prevent the more discomfiting withdrawal symptoms. It is common for individuals to drop out of methadone detoxification some time during the second week of a typical three-week planned detoxification period. Sometimes other medications are given during methadone detoxification to manage particular symptoms.

As shown by the long record of experience with detoxification of heroin dependence, those detoxified were universally found to have a very high susceptibility to relapse—usually well in excess of 90 percent of followed cases (see Vaillant, 1973). After detoxification, and often before its procedures had been completed, there was a resumption of craving for opiates. Dole (1988) and others have theorized that the extensive use of opiates may bring on alterations in the brain neurotransmitter/receptor systems affected

by opiates, leaving many individuals with a virtually permanent craving that can only be assuaged by drugs of the opiate family.

Methadone has several unusual pharmacological properties that have made it especially suited to a maintenance approach. Unlike many opiates, it is effective orally, a significant advantage in that oral dosing is more hygienic than the needle and more easily titrated than smoke. Because of methadone's particular pattern of absorption, metabolism, and elimination, a single dose within a train of level doses, in the typical maintenance range of 30 to 100 milligrams per day (mg/day), takes effect gradually and wears off slowly, yielding a fairly even effect across a period of 24 hours or longer. Methadone is thus conducive to a regime of single daily maintenance doses, eliminating dramatic subjective or behavioral changes and making it easy for clinician and client to fit into a routinized clinic schedule.[6] This pattern is very different from the shorter action and more dramatic highs and lows of heroin, morphine, and most other opiates. The long-term toxic side effects of methadone, as of other opiates if taken in hygienic conditions in controlled doses, are notably benign.

The short-term clinical effects of methadone were first studied at the Lexington addiction research center in the 1950s, and research continued there and elsewhere into the 1960s. Since the mid-1960s, about 1.5 million person-years of methadone maintenance have accumulated in the United States. Not all clients have been closely observed for medical side effects, but the thousands of research cases that have been carefully observed yield a well-documented conclusion:

> [P]hysiological and biochemical alterations occur, but there are minimal side effects that are clinically detectable in patients during chronic methadone maintenance treatment. Toxicity related to methadone during chronic treatment is extraordinarily rare. The most important

[6] There was extensive research from the late 1960s to the late 1970s on a longer acting methadone congener, levo-alpha-acetylmethadyl (LAAM), that requires less frequent doses—every two or three days instead of daily. LAAM has been studied in a series of phased clinical trials but has not yet been approved for nonexperimental use, although its safety and freedom from toxic side effects appear comparable to those of methadone (Savage et al., 1976; Ling et al., 1978; Blaine et al., 1981). Overall, during the trials, methadone was more successful than LAAM in retaining clients in treatment (by 20 percentage points), largely because more LAAM recipients felt that the medication was not "holding," that is, not keeping opiate withdrawal symptoms from beginning to emerge between doses, a result that Goldstein and Judson (1974), after a double-blind study, judged to be more psychological than physiological in origin. LAAM recipients who stayed in treatment used less heroin and performed better on other clinical measures than methadone clients, particularly those on lower methadone doses. Some clinicians reported a substantially improved therapeutic climate in LAAM clinics owing to the more relaxed three-days-per-week visiting schedule (Goldstein, 1976). There are probably clients who would do better on LAAM than on methadone, and vice versa, with results for both likely to improve with better dose optimization and counseling about differences between the two drugs. A revival of interest in LAAM and an attempt to restore the initiative toward approval by the Food and Drug Administration for nonexperimental use are under way.

> medical consequence of methadone during chronic treatment, in fact, is the marked improvement in general health and nutritional status observed in patients as compared with their status at the time of admission to treatment. (Kreek, 1983:474)

The most common physical complaints during methadone maintenance are insomnia and weight gain, but these are clinically related both to the consumption of other drugs and alcohol (consumption that continues and sometimes increases among a fraction of clients, the size of which varies from program to program) and to preexisting or coexisting abnormalities common in this population and in the general population.

Clinical Behavioral Strategy

In terms of the social history and individual model of drug-seeking behavior reviewed in Chapters 2 and 3, a program of controlled methadone maintenance at an appropriate dose level could have recovery-inducing effects on heroin dependence. These effects may be felt through two paths corresponding to the two most common motivational processes that operate during heroin dependence: pleasure seeking and withdrawal avoidance.

With regard to pleasure seeking, methadone is an effective analgesic. Yet the effect of an accustomed (tolerated) dose is merely a dim echo or reminder of heroin's most intense effects, not so much a "rush" as a reassurance—which may wear better in the long run and is certainly less disruptive in the short run than the euphoric heroin high with its associated itchiness and dreamy nods. There is also a more subtle and perhaps equally valuable effect: if heroin and methadone are both in the body, their active metabolites compete with each other for access to sites of action in the brain. If the methadone dose is high relative to the heroin dose, the latter will not have a very distinctive effect, and the individual taking methadone will find heroin less rewarding. As a result, the shooting of heroin "over" the methadone may become self-extinguishing.

On the other side of the pharmacological fence, methadone maintenance prevents symptoms of heroin withdrawal, which, although not life-threatening or excruciating, are immiserating (a good parallel is a head cold or a bout of influenza). The critical condition is that the dependent person feeling withdrawal symptoms knows that all of these unwelcome sensations can be banished within minutes with a dose of an opiate. Recurrent withdrawal symptoms stimulate drug seeking during heroin dependence, and the ability of methadone maintenance to keep them at bay is a major attraction and benefit.

In its initial clinical trials, which began in inpatient settings and then were extended to outpatient sites, methadone maintenance proved capable of stabilizing the psychological functioning of the heroin-dependent

individual at a near normal state. Methadone in effect eliminated the alternating phases of euphoria, somnolence, and agitated concern characteristic of the incipient stage of withdrawal from heroin dependence. The clinicians conducting the trials observed that clients on methadone were not obsessed with acquiring the next dose, became interested in the prospects for improving the conventional strands of their lives, and were generally functioning without notable drug impairment or side effects. An individual on methadone was capable of participating in counseling, psychotherapy, and remedial education and training (most of the same rehabilitative services delivered in therapeutic communities and outpatient treatment). This capability was partly the result of the intrinsic pharmacological effects of methadone and partly because, unlike street heroin, it was provided reliably, in legitimate clinical settings, and in reliable doses.

Methadone maintenance was originally defined as the administration of methadone together with rehabilitative and counseling services, and this definition, along with many detailed specifications about facilities and staffing, was built into federal regulations as a required protocol for a licensed methadone maintenance program. These regulations permit methadone to be dispensed only by licensed maintenance or detoxification programs or by hospital pharmacies. (In hospitals, methadone is prescribed mainly for severe postoperative or cancer pain and occasionally for short-term inpatient detoxification.)

Methadone programs are nearly always ambulatory, with daily visits to swallow the methadone dose (usually provided in a 3- to 4-ounce plastic bottle of sweetened, orange-flavored water) in the clinic, except for the traditional Sunday take-home dose. After several months in the program with a "clean" drug-testing record and good compliance with other program requirements such as counseling appointments, clients may regularly take home one or more days' doses between every-other-day, twice-weekly, or even weekly visits—a revocable range of privileges. Some methadone clients voluntarily reduce their doses to abstinence and conclude treatment after some time; others remain on methadone indefinitely.

The role of counseling is multifold. In the first instance, the design of methadone maintenance programs includes numerous monitoring and adjustment features that stress the need for clients to wean themselves away from street drug seeking. Program clinics have specific hours for dispensing, counseling, and medical appointments; there are codes of proscribed behavior (e.g., no violence or threats of violence), and monitored drug tests are conducted at random intervals—at least monthly and as often as weekly, although the cost of the tests have led financially strained programs to cut them back to the minimum. Counseling includes the assessment of client attitudes and appearance (important in themselves and as clues to drug behavior) and the gathering of information about

employment, family, and criminal activities; counselors offer psychotherapy and individualized social assistance and recognition, depending on their caseloads and their training for such tasks.

In most clinics, counselors participate in staff decisions with regard to changing dose levels, requirements for therapeutic contacts, award and revocation of take-home privileges, and decisions regarding termination from the program. Clinical experiments have studied methadone dosage and behavioral techniques (contingent rewards and sanctions for "dirty" urines and missed and late counseling appointments) as part of the modality's repertoire. The clinical trial literature has demonstrated important success in the use of methadone dosage supplements or decrements and take-home privileges to punish or reward clients for noncompliance with such clinical rules as the proscription on continued drug use and the requirement of cooperation by timely attendance for dispersing, participating in counseling, and paying required fees (Stitzer et al., 1983).

The drawbacks to methadone maintenance have been well recognized since its inception: the client is still at least mildly dependent; the drug reduces heroin craving and stabilizes the individual psychologically but does not necessarily modify or rehabilitate other behavior; clients often still use or abuse and sometimes become dependent on other drugs including alcohol; and it is possible for take-home methadone to be diverted from therapeutic uses and sold to permit the client to buy heroin or other drugs. Moreover, methadone has no direct pharmacological bearing on abuse or dependence on alcohol or other drugs, especially cocaine, which has become such a serious and widespread problem in the 1980s. The important question is this: Does the modality reach its primary goals in enough cases to outweigh these limitations and drawbacks?

How Well Does Methadone Work?

The goals of methadone maintenance—to reduce illicit consumption of heroin and other opiates, to reduce other criminal activity, and to help clients become more socially productive and psychologically stable—constitute a continuum that can be cut at various points to designate "success" versus "failure." At the outset of its use, the modality was specifically targeted toward those who were most severely dependent, as judged by substantial histories of relapse from earlier detoxification episodes (frequently in jail); this commitment was built into the early regulations requiring documentation of at least two years of heroin use and two prior relapses.

Early trials of methadone maintenance in New York (Dole and Nyswander, 1965, 1967; Dole et al., 1966, 1968, 1969) noted two striking findings: the majority of clients would remain in treatment for as long as it was

available to them, in substantial contrast to the usual experience in outpatient psychotherapy; and methadone maintenance significantly improved the condition of clients as revealed by studies that considered behavior in the community for periods of several months to several years. Although there was some use of other drugs, including heroin, especially in the first few weeks after admission, such use generally fell off over time, contrasting sharply with the increasing return over time to heroin dependence that was the norm after detoxification or other typical medical or psychiatric treatments. The steadiness of employment increased somewhat, but a much more dramatic change was the sustained reduction in criminal behavior, especially drug trafficking crimes.[7]

The most convincing results about the efficacy of methadone maintenance—the capacity of the treatment to induce client changes independent of initial selection or motivational effects—come from a handful of clinical experiments that are widely separated in time and place but that consistently yield very distinctive findings. In these studies, heroin-dependent, heavily criminally involved populations who were randomly assigned to methadone maintenance or a control condition (an outpatient nonmethadone modality) demonstrated clinically important and statistically significant differences in favor of methadone on the gauges of drug use, criminal activity, and engagement in socially productive roles such as employment, education, or responsible child rearing.

In the landmark experiment, Dole and colleagues (1969) randomly assigned 32 well-motivated criminal addicts to either a methadone treatment group ($N = 16$, of whom 4 declined treatment before program initiation) or a year-long control/waiting list group ($N = 16$). Out of the combined control and refuser group ($N = 16 + 4 = 20$), every individual became re-addicted to heroin soon after release, with 18 individuals returning to jail and the other 2 being lost to the study. At 7 to 10 months after initiation of the study, only 3 of the 12 addicts in the experimental group had been reincarcerated. Furthermore, although 10 of these 12 individuals had used heroin since the program was initiated, for 6 of the 10 this use was limited to the first 3 months of the program.

Gunne and Gronbladh (1984) have also reported a small but persuasive study (Figure 5-1). Thirty-four heroin-dependent individuals applied for admission to the only methadone clinic in a Swedish community; 17 were

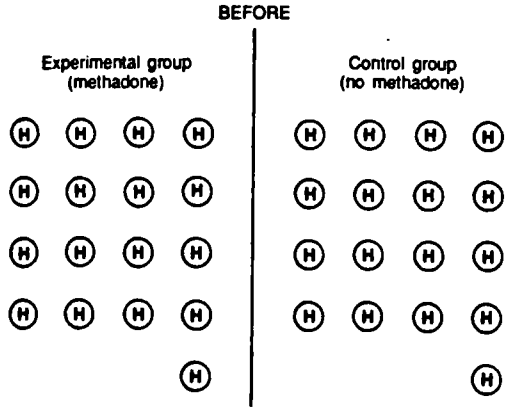
[7] Observational studies of the original Dole-Nyswander program cohorts, which probably engaged the most highly motivated clients and had relatively high-quality staff and resources, yielded good data over time confirming the long-term efficacy of methadone maintenance (Dole et al., 1968; Gearing, 1970, 1974; Dole and Joseph, 1978). Studies in these and later programs also indicated the close relation of retention in treatment and good outcomes; attrition after a short period in treatment was associated with higher rates of relapse (Simpson et al., 1979; Hubbard et al., 1989).

randomly assigned to methadone maintenance, and 17 were assigned to outpatient nonmethadone treatment (these individuals could not apply for admission to the methadone clinic again for 24 months). Two years later, 12 of the 17 clients on methadone were no longer using illicit drugs; 10 were employed, and 2 were in school. Five still had drug problems, and of these, 2 had been discharged from treatment for severe abuse of sedative-hypnotic drugs. Of the 17 individuals who went into the outpatient nonmethadone program, only 1 was doing well; 2 were dead, 2 were in prison, and the rest had returned to taking heroin. After two years, then, 71 percent of methadone clients were doing well, compared with 6 percent of controls. Five years after the study began, 13 of the methadone clients remained in treatment and were still not using heroin, and 4 had been excluded from treatment because of unremitting drug problems. Among the controls, 9 had applied for and entered methadone maintenance; of these, 8 individuals were not using drugs and were socially productive. Of the 8 controls who did not apply for methadone when eligible, "five are dead (allegedly from overdose), two in prison and one is still drug free" (Gunne and Gronbladh, 1984:211).[8]

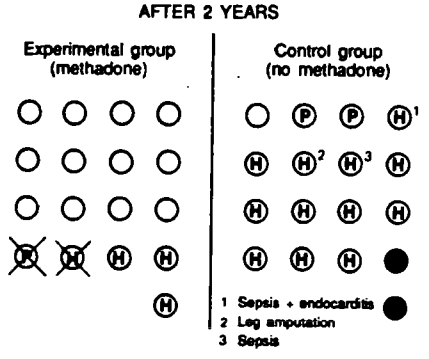
Another perspective on the effectiveness of methadone treatment is offered by the results of several "natural experiments." In one such study, Anglin and McGlothlin (1984) examined the introduction of the methadone maintenance modality to California in 1971, viewing it as a quasi-experimental intervention. They had previously begun a long-term observational study of heroin-dependent individuals who had been apprehended by law enforcement agencies in 1961–1963 (McGlothlin et al.,

[8]One other significant experimental study was reported by Newman and Whitehill (1978) from Hong Kong. This study demonstrated both the attractiveness or retentive power of methadone as such and the difficulties of conducting randomized clinical trials with drug-dependent populations when they are able to act on their own strong preferences about treatment assignment. (Another illustration of that difficulty in the United States was reported by Bale and coworkers [1980].) Newman and Whitehill studied 100 male heroin addicts who were seeking methadone maintenance. The men were hospitalized for one week and stabilized on 60 mg/day of methadone. They were then randomly assigned to ambulatory methadone maintenance or to slow detoxification. The maintenance group started out at 60 mg/day and ended by averaging 97 mg/day. The detoxification group was taken down 1 mg/day over 60 days, after which they were given placebos. The medication was given on a double-blind basis: neither patients nor clinicians had certain knowledge of which group they were in.

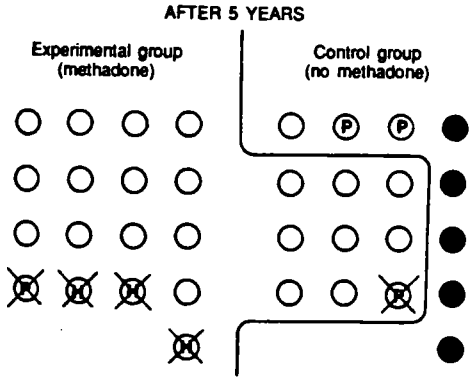
About 60 percent of maintenance patients were retained in treatment for the entire 2.5-year trial period, a rate commensurate with retention studies in the United States. In contrast, the patients who were detoxified dropped out of treatment rapidly. By the time they reached the placebo state, only 20 percent remained in treatment; nearly all had dropped out by the end of a year. Dropouts from the control group were subsequently recruited into methadone maintenance and had the same retention rates from that point on as the original maintenance group. Most of the control group sensed that they were being detoxified rather than maintained, and many quit the study to reenroll in methadone maintenance.



Situation before the randomization study: each circle represents an individual 20 to 24 years old. "H" indicates regular intravenous heroin abuse. The left half represents the experimental group, which will be accepted for methadone maintenance treatment; the right half represents the controls who will not be given methadone maintenance.



Two years after acceptance or decline: white circles = no drug abuse; H = abuse of heroin or (in the experimental group) hypnotic depressants; P = subject in prison; black circle = subject deceased; crossed circle = patient has been expelled from treatment.



Five years after admission: nine persons from the original control group have been accepted in the methadone maintenance program.

FIGURE 5-1 Clinical trial of methadone maintenance versus outpatient nonmethadone for heroin addiction conducted through the Swedish Methadone Maintenance Program. Source: Gunne and Gronbladh (1984).

1977). Drug consumption and criminal involvement in this study population were high just prior to the introduction of methadone, despite the fact that all members of the population had been incarcerated and supervised for several years in the 1960s by the state's Civil Addict Program (CAP). Some of the study population had already stopped using heroin before the introduction of methadone; this group was termed the inactive user sample. Some of the remainder entered methadone treatment when it became available (the methadone sample), and the rest did not (the active user sample; Figures 5-2a, 5-2b, and 5-2c). McGlothlin and colleagues (1977) had found during their earlier study that the active user and methadone samples had reduced drug and crime activity while under CAP supervision but had quickly resumed their prior high activity levels once CAP supervision ended. After the advent of methadone programs in California, a major difference was observed between those in the active user group and the methadone clients, a difference that persisted for at least three years after the introduction of methadone.

Overall, the findings of this natural experiment indicate that a certain proportion of addicts (i.e., the inactive sample) had responded favorably and permanently to a particular form of criminal justice supervision involving specialized prison treatment and intensive parole. Of those who did not, a significant proportion entered methadone maintenance when it became available and responded very well to it (compared with otherwise very similar individuals who did not enter a methadone program): those pursuing methadone maintenance substantially reduced their drug use and criminal activity and (to a lesser degree) increased their employment.

Similar results have been reported in natural experiments involving the limited introduction of publicly supported methadone maintenance programs in a number of California cities and towns in the early 1970s and the subsequent closure of some of these programs for fiscal and political reasons. In cities where methadone maintenance became much less accessible as a result of such closures, former clients as a whole did appreciably less well at the two-year follow-up (in terms of heroin use, other criminal behavior, and, to a lesser degree, employment) than comparison groups in locations where there was continued access to treatment. In cities where public programs closed but private ones opened, those who transferred to the alternative methadone maintenance programs did much better (in terms of staying free of drugs and out of crime) than those who did not or could not continue treatment (McGlothlin and Anglin, 1981; Anglin et al., 1989a). In these as in all other studies, longer retention in methadone as opposed to early attrition from the program was associated with much better results measured by reduced heroin use and other criminal activity.

Why Do the Results of Methadone Treatment Vary?

A significant proportion of methadone maintenance clients do not respond well to treatment, for a variety of reasons relating to the clients themselves and to the programs. This proportion averages about one in four, although there is wide variation from program to program (U.S. General Accounting Office, 1990; Ball et al., 1988). It is clear that some clients who are admitted enter methadone maintenance for purposes other than to receive counseling and other services or to pursue recovery. These clients are not compliant with clinical rules and are less likely than others to be (or become) motivated; most leave treatment after short periods. It is much easier to identify these clients after the fact than before; programs screen out some but not all such clients through pretreatment intake reviews. There are also probably some clients who would recover just as quickly without methadone maintenance, but they choose methadone treatment because it is helpful or attractive in some ways that other treatments (or no treatment) are not. The proportion of such clients is variable—it may be as low as 1 in 20 or as high as 1 in 10. These clients are beneficial in terms of positive program statistics but somewhat exaggerate the degree to which the program is actually generating worthwhile effects.

The largest group of clients is clearly at some point in the middle. The evidence from experimental and quasi-experimental studies clearly points toward the existence of a substantial number of heroin-dependent individuals who perform at least moderately well in response to methadone maintenance and who would do poorly without it, even when other kinds of treatment are available.

There is compelling evidence that program factors such as methadone dosing policies and counselor characteristics affect the behavior of such relatively malleable clients above and beyond any initial differences in motivation. The strongest treatment retention and outcomes (measured as improved social functioning) were seen in the initial methadone clinical trials (Dole and Nyswander, 1965, 1967) and in cohorts admitted to methadone treatment in New York during the pilot stage of developing the treatment (Gearing, 1970, 1974). This phase of history was characterized by careful screening of clients, self-selection by addicts—as a result of admission waiting lists of up to a year—and extensive adjunctive services provided by highly skilled and motivated clinical staff (Lukoff and Kleinman, 1977).

Later evaluations found that retention rates and outcomes were somewhat poorer when the New York programs had reached large-scale operation, were no longer highly selective in admissions, and had reduced their waiting time for admission to a few weeks (Dole, 1971; Dole and Nyswander, 1976; Dole and Joseph, 1978). Some observers attributed this decline to strains on system capacity and the onset of rigid and antipathetic

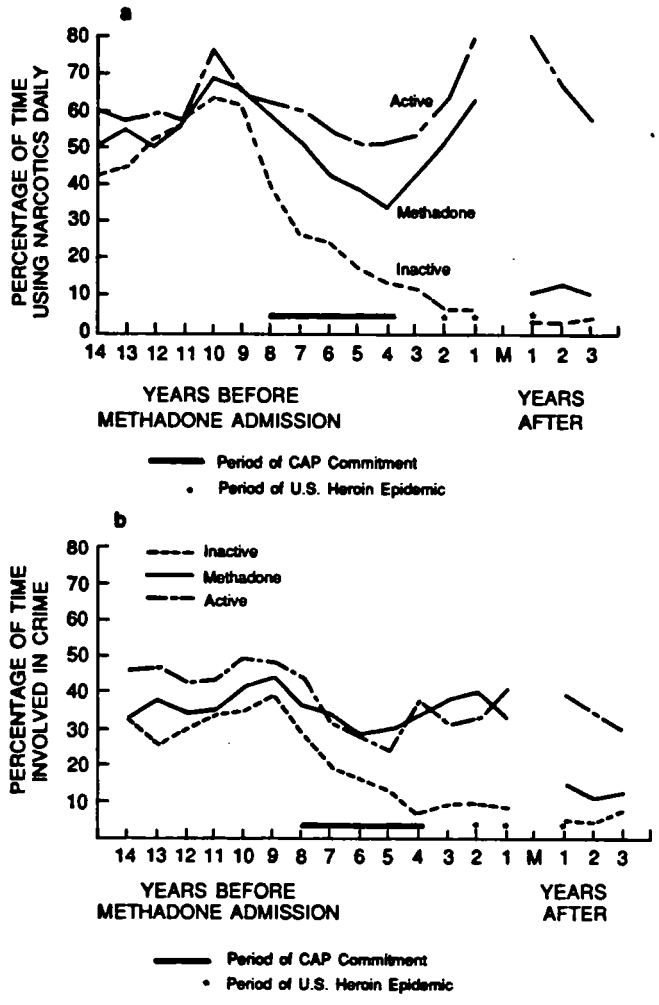


FIGURE 5-2

federal regulations in contravention of good clinical practices (Dole and Nyswander, 1976). Kleber (1977:268) has contended that the programs' primary problems were greatly reduced selectiveness in admissions and the shortage of skilled and motivated staff: "it is not surprising that retention rates dropped and the number of urines containing heroin rose. What is surprising is that the figures were not worse than they were."

Program performance (in terms of client retention and continued use of drugs) has also been observed to vary across programs at the same point in time. The Treatment Outcome Prospective Study, for example, showed a large degree of variation in clinically important client outcomes across nine

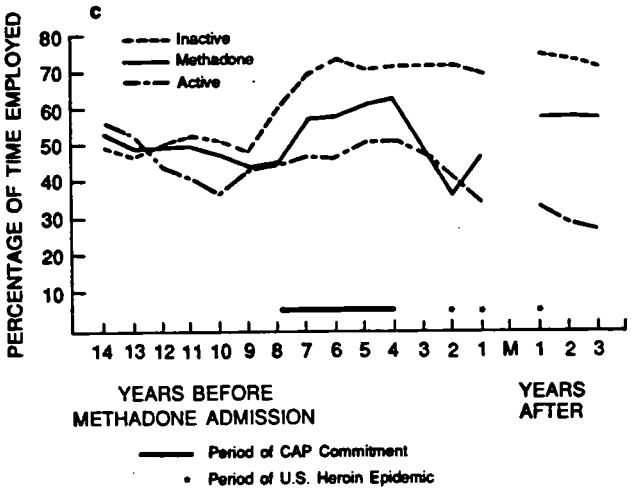


FIGURE 5-2 Effects of methadone maintenance in a sample of California ex-parolees who participated in the Civil Addict Program (CAP) measured on three parameters: (a) percentage of time reported as daily narcotic use; (b) percentage of nonincarcerated time spent in criminal activity; and (c) percentage of nonincarcerated time the individual was employed. CAP clients were divided into three groups: inactive users, active users, and methadone recipients. Source: Anglin and McGlothlin (1984).

methadone maintenance programs. Twelve-month retention rates averaged 34 percent of admissions, but five programs had low rates of 7 to 25 percent, whereas two programs had rates greater than 50 percent. Regular heroin use by clients at follow-up (approximately three years later) was reported by 21 percent of the entire follow-up sample, but two programs had rates greater than 30 percent, and three had rates of 11 to 14 percent (Hubbard et al., 1989).

Variation in performance has been linked most strongly to variations in methadone dosage policies. Programs that are committed to maintaining low average doses (30–50 mg/day) as a virtual goal of treatment—because of therapeutic philosophy or because state regulators strongly discourage higher doses—are less tolerant of occasional client drug use, missed counseling appointments, and other such treatment lapses, and have markedly lower client retention rates than more tolerant higher dosage programs. This lower tolerance does not, however, act as a stimulant to better client behavior or as a conveyor to move poorly responding clients out and bring in or keep better ones. There is solid, experimentally grounded evidence (see the major review by Hargreaves, 1983, and the associated conclusions of the expert consensus conference; reported in Cooper et al., 1983) that higher dose levels are fundamentally more successful in controlling a client's illicit drug consumption while he or she is in treatment. Although

dose levels must necessarily be adjusted according to individual variations in metabolism and size, programs that maintain an overall average dose of 60–100 mg/day yield consistently better results than those averaging less. Doses in excess of 120 mg/day are seldom needed.

The most recent illustration of the importance of dose levels—and the fact that many programs continue to be committed to low-dose regimes in spite of strong evidence against their relative effectiveness—comes from a study reported by Ball and coworkers (Ball et al., 1988; Ball, 1989; see also Dole, 1989). Dramatic differences in client use of opiates and retention in treatment were found among six methadone clinics in three eastern cities studied in 1985–1986 and selected to begin with as well-regarded programs. In the best clinic, urinalysis revealed that 10 percent of enrolled clients in the sample had used drugs intravenously in the month prior to the one-year follow-up. In the two worst clinics, more than 55 percent of clients had used intravenous drugs in the previous month.

Discriminant function analysis found that the most important factor in predicting intravenous drug use was the methadone dose level (Table 5-1). Among clients in treatment from 6 months to 4.5 years the odds of recent heroin consumption decreased at each higher level of methadone. There was also a dose-related decrease in the chances of cocaine use, although the gradient was less steep. (This trend probably has little direct pharmacological cause but instead arises from the generalized behaviors of drug marketing and drug seeking: those who are actively seeking heroin are more likely to seek out or at least happen upon cocaine while doing so, and vice versa.) The programs with the highest illicit drug consumption among clients not only had low methadone doses but also had high rates of staff turnover and poor relationships between staff and clients. Knowledge of and sensitivity to the clinical significance of appropriate dose levels is probably one sizable element in a constellation of clinical competencies and strategies that contribute to the greater or lesser effectiveness of methadone maintenance programs. There are only rudiments of standards for training, credentialing, continuing education, evaluation, and clinical performance of counselors and other treatment program staff. It is remarkable how few research efforts have focused on this larger area of competence, appropriate training, and different service arrangements in the clinical management of methadone clients. A serendipitous experimental study by McLellan and colleagues (1988), which demonstrated striking differences in counselor effectiveness within the framework of a large, stable, well-regarded methadone maintenance program,[9] is a lonely beacon in the literature.

[9] Only four counselors participated in the McLellan study, however.

TABLE 5-1 Heroin or Cocaine Consumption of 338 Methadone Clients (in treatment from 6 months to 4.5 years) in Past 30 Days by Methadone Dose

			Percentage Who Used Drug Within Past 30 Days			
Dose (mg/day)	*N*	%	No Heroin	No Heroin or Cocaine	Any Heroin	Any Cocaine
0–39	105	100	69	57	31	29
40–59	99	100	86	68	14	28
60–79	89	100	94	80	6	18
80–100	45	100	98	89	2	9
Total	338					

Source: Unpublished data from Dr. John C. Ball, Addiction Research Center, National Institute on Drug Abuse. See also Ball and colleagues (1988).

Costs and Benefits of Methadone Treatment

Analyses of the economic costs and benefits of methadone maintenance have been derived from a handful of treatment effectiveness studies, and their results are rather sensitive to how these effectiveness studies are interpreted. An early simulation by Maidlow and Berman (1972), for example, concluded that methadone maintenance could yield lifetime benefits to society of $348,000 compared with average treatment costs of $13,200, a benefit/cost ratio of 26 to 1. However, their assumptions about the effectiveness of methadone were overly optimistic. A simulation by Rufener and colleagues (1977a) was more firmly grounded, yielding a smaller but still quite healthy benefit/cost ratio of 4.4 to 1 for a short period of time. Extended over lifetimes this result would not be too disparate with that of Maidlow and Berman; however, the Rufener team's assumptions about effectiveness also appear to be too optimistic.[10]

Using more realistic effectiveness data—but from only low-dose programs—McGlothlin and Anglin (1981) compared clients who left methadone maintenance when a community clinic was closed in Bakersfield, California, with clients in another community's program, which remained open. For men, the ratio of crime-related economic benefits to treatment costs was 1.7 to 1, over a short, two-year period. Additionally, the continuous

[10]Rufener and coworkers (1977a) examined the cost-effectiveness of three major treatment modalities (methadone maintenance, TCs, and outpatient nonmethadone) based on an analysis of the DARP data base (Sells, 1974a,b). Methadone maintenance was decidedly the most cost-effective treatment in terms of lowest cost per opiate-free days, non-opiate-free days, days not spent in criminal activity, and legitimately employed days. Goldschmidt (1976) similarly compared methadone maintenance and therapeutic communities, but his effort identified the benefits of both the in-treatment and posttreatment periods. He concluded that methadone and therapeutic communities produced similar "effectiveness units" (percentage of addicts meeting success criteria). The cost advantage of methadone, however, made its cost-effectiveness about twice that of therapeutic communities.

treatment group reported significantly higher rates of employment than those who had been closed out of treatment, although this factor was not formally valued in the study. The results for women were contrary but can be considered little more than a preliminary indication because the sample size was too small for statistical stability. A study of a public clinic methadone program closure in San Diego (Anglin et al., 1989a) showed virtually no net economic loss but also no net gain. In this instance, a private methadone program picked up a large proportion of the clients on a self-pay basis.

The most comprehensive examination of economic benefits and costs of drug treatment was performed with data from the TOPS (Harwood et al., 1988). The data included the average cost of a treatment day in methadone programs in 1979 and detailed interview measures of rates of criminal activities in the TOPS sample in the year before treatment, the period in treatment, and the year after discharge (where applicable). The study also factored in estimates of the average cost to society of particular crimes, based on surveys conducted in 1979 by the Bureau of Justice Statistics. The benefits of methadone maintenance treatment in terms of reduced crime-related costs to law-abiding citizens (including the value of stolen goods) were $13 per day compared with the $6 per day average cost of the program. Moreover, multivariate regression analysis found significant benefits in the year following discharge, such that retention for an additional day in treatment was worth $11 per day in delayed benefits. The final benefit/cost ratio was therefore 4 to 1. An alternative and much more conservative cost/benefit model in which only increases in employment (which were limited) rather than reductions in goods stolen (which were much larger) were valued found a cost/benefit ratio of about 1 to 1. Using either model, methadone maintenance pays for itself on the day it is delivered, and posttreatment effects are an economic bonus.

Conclusions

Methadone maintenance is a treatment that is designed for severe dependence on heroin. Prior to admission to a methadone program, the great majority of clients are consuming large amounts of heroin and other illicit drugs and committing predatory crimes (including drug selling) on a daily basis, a behavior pattern usually extending back several years or more. Although methadone is a relatively long-acting narcotic analgesic and produces dependence symptoms, the consumption of a clinically adjusted oral dose yields a steady metabolic level of the drug, produces little if any behavioral or subjective intoxication, and does not impair functioning or generate appreciably morbid side effects. Once such a solid, comfortable level is reached, suppressing the psychophysiological cues that precipitate and reinforce opiate craving, the client is amenable to counseling and

related services that can help shift his or her orientation and lifestyle away from drug seeking and related crime and toward more socially acceptable behaviors.

Methadone maintenance has been the most rigorously studied of all the drug treatment modalities, and the studies have yielded positive results (although some programs have good and others poor client compliance with rules against illicit drug use and criminal activity). Nevertheless, methadone maintenance is a controversial treatment: its critics contend that methadone clients have "merely" switched their dependence to a legally prescribed narcotic and that many clients continue to use heroin and other drugs intermittently and to commit crimes, including the sale of their take-home methadone. In the committee's judgment, these controversies and reservations are neither trivial nor in themselves compelling. The issues are to what extent undesirable behaviors are reduced and positive behaviors increased as a result of methadone maintenance (in comparison with no treatment or with alternative treatment measures) and whether poorly performing programs can be improved. The extensive evaluation literature on methadone maintenance yields the following conclusions:

- There is strong evidence from clinical trials and similar study designs that heroin-dependent individuals have better outcomes on average (in terms of illicit drug consumption and other criminal behavior) when they are maintained on methadone than when they are not treated at all or are simply detoxified and released, or when methadone is tapered down and terminated as a result of unilateral client request, expulsion from treatment, or program closure.
- Methadone dosages need to be clinically monitored and individually optimized, but in general most clients have substantially better responses when maintained at the higher rather than lower end of the dose ranges currently being prescribed (up to 100 mg/day).
- During and after methadone maintenance treatment, criminal behavior declines and employment increases relative to untreated comparison groups, and the utility of these results substantially exceeds the cost of the treatment, especially when both the crime and employment dimensions are considered over an extended time period.

Methadone maintenance is not the answer for every heroin-dependent individual. At any one time, perhaps one-eighth to one-fifth of all individuals who were recently dependent on heroin can be found in a methadone maintenance program.[11] This figure could undoubtedly be increased if program quality were optimized, hostile stereotypes of methadone treatment

[11]This estimate derives from experiments such as that of Bale and colleagues (1980), which is described in the following section, and from national surveys of the treatment system, described in Chapter 6, combined with estimates of the prevalence of heroin dependence.

eliminated, and availability extended. When viewed in terms of lifetime prevalence, the number of current heroin-dependent individuals who will at some time enter the portals of methadone is higher, probably 30 to 40 percent. This range, like the preceding figure, is necessarily only an approximation because the research data that could give more precision to these estimates are inadequate, particularly in light of such recent developments as the AIDS epidemic. Nevertheless, in the committee's judgment, an improved network of methadone maintenance clinics might realistically be capable of reaching and dramatically accelerating the recovery of one-third of all those who become dependent on heroin.

THERAPEUTIC COMMUNITIES

What Is a Therapeutic Community?

The residential therapeutic community, or TC, is a way of defining the nature of individual drug problems as much as a therapeutic approach to the rehabilitation or, more frequently, the habilitation of drug-dependent persons. It is from this understanding that the TC derives its encompassing and intensive approach.

TCs were originally developed to treat the same problem as methadone maintenance programs: the "hard-core" heroin-dependent criminal. The residential TC has a broader perspective, however; it treats individuals who are severely dependent on any illicitly obtained drug or combination of drugs and whose social adjustment to conventional family and occupational responsibilities is severely compromised as a result of drug seeking—but who were compromised before drug seeking entered the picture. In this context, the specific drug (or more accurately, combination of drugs) represents a sociological fact more than a pharmacological foundation for treatment. In the 1980s, cocaine dependence has overtaken heroin dependence in the TC population. The profile of TC clients is also more demographically diverse than that of the heroin-dependent population. Generally, on average, TC clients in the early 1970s, when there was a national counting system, were several years younger and predominantly white by a modest margin, a pattern that has continued in later, more partial statistics (e.g., the 1979–1981 Treatment Outcome Prospective Study sample; Hubbard et al., 1989).[12]

The TC's group-centered methods encompass the following, all of which are grounded in an interdependent social environment with a direct link to a specific historical foundation:

[12]TC clients were 57 percent white, 34 percent black, and 9 percent Hispanic. Methadone clients were 16 percent white, 58 percent black, and 26 percent Hispanic (Sells, 1974a).

- firm behavioral norms across a wide range of proscriptions and specifications;
- reality-oriented group and individual psychotherapy, which extends to lengthy encounter sessions focusing on current living issues or more deep-seated emotional problems;
- a system of clearly specified rewards and punishments within a communal economy of housework and other roles;
- a series of hierarchical responsibilities, privileges, and esteem achieved by working up a "ladder" of tasks from admission to graduation; and
- some degree of potential mobility from client to staff statuses.

Because the therapeutic regimen of TCs has not been uniformly codified—and even if it had, would necessarily still involve substantial clinical discretion and creativity—there are great differences across programs in their recommended lengths of stay, staff-to-client ratios, and types of staff. These differences, which may be determined more by financial realities than by therapeutic philosophies, may have a great deal of influence over the differential clinical effectiveness of TCs.

De Leon (1986:5,7–8) has summarized the approach as follows:

> The TC views drug abuse as a deviant behavior, reflecting impeded personality development and/or chronic deficits in social, educational and economic skills. Its antecedents lie in socio-economic disadvantage, poor family effectiveness and in psychological factors . . . affecting some or all areas of functioning. . . . Thinking may be unrealistic or disorganized; values are confused, nonexistent or antisocial.
>
> Physiological dependency is secondary to the wide range of influences which control the individual's drug use behavior. Invariably, problems and situations associated with discomfort become regular signals for resorting to drug use.
>
> Thus, the problem is the person, not the drug. . . . In the TC's view of recovery, the aim of rehabilitation is global. . . . The primary psychological goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use; the main social goal is to develop a responsible drug free lifestyle. Stable recovery, however, depends upon a successful integration of these social and psychological goals.

Sugarman (1986:66,69) elaborates further:

> All models of the TC involve a set of explicit behavior norms which members support and a set of contingent sanctions, positive and negative. . . . [H]ierarchical programs have extensive and demanding limits, strictly enforced, on the grounds that addicts need to learn self-control, and to experience the security of a firm framework of order. . . . Behavioral limits and sanctions plus positive peer pressure engender a short-term process of behavior modification. Even though this changed behavior is dependent upon the external controls of the social setting, still it has a real significance. . . . The message is: you can change in ways that you would not have thought possible.
>
> The self-sufficient group is a particularly important setting for learning the nature of social responsibility and the interdependence of individual interests. Ideally, the ordinary family and the ordinary peer groups that a child experiences in growing up convey this kind of learning; in practice, the lesson is often missed.

To a significant extent the TC simulates and enforces a model family environment that the client, so to speak, should have had during critically formative preadolescent and adolescent years. The TC tries to make up for lost years of formation in an intensive, relatively short period of time—approximately 6 to 12 months of residential envelopment and an additional 6 to 12 months of gradual reentry to the outside community prior to "graduation." There is encouragement as well of continued alumni involvement for the benefit of role modeling for new residents, recognition and reinforcement for the graduate, and psychological and financial support for the program.

How Well Do Therapeutic Communities Work?

Conclusions about the effectiveness of TCs are limited by the difficulties of applying standard clinical trial methodologies to a complex, dynamic treatment milieu and a population resistant to following instructions. Randomized trials or natural experiments in the community, which would permit a well-controlled comparison of clients admitted to TC treatment versus an equivalent group (e.g., persons seeking treatment but denied admission, individuals admitted to other treatment modalities or arbitrarily excluded from TC treatment as a result of program closure) are not feasible or appropriate; when attempted, such experimental protocols have failed (see Bale et al., 1980). Currently, the strongest conclusions on the effectiveness of TCs are based on nonrandomized or nonexperimental but rigorously conducted studies of clients seeking admission to therapeutic communities. It is therefore worthwhile to look more closely at the nature, strengths, and weaknesses of such evidence.

The Character of Nonexperimental Evaluations

In nonrandomized or nonexperimental studies of treatment effects, conclusions generally depend on two kinds of comparisons. One is the contrast of observed TC outcomes with the record of similarly troubled individuals from the pretreatment era (e.g., those seen at Lexington or other prisons or hospitals). The problem with such comparisons is that one cannot be certain that the people of one historical period are totally similar to those of another. Likewise, there may or may not be similarities between a group seeking TC (or any other specific) treatment and a group seeking detoxification, or between a self-selected group from the community and a group culled from the drug-dependent population by the criminal justice system. Those seeking admission to TCs might (although they just as easily might not) represent a different kind of drug population or a very specialized slice of the population, or at least a different enough slice to honestly confound any comparisons of this sort. Because the same data are

not collected on the different groups being compared, one cannot really reduce this uncertainty very much.

The second comparisons are internal ones, between those who enter TC treatment and those who apply for it but break off the process before entry, and between clients staying for longer versus shorter periods of treatment (receiving, in effect, larger and smaller "doses" of TC). In this case, the groups at least are being compared within the same time and data collection frame. Still, there may be selection effects that threaten the validity of the comparison, that is, its capacity to determine treatment effects. Those who stayed may have been different to begin with from those who left earlier. For example, they may have been intrinsically more or less likely to do well, treatment or no treatment (because of lesser or greater initial criminality, shorter or longer drug histories, better or worse family support). These differences may bias the comparison one way or another—either in favor of or against treatment effectiveness.

To guard against such biases, researchers rely on baseline measurements and statistical adjustments to control for preadmission client characteristics that might account for differential retention or outcome.[13] These procedures increase one's assurance that the results are not confounded by selection effects; however, because some pretreatment characteristics that might conceivably affect retention and outcome may not have been measured well or even measured at all, they do not offer as much assurance as a successfully implemented, randomized clinical trial with minimal attrition.

The lack of randomized trials involving TCs is in some ways not surprising; most medical and criminal procedures became widely used without the benefit of such trials. The early success stories from the therapeutic communities Synanon and Daytop Village, in contrast to most treatment modalities' gloomy prior experience with heroin addiction, were positive and convincing enough that many clinicians and policymakers backed the establishment of TCs in the late 1960s and early 1970s. The scientific community paid them relatively little attention (a notable exception was Yablonsky, 1965), and many researchers viewed randomized trials as impossible to perform because heroin cases are so prone to noncompliance.[14]

[13]The causal model here attributes the client's status at a later point in time to three kinds of factors: predisposing conditions, which are controlled for by the baseline measurement procedures (e.g., why the client sought treatment, how much recovery the client wants to achieve); exterior factors during treatment, which are assumed to affect clients more or less at random; that is, they are not correlated with being admitted to treatment (changes in the price of drugs, for example, or police attitudes toward an individual, or the likelihood of being caught in a job layoff); and the units of treatment received, the element whose effects the researcher really wants to measure. There are three corresponding sources of error: unmeasured predisposing conditions, exterior factors that are correlated with being in treatment, and variations in the consistency of treatment units.

[14]The problem of heroin-dependent individuals' noncompliance with experimental and control

The Bale Study

The one notable attempt to undertake an experimental evaluation of the effectiveness of TCs compared with groups who were not treated or who were treated in other ways was conducted in California by Bale and coworkers (1980). This study, which examined methadone maintenance as well as TCs, did not work well as a random-assignment trial; in addition, the subject population was skewed from national norms. Nevertheless, its results are unique, important, and deserving of detailed attention for they underwrite much of the confidence that can be attached to results from studies that had no untreated control groups.

The subjects were 585 heroin-addicted male veterans who sought and gained entry to the Veterans Administration (VA) Medical Center in Palo Alto, California, for a 5-day opiate detoxification program during an 18-month intake period in the mid-1970s—who also met the study's requirements.[15] When asked, about one-fifth of the subjects denied any interest in transferring to a VA drug treatment program after detoxification (some later changed their minds). The balance (plus the changers) were randomly assigned to either of two methadone maintenance clinics or one of three residential programs, each a different kind of 6-month TC.

The clinical staff invested significant time in trying to enlist every subject in his assigned program, and the overall rate of transfers from detox to VA programs doubled as a result. Nevertheless, the random-assignment design was thoroughly compromised (Tables 5-2a and 5-2b). Less than half of the randomly assigned subjects entered and spent as long as a week in any of the VA treatment programs, and only half of those entered the specific programs they had been assigned to (the others waited out at least a 30-day exclusion period to enter their own preferred program). Altogether, 42 percent of the total study cohort did not enter

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protocols is not specific to experiments involving TCs. Noncompliance has compromised attempts to compare alternative pharmacologically based modalities, as vividly demonstrated in several large-scale studies, including the attempted comparison of the effectiveness of methadone maintenance versus maintenance with the narcotic antagonist naltrexone (National Research Council, 1978) or methadone versus the longer acting methadone congener LAAM (Savage et al., 1976; Ling et al., 1978).

[15]There were 710 total drug detox admissions; exclusions from the study sample were for pending felony charges (51), major psychiatric problems (41), falsified eligibility for VA treatment (13), and miscellaneous reasons (19). The study population differed from the opiate-dependent DARP sample in several important particulars: they were all honorably discharged veterans (100 percent versus 25 percent in the DARP), all male (100 percent versus 77 percent), and mostly high school graduates (71 percent versus 39 percent) and ex-convicts (80 percent versus 60 percent) who used other drugs in addition to heroin (72 percent versus 52 percent). They were also less often black (41 percent versus 54 percent) or Hispanic (13 percent versus 22 percent) and more often employed (76 percent versus 57 percent) in white-collar jobs (36 percent versus 11 percent).

TABLE 5-2A Subject Compliance (percentage) with Assignment to a Therapeutic Program

	Program Assigned					
Program Entered	TC I[a]	TC II	TC III	Methadone	Detox (self-selected)	Total
	(79)[b]	(147)	(137)	(94)	(128)	(585)
None	44	40	36	28	59	42
Non-VA	9	16	20	20	28	19
TC I	18[c]	1	2	5	0	4
TC II	13	24[c]	9	9	6	13
TC III	13	10	22[c]	8	2	11
Methadone	4	10	12	31[c]	4	12
Total[d]	100	100	100	100	100	100

[a]TC = therapeutic community.
[b]Numbers in parentheses are subjects assigned to the program.
[c]Percentage entering program to which assigned.
[d]Totals may not add to 100% due to rounding.

Source: Bale et al. (1980).

TABLE 5-2B Subject Compliance (number and percentage) with Assignment, Combining Therapeutic Communities (TCs)

	Program Assigned							
	TCs		Methadone (eligibility requirement)		Detox (self-selected)		Total	
Program Entered	No.	%	No.	%	No.	%	No.	%
None	143	39	26	28	76	59	245	42
Non-VA	58	16	19	20	36	28	113	19
TCs	129[a]	36[a]	20	22	11	8	160	28
Methadone	33	9	29[a]	31[a]	5	4	67	12
Total[b]	363	100	94	100	128	100	585	100

[a]Number or percentage entering program to which assigned.
[b]Totals may not add to 100% due to rounding.

Source: Bale et al. (1980).

any kind of treatment during the follow-up year, about 28 percent entered one of the VA TCs, 12 percent entered a VA methadone clinic, and 19 percent entered a non-VA program.

The lack of compliance affected the study so profoundly that research analysts (who were independent of the clinical staff) were obliged to switch from the simplicity of randomizing assumptions to the use of multivariate statistical procedures to control for initial differences in age, ethnicity, prior

treatment, drug use patterns, and criminal history among treatment and nontreatment groups.

At the one-year follow-up, those who had been successfully recontacted (the follow-up contact rate was 93 percent) were divided among the no-treatment (41 percent), non-VA (21 percent), short-term TC (14 percent), long-term TC (14 percent), and methadone (11 percent) options.[16] Controlling for pretreatment characteristics, the no-treatment, non-VA treatment, and short-term TC groups were statistically indistinguishable from each other at the follow-up. Compared with these groups, however, the long-term TC and methadone client groups (comprising one-fourth of the total sample originally contacted during the detox program) were clearly different. The long-term TC and methadone clients were:

- two-thirds as likely to have used heroin in the past month (41 percent versus 64 percent);
- three-fifths as likely to have been convicted during the year (22 percent versus 37 percent);
- one-third as likely to be incarcerated at year's end (7 percent versus 19 percent); and
- one-and-a-half times as likely to be at work or in school at year's end (59 percent versus 40 percent).

The long-term TC group ranked somewhat better than the total methadone group on each measure, but the differences were not large enough to be statistically distinguishable in a sample of this size.

Other Significant Follow-up Studies

Beyond the efforts of Bale and colleagues, there is a significant controlled observational literature on therapeutic communities. The bulk of these studies have focused on clients admitted to particular programs such as Phoenix House and Daytop Village in New York; in addition, the DARP (Simpson et al., 1979) and the TOPS (Hubbard et al., 1989) separately examined clients who were admitted to about 10 TCs across the country (not the same programs and 10 years apart).

[16] Retention in treatment was not high for the 6-month residential programs. About 13 percent of the clients stayed less than 1 week (these were considered "no treatment"), 57 percent dropped out within 7 weeks, and 85 percent left treatment before 6 months. In contrast, about 65 percent of clients entering methadone maintenance were continuously in treatment for the follow-up year.

The TC group was therefore divided at the median length of stay (for all admissions who had remained longer than a week), which was 50 days. The short-term group stayed in treatment about 3 weeks on average; the long-term group stayed about 20 weeks on average. The methadone group on average stayed in treatment about 40 weeks.

The most extensive outcome evaluations from a single program come from Phoenix House in New York. De Leon and coworkers (1982) studied a sample of 230 graduates and dropouts and found that before admission the two groups were very similar with respect to criminal activity and drug use but that dropouts had somewhat greater employment. After treatment, the status of both groups was much better than before, but graduates had dramatically superior posttreatment outcomes compared with dropouts (Table 5-3).[17]

The Drug Abuse Reporting Program provided further important controlled observational findings about the effectiveness of therapeutic communities (Sells, 1974a,b). The mean and median lengths of stay in the traditional TCs involved in the DARP were close to 7 months, which was well below the average 16-month treatment plan. At 12 months after admission, 71 percent of those admitted had left the TC voluntarily or by expulsion, although only 5 percent had completed their treatment plan by then; the ultimate graduation rate was 23 percent (Simpson et al., 1979).

Most of the DARP's outcome measures at one year after discharge (daily opiates, daily nonopiates, arrests, incarceration) were significantly better for TC clients compared with the outcomes of detoxification-only and intake-only cases (Simpson et al., 1979). As in the Bale study, the multivariate-adjusted outcomes for TCs and methadone maintenance clients (matched for time since admission) on daily opiate use, nonopiate use, employment, and a composite index were quite similar. The length of stay in treatment was a positive, robust, significant predictor of posttreatment outcomes (drugs, jobs, and crime). Among clients staying more than 90

[17]One smaller study that is notable for its careful execution followed a random sample of graduates and dropouts from a Connecticut TC (Romond et al., 1975) with an 18- to 24-month treatment plan. The authors found few pretreatment differences between the graduate and dropout groups except that women were much less likely than men to graduate. All 20 graduates in the sample were successfully contacted; 10 of 31 dropouts in the sample were not located, and 1 refused an interview, yielding 20 successful contacts. Graduates had spent on average 21 months in treatment, compared with 5.7 months for dropouts (range: 10 days to 16 months). Interview data were corroborated through formal and informal community networks.

Graduates had consistently better outcomes. Only 1 of 20 graduates relapsed to dependence for some part of the follow-up period, another 5 sometimes used nonopiate drugs, and 14 remained drug free throughout the interval; altogether, graduates spent 0.5 percent of the follow-up period dependent. Of the 20 dropouts interviewed, 14 relapsed to dependence for some of the follow-up period, 2 more used nonopiates occasionally, 1 was incarcerated for the entire period, and 3 had used no drugs; 35 percent of the dropouts' posttreatment time was spent as drug dependent. Ninety-four percent of the graduates' posttreatment time had been in school or employed, and at the time of the interview, none were institutionalized and 2 had some criminal justice involvement (probation, parole, pending case). Forty percent of the dropouts' posttreatment time had been in school or employed; at the time of the interview, 4 were in other drug programs, 1 was in a psychiatric hospital, 4 were in jail, and 7 others had a pending court case or were on probation or parole.

days in treatment, there was a positive and linear relationship between outcome and retention. The outcomes among clients staying less than 90 days were indistinguishable from detox-only and intake-only cases, and there was no discernible relation between outcome and short lengths of stay.

The final results of the TOPS, which were derived using multivariate logistical regression to control for pretreatment demographics, drug use, and criminality, yielded the familiar positive relationship between length of stay and outcome but with no clear threshold (Hubbard et al., 1989; see Figure 5-3). One year or more in a TC was significantly related to reduced heroin use, lower crime involvement, and increased employment at a 12-month follow-up. The odds of having problems with heroin or crime were about two-fifths as great for the long-term residential clients as for early dropouts, and their odds of having a job were nearly 1.7 times higher. Cocaine use followed a similar pattern, but the effect was not statistically significant. Alcohol problems were not related to treatment retention.

In summary, multisite evaluations of the DARP (Simpson et al., 1979; Simpson, 1981) and the TOPS (Hubbard et al., 1989) both produced strong results supporting those of Bale and coworkers and the one or two useful

TABLE 5-3 Follow-up Results of Treatment at Phoenix House (New York City) Measured on Crime, Drug Use, and Employment Indices (percentage)

Index	*N*	Pretreatment	Post-treatment	*p*
Crime				
Total	226	96.5	29.2	<.001
Dropouts	154	97.4	40.9	<.01
Graduates	72	94.4	4.2	<.001
Dropout/graduate differences (*p*)		Not signif.	<.001	
Drug use				
Total	229	94.3	32.3	<.001
Dropouts	156	96.8	43.6	<.05
Graduates	73	89.0	9.2	<.001
Dropout/graduate differences (*p*)		Not signif.	<.001	
Employment[a]				
Total	230	32.6	75.7	<.001
Dropouts	156	36.5	66.0	<.001
Graduates	74	24.3	95.9	<.001
Dropout/graduate differences (*p*)		<.10	<.001	

[a]Employed more than 50 percent of the time.

Source: De Leon et al. (1982:Table 5).

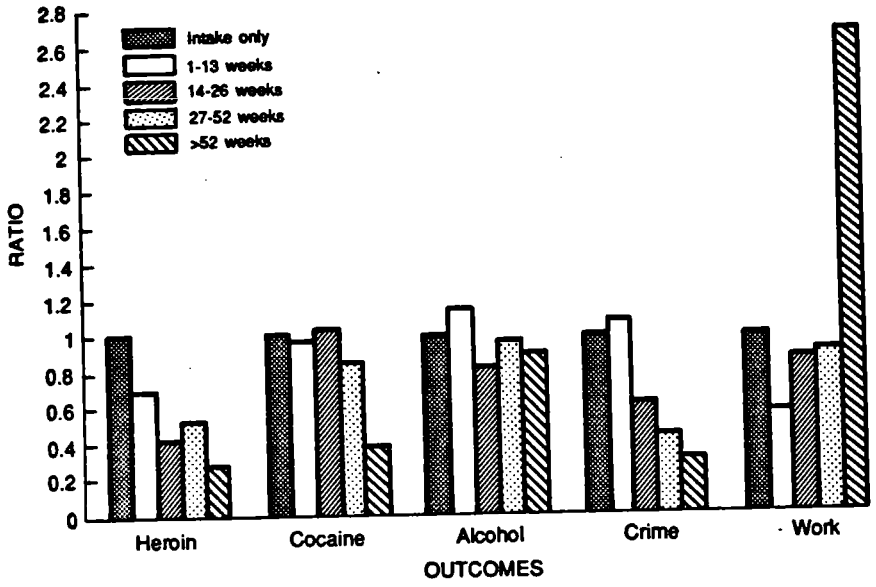

FIGURE 5-3 Outcomes and retention in therapeutic communities based on data from the Treatment Outcome Prospective Study and shown as odds ratios derived from multivariate analyses. The odds that members of the intake-only group will report a successful outcome at follow-up are compared with the odds for those who were in treatment for 1–13 weeks, 14–26 weeks, 27–52 weeks, and 53 or mor weeks. The intake-only odds are standardized or set equal to 1 for each criterion; the other group odds are expreased as ratios of 1. Source: Hubbard et al. (1989).

single-program studies. Even in the absence of clinical trials, it is difficult to credit any explanation of these results other than the following: TCs can strongly affect the behavior of many of the drug-dependent individuals who enter them, and retention in treatment after some minimum number of months—how many seems to vary with the program—is positively and significantly related to improved outcomes as measured by illicit drug consumption, other criminal activity, and economically productive behavior.

Why Do the Results of Therapeutic Communities Vary?

No one really knows why there is such variation in TC performance and client responses (although strong views are often expressed about the matter) because there has been virtually no systematic research about the determinants of client success and failure in TCs. It is highly plausible that the results of TC treatment depend on its primary elements: the client's motivations, the quality and quantity of staffing, and the psychoso-

cial organization and therapeutic design of the program. The committee heard anecdotally that TC staffing has been problematic during the 1980s as a result of constant budget pressures (staff numbers or salaries can be cut or held down more readily than room-and-board expenses) and rising competition with private-tier outpatient and chemical dependency treatment providers for credentialed, experienced staff. Yet there are no studies that specifically investigate how TC staffing relates to the effectiveness of treatment.

There are clearly wide variations in outcome indicators across programs. Client-Oriented Data Acquisition Process (CODAP) reports published from 1976 through 1981 make it possible to examine variations across cities in client status at discharge. The crude city differences are not adjusted to account for differences in the characteristics of clients treated in the various cities, nor can they be broken down to the program level. Nevertheless, the 1976–1981 CODAP reports demonstrate graphically that effectiveness varied significantly from area to area and undoubtedly even more so from program to program.

The year 1980 was one of relative program stability: the treatment system had been in place from five to six years and had not yet been disrupted by the massive system changes that resulted from the institution of block grants with their devolution of management responsibility to the states. Yet very large variations were seen in the treatment "completion" rates reported for that year by residential programs (Figure 5-4), most of which were TCs. From the figure it is apparent that TCs in some cities diverged widely from the national average. Although the average residential completion rate across the nation was 10 percent, a sizable number of communities had averages well below and above this rate: 23 cities had rates between 5 and 15 percent, 9 cities were below 5 percent, 13 were between 15 and 24 percent, and 9 were above 25 percent. These variations have not been analyzed for possible attribution to differences in client characteristics, treatment process, quality of staff, or random processes. There is also currently no usable evidence of national scope showing whether client discharge statuses still exhibit such differences across geographic areas, or why.

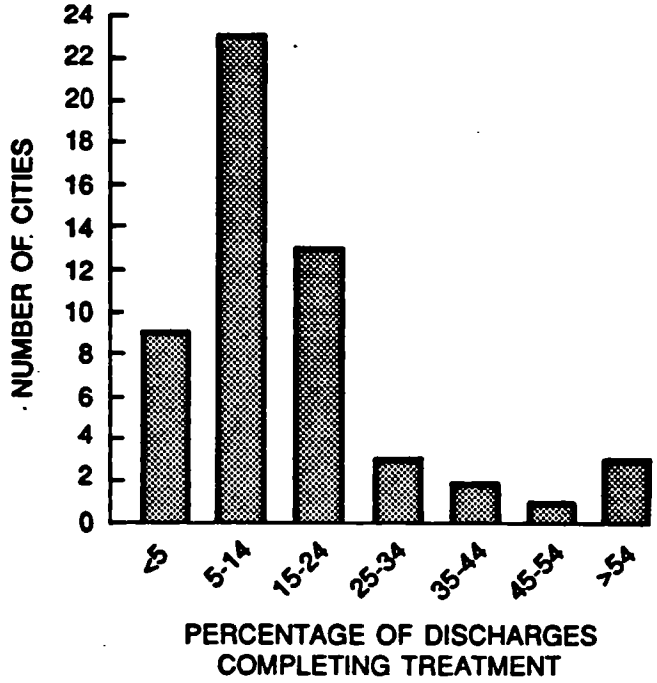

FIGURE 5-4 Variations in "completion" rates of opiate clients in residential programs in U.S. cities, 1980. Source: National Institute on Drug Abuse (1981).

Costs and Benefits of Therapeutic Community Treatment

Most evaluations of TCs indicate that they are cost-effective or cost-beneficial, or both. There have been fewer rigorous evaluations of costs and benefits than of cost-effectiveness, however. A simulation by Maidlow and Berman (1972) showed that a TC produces $213,000 of economic benefits to society per client at a cost of $14,700 (a benefit/cost ratio of 14.5 to 1). These authors concluded that TCs were highly cost-beneficial compared with prisons (which were much more expensive and had high recidivism rates). Rufener and coworkers (1977a) focused only on benefits after treatment (ignoring benefits during treatment) and tried to sort out the benefits that accrue variously to the client, the government account, and society as a whole. They estimated that the combined benefit/cost ratio of TCs after the treatment period was 1.9 to 1. As discussed earlier, however, both of these sets of benefit/cost ratios are biased upward because the assumptions used to produce them were overly optimistic compared with what is now known about treatment retention and effectiveness.

A more realistic cost-effectiveness study using the DARP data base

(Rufener et al., 1977a) found that TCs generally produced greater differentials than methadone or outpatient nonmethadone treatment in terms of legitimate income and employment status after treatment versus before. But methadone was decidedly more cost-effective—measured as the cost per added day of desirable outcome—because it was cheaper. Of course, these comparisons work only to the degree that those entering one treatment would as readily have entered the other.

A cost/benefit study of the Gaudenzia House TC (Griffin, 1983) compared the expense of operations over a five-year period with the benefits from reduced criminal activity and increased social productivity. The analysis distinguished the benefits to be derived from treatment "successes" and "failures," finding positive ratios of benefits to costs for both groups (9 to 1 for "successes" and 3.4 to 1 for "failures"). Benefits accrued even for "failures" because while in residence for treatment they were unable to commit as many street crimes (analogous to the incapacitation effect of incarceration) as they would have if not in residence.

Most recently, Harwood and colleagues (1988) analyzed the TOPS data base, examining the reduced crime-related impacts on society that result from drug treatment. A particularly important finding was that TC treatment, as with methadone treatment (see the section above entitled "Costs and Benefits of Methadone Treatment"), virtually pays for itself during the time it is delivered, owing to the reduced criminal activity of clients in treatment relative to either the pre- or posttreatment periods. Further benefits accrue after leaving treatment. The final benefit/cost ratio for TCs was 3.8 to 1 using the primary measure (the costs of crime) and 2.1 to 1 using a more conservative employment-oriented measure.

Conclusions

TCs are for the most part designed to treat individuals who are badly impaired by drug problems and other deficits, and client decisions about whether to seek TC treatment reflect an awareness of that design. Even those who do seek treatment often drop out of TCs in short order, in contrast to the much higher retention rates of those who enter methadone maintenance. There is, nevertheless, a sizable population who not only find TC treatment initially attractive but also will remain in this modality for a substantial fraction (up to the whole course) of planned treatment. This segment is distinct from the typical methadone maintenance population: it is appreciably younger, more heavily white, and more likely to use multiple drugs.

The committee considers the evidence about the following to be fairly persuasive (although not ironclad): those clients who stay in TCs for at least a third or half of the planned course of treatment, a threshold that

seems to vary greatly from program to program—that is, those who stay in treatment for at least 2 to 12 months, varying from program to program for reasons that are not yet clear—are much closer to achieving the treatment's goals at follow-up than those who drop out earlier. The outcomes of the earlier dropouts basically cannot be distinguished from those of individuals who did not enter any treatment modality.

These improvements over nontreatment, which are estimated to be in the neighborhood of one- to two-thirds reductions in the rates of primary drug consumption and other criminal activity and half-again increases in the rates of employment or schooling, vary with the amount of time spent in treatment. TC graduates have outcomes that are even better than these rates, but they are a small percentage (usually 15 to 25 percent) of total TC admissions. What is most important here is that graduates are not the only ones who benefit themselves and society as a result of spending time in a TC. Even for those individuals who "split" early, even for those who show no later effects, the TC may be a good social investment considering that a day in a TC is a day away from street crime.