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

April 18, 1994

MEMORANDUM FOR BOB PELLICI
NANCY ANN MIN
CHRIS EDLEY
PETER EDELMAN

FROM: RICIA MCMAHON

SUBJECT: HHS Draft SAMHSA Amendments of 1994

Please find attached ONDCP's response (Tab 1) to the legislative proposal, LRM #D-704, HHS Draft SAMHSA Amendments of 1994. We have also prepared a notebook that articulates background information on the hardcore initiative, as well as backup for ONDCP's position.

If your staff has any questions as they review the ONDCP response and the notebook, they should feel free to contact Babette Hankey of my staff at 395-6736.

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

April 18, 1994

MEMORANDUM FOR BOB PELLICCI

FROM: RICIA MCMAHON

SUBJECT: Substance Abuse and Mental Health Services Amendments of 1994

Highlighted below are ONDCP's comments on LRM #D-704, the "HHS Draft Bill Substance Abuse and Mental Health Amendments of 1994." Dr. Brown has been briefed on the legislative proposal and his position is reflected in this memorandum.

While we have focused the majority of our review on the specific language in the bill, we have also attached a marked up copy of the report language for your use. (Tab 3 in your notebook.)

Our comments are as follows:

- The intent of the Hardcore Initiative, as outlined in the President's National Drug Control Strategy in chapter two "Treating America's Drug Problem" is to expand the capacity to treat chronic hardcore drug users. However, since the definition for chronic, hardcore user in the current DHHS/SAMHSA proposal allows for 100% of the funds to be spent on treatment for clients whose only drug of abuse is alcohol, this definition should be modified as follows.

  On page 3 of the bill language, the definition of hardcore substance abuser should be revised to state:

  > *The term hardcore substance abuser means an individual who uses illicit drugs or illicit drugs in combination with alcohol at levels sufficient to cause functional impairment.*

  The definition can be further modified to include:

  > *except in the instances when a State requests a waiver as described in section (d) (2).*

- Page 4 of the bill indicates that a State can use funds for alcohol only abuse for those clients that are 21 years of age or older provided that the State **certifies** that those amounts are not needed for the treatment of other hardcore substance abusers.

ONDCP will agree to allow States to use these funds for alcohol only when they have already met the needs of hardcore substance users (as defined in the comments above) and only when the States have properly requested a **waiver** from the Secretary. (If you recall, this was offered by the Health Branch at the meeting.)

We do not believe that a waiver will pose a very large burden on HHS, because most States do have a need for funding for illicit drug use, including illicit drug use in combination with alcohol. We would expect very few States to request a waiver for use of these funds since it would require that they first adequately identify how they are fulfilling the needs for the hardcore user population. (See Tab 3 in your notebook for suggested language.)

Moreover, during the HHS/OMB/ONDCP meeting of March 16, HHS mentioned that Colorado had approximately a 70% alcohol-only use rate and would likely be one of the States that has met the need for treatment of illicit drug use and illicit drug use in combination with alcohol clients. While it is true that the majority of the publically funded programs in Colorado provide services for those with alcohol-only problems, this is because the majority of the publically funded treatment centers in Colorado provide detox services. To further expand, 67 percent of the publically funded treatment centers in Colorado are detox programs which typically serve those with alcohol problems. Therefore, in order to examine the needs of drug user in Colorado, one must explore the different modalities. For example, of the residential and outpatient programs in Colorado, nearly 60% of clients are drug/poly drug users and only 40% are alcohol-only users. Therefore, it is likely that Colorado **will** have a need for additional funds for the hardcore polydrug user and will not request a waiver. (See Tab #2.)

- On page 7 of the legislative proposal, the $35 million demonstration for the hardcore user is highlighted under section (b) titled "Set Aside for Hard Core Substance Abuse." This section indicates that the funding will be available for the populations defined under the Block Grant. Under no circumstances will ONDCP clear legislation for hardcore demonstration initiatives that allow money to be spent on alcohol-only treatment. The purpose of the demonstration program is to target those areas most in need for drug treatment services for the hardcore, polydrug-user population.

- For both the drug treatment and prevention demonstrations, the language indicates that the

Secretary will evaluate **all** projects. While we are not opposed to such evaluations, we believe that mandating evaluations on all projects will dilute the funding base for services by at least 10 to 15 percent. Therefore, we believe that the language should include a provision allowing the Secretary to evaluate only a portion of projects. Further, we believe that evaluations are most successful when done at the community/provider level since the evaluation component can become part of the program design. It is under these circumstances that the results are most conclusive. Therefore, for programs that will be evaluated, we should ensure the legislation includes a provision that requires the evaluation component to be part of the program design. Finally, we believe that if the evaluations are conducted by HHS, NIDA should have the lead. This will ensure that the funding base of the demonstration program is not diluted for evaluation purposes.

- Finally, with regard to the issue of mandates, we provided our position to OMB on <u>requiring</u> TB/HIV early intervention services on April 11. (The reponse can be found at Tab 5 in your notebook.) The bottom line is that whatever the outcome of the mandates, we need to ensure that an additional 74,000 hardcore polydrug users will receive treatment.

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STATE OF COLORADO

COLORADO DEPARTMENT OF HEALTH
Dedicated to protecting and improving the health and environment of the people of Colorado

4300 Cherry Creek Dr. S.
Denver, Colorado 80222-1530
Phone (303) 692-2000

Laboratory Building
4210 E. 11th Avenue
Denver, Colorado 80220-3716
(303) 691-4700

Roy Romer
Governor

Patricia A. Nolan, MD, MPH
Executive Director

SUBJECT: Unduplicated Admissions for Calendar Year 1993 by Type of Drug Use

DATE: 4-15-94

UNDUPLICATED ADMISSIONS TO PUBLICLY FUNDED ALCOHOL AND DRUG TREATMENT IN COLORADO BY CATEGORY OF DRUG USED CY 1993

MODALITY	ALCOHOL ONLY	DRUG/POLYDRUG	TOTAL
DETOXIFICATION			
N	22148	4547	26695
ROW %	83%	17%	67.2%
COLUMN %	80.8%	36.9%.	
REHABILITATION (RESIDENTIAL & OUTPATIENT)			
N	5255	7766	13021
ROW %	40.4%	59.6%	32.8%
COLUMN %	19.2%	63.1%	
TOTAL	27403	12313	39716

The table above shows unduplicated admissions to publicly funded alcohol and drug treatment in Colorado for CY 1993. **For detoxification, 67.2% of total admissions, 83% of clients reported alcohol use only and 17% reported drug/polydrug use** (drug/polydrug use includes alcohol in combination with other drugs and drugs other than alcohol either alone or in combination). **However, for the rehabilitation programs, including both residential and outpatient which account for 32.8% of admissions, 40.4% of clients reported alcohol only while 59.6% reported drug/polydrug use.**

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

SPECIAL

April 7, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #D-704
DRAFT #573

TO: Legislative Liaison Officer -

ONDCP - Babette Hankey - (202)395-6739 - 257

FROM: JANET R. FORSGREN (for)
Assistant Director for Legislative Reference

OMB CONTACT: Matthew WELBES (395-7362)
Secretary's line (for simple responses): 395-7362
Jill BLICKSTEIN (395-4926)

SUBJECT: HHS Draft Bill Substance Abuse and Mental Health Services Amendments of 1994

DEADLINE: 1:00 PM April 14, 1994

COMMENTS: Please comment on this revised version of the SAMHSA Amendments of 1994.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Barry Clendenin
Bill Dorotinsky
Jill Blickstein
Ken Schwartz
Jim Duke
Janet Forsgren
Bob Pellicci

LRM #D-704

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Matthew WELBES
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-7362
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Draft Bill Substance Abuse and Mental Health Services Amendments of 1994

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Office of the General Counsel
Legislation Division
Washington, DC 20201

April 11, 1994

NOTE TO BOB PELLICCI

Attached, for OMB clearance, is a revised version of the draft Substance Abuse and Mental Health Services Amendments of 1994, along with a section-by-section summary and draft Speaker letter.

Paul M. Spiegel
690-7773

The Honorable Thomas S. Foley
Speaker of the House
of Representatives
Washington, DC 20515

DRAFT

Dear Mr. Speaker:

Enclosed for consideration by the Congress is a draft bill "To extend and amend substance abuse and mental health services authorities."

The draft bill would reauthorize for three years the mental health services block grants, substance abuse block grants, training program for substance abuse professionals, Projects for Assistance in Transition from Homelessness (PATH), and community mental health services for children. In addition, the draft bill would establish a special block grant initiative for the treatment of hard core substance abusers, for which $310 million would be authorized for fiscal year 1995 (in addition to the funding for the regular substance abuse block grants). This initiative is a critical component of the President's National Drug Control Strategy. Breaking the cycle of hard core substance abuse is essential to treating America's substance abuse problem. Providing treatment is both compassionate and pragmatic.

The draft bill would also consolidate in three flexible demonstration authorities (substance abuse treatment, substance abuse prevention, and mental health services) a number of scattered, categorical demonstration authorities under current law. This consolidation would simplify application procedures for prospective grantees, provide increased flexibility to support projects with multiple program components, and improve the efficiency of the grant review process. The proposed substance abuse treatment demonstration authority includes the new hard core treatment demonstration program requested in the President's Fiscal Year 1995 Budget ($35 million) and included in the National Drug Control Strategy.

The draft bill would authorize total appropriations of $2,315 million for fiscal year 1995. The provisions of the draft bill are described in detail in the enclosed section-by-section summary.

We urge the Congress to give the draft bill its prompt and favorable consideration.

Page 2 - The Honorable Thomas S. Foley

We are advised by the Office of Management and Budget that enactment of the draft bill would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

SUMMARY OF PROPOSED SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES AMENDMENTS OF 1994

Section 1 assigns the draft bill the short title "Substance Abuse and Mental Health Services Amendments of 1994".

Section 2 authorizes appropriations of $277,919,000 for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997, for mental health services block grants, and for related data collection activities.

Section 3 authorizes appropriations of $1,177,107,000 for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997, for substance abuse prevention and treatment block grants, and for related data collection activities and a substance abuse prevention data base. In addition, the section authorizes appropriations of $310,000,000 for fiscal year 1995, and "such sums" as may be necessary for fiscal years 1996 and 1997, for a new initiative directed specifically toward the treatment of unserved or underserved hard core substance abusers (those abusing substances at levels sufficient to cause functional impairment, ~~and who are victims of,~~ or at greatest risk of suffering, the negative consequences of substance abuse). Amounts under this new initiative may be spent on treatment for the subpopulation of adults who abuse only alcohol if a State certifies that the amounts are not needed in relation to other hard core substance abusers. Funds for this new initiative are to be distributed among the States in the same proportions as are regular substance abuse block grant funds. The same terms and conditions that apply to regular block grant funding apply to the new funding, with the following exceptions:

Note: (Abusers are not victims of their own adverse behavior.)

The funding will be allocated for illicit drug use in combination with alcohol unless the Secretary grants a waiver to a State that has met the need for that population under those circumstances. A State can allocate funds for alcohol only services

- There is no specific requirement for allocation between alcohol and other substance abuse.
- None of the new funding is to be spent on prevention.
- States will describe the areas in which there is a high incidence or prevalence of substance abuse by hard core substance abusers, and will provide information on the population served, the specific services provided, and the costs of those services, and relevant outcome data as may be specified by the Secretary of Health and Human Services in consultation with the States. States may use up to 2 percent of the new funding for monitoring and evaluation (but may not use any of the new funding for administrative expenses).
- The Secretary will spend 3 percent of the new funding for technical assistance and outcome evaluations in relation to hard core substance abusers.

Section 4 establishes a general authority to demonstrate innovative models of treatment interventions, and innovative, viable, and cost-effective systems of care to improve recognition, assessment, clinical management, and treatment outcomes, for individuals suffering from substance abuse disorders. Appropriations of $207,009,000 are authorized for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997. For fiscal year 1995, at least $35 million is to be used for hard core substance abuse. The Secretary, in carrying out this authority, may provide funding to public and private (including for-profit) entities, may utilize grants, contracts, or cooperative agreements, and may establish financial matching, maintenance of effort, and non-supplantation requirements. Evaluations are required for all projects. The Administration intends to focus continued attention on such groups as women, the homeless, those involved with the juvenile and criminal justice systems, those with co-occurring disorders, individuals in public housing, racial and ethnic minorities, and substance abusers with, or at high risk of, HIV/AIDS. The section also eliminates current separate categorical authorities in this area for residential treatment programs for pregnant and postpartum women, for outpatient treatment programs for pregnant and postpartum women, for demonstration projects of national significance, for substance abuse treatment in State and local criminal justice systems, for a demonstration program in the national capital area, and for capacity expansion.

Section 5 authorizes appropriations of $8,241,000 for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997, for the training of substance abuse treatment professionals, and permits grants to be awarded to for-profit entities.

Section 6 establishes a general authority to demonstrate effective approaches for the prevention of substance abuse. Appropriations of $223,119,000 are authorized for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997. The Secretary, in carrying out this authority, may provide funding to public and private (including for-profit) entities, may utilize grants, contracts, or cooperative agreements, and may establish financial matching, maintenance of effort, and non-supplantation requirements. Evaluations are required for all projects. The Administration intends to support such projects as the prevention of, and early intervention in, substance abuse and HIV/AIDS; the establishment of business-based substance abuse prevention and employee assistance programs; and the development and assessment of innovative models for addressing high risk youth and community-wide approaches to substance abuse prevention. The Administration intends to focus attention on such groups as women, children, youth, and racial and ethnic minorities, and to require projects directed toward children and youth to address how the project will help reduce tobacco and alcohol use. The section also eliminates current

pregnant

will be conducted

some

The reference to youth and community wide approaches should precede the other areas. The strategy emphasizes these areas.

separate categorical authorities in this area for community programs, for prevention, treatment, and rehabilitation model projects for high risk youth, and for employee assistance programs.

Section 7 establishes a general authority to demonstrate effective service delivery and comprehensive systems of care for the prevention of mental illness and serious emotional disturbance, for treatment of individuals with, or at risk of, serious mental illness, and for treatment of children or adolescents with, or at risk of, serious emotional disturbances. Appropriations of $47,321,000 are authorized for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997. The Secretary, in carrying out this authority, may provide funding to public and private (including for-profit) entities, may utilize grants, contracts, or cooperative agreements, and may establish financial matching, maintenance of effort, and non-supplantation requirements. Evaluations are required for all projects. The Administration intends to support demonstrations that include components such as planning, coordination, and improvement of community services; improved recognition, assessment, treatment, and clinical management of depressive disorders; prevention of youth suicide and sex offenses; and services for the victims of violence. The Administration intends to focus attention on such groups as severely mentally ill individuals with, or at risk for, HIV/AIDS, the homeless, and the elderly. The section also eliminates current separate categorical authorities in this area for seriously mentally ill individuals and children and adolescents with serious emotional disorders, for the homeless, and for HIV-positive individuals.

Section 8 provides for the application of previous requirements to continuation projects funded under the new demonstration authorities enacted by this bill, unless the Secretary determines otherwise.

Section 9 authorizes appropriations of $29,462,000 for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997, for Projects for Assistance in Transition from Homelessness (PATH). The section also permits States to spend money directly for services (rather than solely through grants to other entities), requires special consideration to be given by States to potential grantees with effectiveness in serving mentally ill homeless veterans (rather than homeless veterans in general), limits a State's own outlays for administrative expenses to 4 percent (rather than so limiting such outlays by grantees, and permits the Secretary to waive the matching requirement for the United States territories.

Section 10 authorizes appropriations of $35,000,000 for fiscal year 1995, and "such sums as may be necessary" for fiscal years 1996 and 1997, for comprehensive community mental health services for children with a serious emotional disturbance.

Section 11 directs the Secretary of Health and Human Services to transfer to the District of Columbia the remaining portions of Saint Elizabeths Hospital that are still owned by the Government (certain buildings needed for Federal programs, primarily in relation to research and to services for refugees, are to be retained). This transfer replaces the process under existing law under which Congress first considers a master plan prepared by the District of Columbia. In addition, the Civil War cemetery will be transferred to the Department of the Interior.

Section 12 repeals obsolete provisions of law providing for the treatment of drug abusers by the Public Health Service.

Section 13 prohibits the discharge in bankruptcy for seven years of the financial payback obligation incurred by an individual who has received a mental health clinical traineeship but has failed to carry out his service obligation. After that seven year period a discharge may be granted only if the Bankruptcy Court finds that nondischarge would be unconscionable. The section also inserts clarifying references in the bankruptcy title of the United States Code to this and similar provisions found in the Public Health Service Act.

draft 4/6/94

A B I L L

To extend and amend substance abuse and mental health services authorities

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE AND REFERENCES IN ACT.

(a) Short Title.--This Act may be cited as the "Substance Abuse and Mental Health Services Amendments of 1994".

(b) References in Act.--The amendments in this Act apply to the Public Health Service Act unless otherwise specifically stated.

SEC. 2. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANTS.

Section 1920(a) is amended--

(1) by striking "and" after "1993,", and

(2) by inserting before the period the following: ", $277,919,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years".

SEC. 3. SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANTS.

(a) Authorization of Appropriations and Allotments.--

(1) Section 1935(a) is amended to read as follows:

"(a) Authorization of Appropriations.--

"(1) General Funding.--For the purpose of carrying out this subpart with respect to general funding (including funding for activities also covered under paragraph (2)), subpart III and section 505 with respect to substance abuse, and section 515(d), there are authorized to be appropriated

$1,177,107,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years.

"(2) Special Funding for the Treatment of Hard Core Substance Abusers.--For the purpose of carrying out this subpart with respect to special funding for the treatment of hard core substance abusers, and subpart III with respect to such abusers, there are authorized to be appropriated $310,000,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years.".

(2)(A) The matter in section 1933(a)(1) preceding subparagraph (A) is amended by inserting "for amounts appropriated under section 1935(a)(1)" after "State".

(B) The matter in section 1933(c)(1) preceding subparagraph (A) is amended by inserting "for amounts appropriated under section 1935(a)(1)" after "United States".

(C) The matter in section 1933(c)(2) preceding subparagraph (A) is amended by inserting "for amounts appropriated under section 1935(a)(1)" after "United States".

(D) Section 1933(c)(3) is amended by striking "1935(a)" and inserting "1935(a)(1)".

(E) The matter in section 1933(d)(1) following subparagraph (B) is amended by inserting "for amounts appropriated under section 1935(a)(1)" after "State".

(F) Section 1933 is further amended by adding at the end the following:

"(e) Allotments of Special Funding for Hard Core Substance Abusers.--Amounts appropriated under section 1935(a)(2) for a fiscal year shall be allotted among the States (including the District of Columbia and the territories of the United States), Indian tribes, and Indian tribal organizations in the same proportions as are amounts appropriated under section 1935(a)(1) for that fiscal year.",

(3) Section 1934 is amended--

(A) by renumbering paragraphs (3) through (6) as paragraphs (4) through (7), and

(B) by inserting after paragraph (2) the following:

"(3) The term 'hard core substance abuser' means an individual who ~~abuses alcohol or other drugs at levels~~ uses illicit drugs or illicit drugs in combination with alcohol at levels sufficient to cause functional impairment, and who is a ~~victim of~~ or at greatest risk of suffering, the negative consequences of substance abuse (including violence, incarceration, infectious disease, abuse, neglect, homelessness, educational dysfunction, unemployment, and other forms of socioeconomic dislocation).".

Awkward to say that the user is a victim of his/her own negative behavior.

(b) Special Rules Concerning Treatment for Hard Core Substance Abusers.--

(1) The matter in section 1922(a) preceding paragraph (1) is amended by striking "the grant" and inserting "amounts appropriated under section 1935(a)(1)".

(2)(A) The matter in section 1922(b) preceding paragraph (1) is amended by striking "the grant" and inserting "amounts appropriated under section 1935(a)(1)".

(B) Section 1922 is further amended by adding at the end the following:

"(d) Allocation Regarding Grants for the Treatment of Hard Core Substance Abusers.--A funding agreement for a grant under section 1921 is that, in expending amounts appropriated under section 1935(a)(2), the State involved--

"(1) will expend amounts solely in relation to the treatment of hard core substance abusers located in geographic areas with concentrations of such abusers who are unserved or underserved, and

"(2) may expend ~~amounts~~ (as provided by paragraph (1)) in relation to the treatment of the subpopulation of hard core substance abusers who abuse only alcohol and are 21 years of age or older, ~~but only if the State certifies that those amounts are not needed in relation to other hard core substance abusers.~~

Secretary grants a waiver to the State upon a satisfactory showing that the needs of the other subpopulation of harder substance abusers have been me-

(3) Section 1929 is amended--

(A) by renumbering paragraphs (2) through (5) as (3) through (6), and

(B) by inserting after paragraph (1) the following:

"(2) the areas in the State in which there is a high incidence or prevalence of abuse by hard core substance abusers (with particular emphasis on juveniles under court

supervision, adults on parole or probation, pregnant women, women with dependant children, and individuals living in rural or remote areas);".

(4)(A) Section 1931(a)(2) is amended by striking "of the grant" and inserting "of amounts appropriated under section 1935(a)(1) (and none of the amounts appropriated under section 1935(a)(2))".

(B) Section 1931(a) is further amended by adding at the end the following:

"(4) Limitation on Monitoring and Evaluation.--A funding agreement for a grant under section 1921 is that the State involved will expend not more than 2 percent of the amounts appropriated under section 1935(a)(2) to monitor and evaluate the provision of services to hard core substance abusers.".

(5) Section 1935(b)(1)(A) is amended--

(A) by striking "subsection (a)" and inserting "subsection (a)(1)",

(B) by striking the subparagraph designation "(A)" and inserting "(A)(i)", and

(C) by adding at the end the following:

"(ii) For the purpose of carrying out section 1948(a), and the purpose specified in (C) (limited to outcome evaluations), with respect to hard core substance abusers, the Secretary shall obligate 3 percent of the amounts appropriated under subsection (a)(2) each fiscal year.".

(6) Section 1935(b)(2) is amended by striking "under paragraph (1)" and inserting "under paragraph (1)(A)(i)".

(7) Section 1942(a)(1) is amended by inserting before the semicolon the following: "(including, under subpart II with respect to hard core substance abusers, information on the population served, the specific services provided, and the costs of those services, and relevant outcome data as may be specified by the Secretary in consultation with the States)".

(c) Repeal of Obsolete Subsection.--Section 1932(d) is repealed.

(d) Effective Date.--The amendments made by the preceding subsections apply after fiscal year 1994.

SEC. 4. SUBSTANCE ABUSE TREATMENT DEMONSTRATIONS.

(a) General Demonstration Authority.--Section 508 is amended to read as follows:

"SUBSTANCE ABUSE TREATMENT DEMONSTRATION PROJECTS

Sec. 508. (a) In General.--The Secretary, acting through the Director of the Center for Substance Abuse Treatment, may make grants to, and enter into contracts and cooperative agreements with, public and private entities for projects to demonstrate innovative models of treatment interventions, or innovative, viable, and cost-effective systems of care to improve recognition, assessment, clinical management, or treatment outcomes, for individuals suffering from substance abuse disorders (and may establish financial matching, maintenance of

effort, or non-supplantation requirements for any or all projects).

"(b) Evaluation.--The Secretary shall evaluate projects carried out under subsection (a) and shall disseminate to appropriate public and private entities information on effective projects.

"(c) Authorization of Appropriations.--For the purpose of carrying out this section there are authorized to be appropriated $207,009,000 for fiscal year 1995 and such sums as may be necessary for each of the two succeeding fiscal years.".

(b) Set-Aside for Hard Core Substance Abuse.--Of the amounts appropriated for fiscal year 1995 under section 508 of the Public Health Service Act, at least $35 million shall be used in relation to hard core substance abusers, (as that term is defined by section 1934(3) of that Act).

(c) Repeal of Redundant Authorities.--

(1) Sections 509, 510, and 511, part F of title V, and subpart I of part C of title XIX are repealed.

(2) Part C of title XIX is further amended--

(A) by striking the heading to subpart II, and

(B) by striking "Certain Programs Regarding Substance Abuse" in the heading to the part and inserting "Interim Maintenance Treatment of Narcotics Dependence".

SEC. 5. TRAINING OF SUBSTANCE ABUSE TREATMENT PROFESSIONALS.

(a) Appropriation Authorizations.--Section 512(d) is amended--

Amend this section Not all program to be evaluated

None of these funds should be used for alcohol only treatmen

(1) by striking "and" after "1993,", and

(2) by inserting before the period the following: ",$8,241,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years".

(b) Grants to For-Profit Entities.--Section 512(a) is amended by striking "non-profit".

SEC. 6. SUBSTANCE ABUSE PREVENTION DEMONSTRATIONS.

(a) General Demonstration Authority.--Section 516 is amended to read as follows:

"SUBSTANCE ABUSE PREVENTION DEMONSTRATION PROJECTS

Sec. 516. (a) In General.--The Secretary, acting through the Director of the Prevention Center, may make grants to, and enter into contracts and cooperative agreements with, public and private entities for projects to demonstrate effective approaches for the prevention of substance abuse (and may establish financial matching, maintenance of effort, or non-supplantation requirements for any or all projects).

"(b) Evaluation.--The Secretary shall evaluate projects carried out under subsection (a) and shall disseminate to appropriate public and private entities information on effective projects.

Amend - Not all programs should be awarded

"(c) Authorization of Appropriations.--For the purpose of carrying out this section there are authorized to be appropriated $223,119,000 for fiscal year 1995 and such sums as may be necessary for each of the two succeeding fiscal years.".

(b) Repeal of Redundant Authorities.--Sections 517 and 518 are repealed.

SEC. 7. MENTAL HEALTH SERVICES DEMONSTRATIONS.

(a) General Demonstration Authority.--Section 520A is amended to read as follows:

"MENTAL HEALTH SERVICES DEMONSTRATION PROJECTS

Sec. 520A. (a) In General.--The Secretary, acting through the Director of the Center for Mental Health Services, may make grants to, and enter into contracts and cooperative agreements with, public and private entities for projects to demonstrate effective service delivery or comprehensive systems of care for the prevention of mental illness and serious emotional disturbance, for treatment of individuals with, or at risk of, serious mental illness, or for treatment of children or adolescents with, or at risk of, serious emotional disturbance (and may establish financial matching, maintenance of effort, or non-supplantation requirements for any or all projects).

"(b) Evaluation.--The Secretary shall evaluate projects carried out under subsection (a) and shall disseminate to appropriate public and private entities information on effective projects.

"(c) Authorization of Appropriations.--For the purpose of carrying out this section there are authorized to be appropriated $47,321,000 for fiscal year 1995 and such sums as may be necessary for each of the two succeeding fiscal years.".

(b) Repeal of Redundant Authorities.--

(1) Sections 506 and 520B are repealed.

(2) Section 612 of the Stewart B. McKinney Homeless Assistance Act is repealed.

SEC. 8. REQUIREMENTS FOR CONTINUATION PROJECTS.

A project supported for fiscal year 1995, 1996, 1997, or 1998 under section 508, 516, or 520A of the Public Health Service Act (as amended by section 4(a), 6(a), or 7(a) of this Act, respectively) that received support under title V of the Public Health Service Act for fiscal year 1994 and each succeeding fiscal year shall be subject to the requirements to which that project was subject for fiscal year 1994 unless the Secretary of Health and Human Services determines otherwise.

SEC. 9. PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS.

(a) Appropriation Authorizations.--Section 535(a) is amended by inserting before the period the following: ", $29,462,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years".

(b) Modifications to Certain Requirements.--

(1) The matter in section 522(a) preceding paragraph (1) is amended by striking "solely" and inserting ", either directly, or".

(2) Section 522(d) is amended by inserting "mentally ill" after "serving".

(3) Section 522(f) is amended by striking "not more than 4 percent of the payments will be expended" and inserting "it will not expend more than 4 percent of the payments".

(4) Section 523 is amended by adding at the end the following:

"(d) Waiver for Territories.--In the case of a territory of the United States (as defined by section 1954(b)(3)), the Secretary may waive (or reduce) the requirement of subsection (a).".

SEC. 10. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE.

Section 565(f)(1) is amended--

(1) by striking "and" after "1993,", and

(2) by inserting before the period the following: ",$35,000,000 for fiscal year 1995, and such sums as may be necessary for each of the two succeeding fiscal years".

SEC. 11. SAINT ELIZABETHS HOSPITAL PROPERTY TRANSFER.

Section 8(b) of the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act is amended to read as follows:

"(b)(1) Except as provided in paragraph (2), on or before October 1, 1995, the Secretary shall transfer to the District, without compensation, all right, title, and interest of the United States in all real property, buildings, improvements, and personal property comprising Saint Elizabeths Hospital in the District of Columbia not transferred or excluded pursuant to subsection (a).

"(2)(A) The real property, together with the buildings and other improvements thereon, including personal property used in connection therewith, known as the Oxon Cove Park and operated by the National Park Service, Department of the Interior, shall not be transferred under this Act.

"(B) The Civil War cemetery is transferred from the control of the Secretary to the control of the Secretary of the Interior.

"(C) Such real property, buildings, improvements, and personal property as are identified by the Secretary as needed for Federal programs shall not be transferred under paragraph (1).".

SEC. 12. REPEAL OF OBSOLETE ADDICT REFERRAL PROVISIONS.

(a) Repeal of Obsolete Public Health Service Act Authorities.--Part E of title III is repealed.

(b) Repeal of Obsolete NARA Authorities.--Titles III and IV of the Narcotic Addict Rehabilitation Act of 1966 are repealed.

(c) Repeal of Obsolete Title 28 Authorities.--

(1) Chapter 175 of title 28, United States Code, is repealed.

(2) The table of contents to part VI of title 28, United States Code, is amended by striking the material related to chapter 175.

SEC. 13. NONDISCHARGEABILITY IN BANKRUPTCY OF PAYBACK FOR MENTAL HEALTH CLINICAL TRAINEESHIPS.

(a) General Rule.--Section 303(d) is amended by adding at the end the following:

"(6) Any obligation of an individual under paragraph (3) may be released by a discharge in bankruptcy under title 11, United States Code, only if the discharge is granted after the expiration of the seven-year period beginning on the first date that payment under that paragraph is required, and only if the

Bankruptcy Court finds that the nondischarge of the obligation would be unconscionable.".

(b) Effective Date.--The amendment made by subsection (a) applies to bankruptcy proceedings in which a discharge has not been granted before 31 days after the date of enactment of this Act.

(c) Conforming Amendments to Bankruptcy Code.--

(1) Section 523(a) of title 11, United States Code, is amended--

(A) by striking "or" at the end of paragraph (11),

(B) by adding "or" at the end of paragraph (12), and

(C) by adding at the end the following:

"(13) that under provisions of the Public Health Service Act is not to be discharged.".

(2) Section 1328(a)(2) of title 11, United States Code, is amended by striking "or (8)" and inserting ", (8), or (13)".

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4

Divider Title: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

DRAFT

Memorandum to: Chris Edley
Nancy-Ann Min

From: Peter Edelman PGE
Counselor to the Secretary

Subject: SAMHSA Hard Core Treatment Initiative - Additional Information on Substance Abuse Block Grant HIV and TB Services

Here is the information you asked for at our March 16, 1994, meeting about the impact of the Department's proposal to maintain in the Hard-Core Treatment Initiative the current requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant to provide HIV and tuberculosis (TB) early intervention services. These requirements are defined in Section 1924 of the Public Health Service (PHS) Act.

The Department continues to take the stand that individuals being served under the Hard-Core Initiative should receive comprehensive care including TB services and early intervention services for HIV. This stand is taken because the public health concerns of substance abuse, TB, and HIV/AIDS are so intimately interwoven that they cannot and should not be treated in isolation. The Department also realizes that substance abuse services are most effective when they are comprehensive.

Unfortunately, the current discussion on whether the Administration's legislative proposal for the Hard-Core Initiative should require States to provide these services and to set aside certain amounts of their allocations under the Initiative for early intervention services for HIV and TB has come down to a question of whether we can continue to say that up to approximately 70,000 hard core substance abusers will be served with the additional $310 million proposed for the SAPT Block Grant.

For the following reasons, the Department continues to assert that requiring the States to fulfill their Section 1924 obligation with these new funds would not affect the projected numbers of persons served.

First, SAMHSA has estimated the average cost for providing treatment under the base SAPT Block Grant to be approximately $2,300 per person (or about $5,800 per treatment slot serving about 2.53 persons per year). This estimate has always been derived by a top-down method, using SAMHSA survey data, such as from the National Drug and Alcoholism Treatment Unit Survey (NDATUS) and the Alcohol and Drug Services Survey (ADSS) (formerly called the Drug Services Research Survey – DSRS), to estimate the number of treatment slots provided by the

public and private sectors in the nation. This level of treatment slots is then divided by the known level of dollars spent to support these slots at the Federal, State and local, and private levels to fashion the average cost per slot and per person estimates for each level.

Second, a recent review of at least 20 State applications for FY 1994 funds shows, contrary to ONDCP staff claims, that the States are carrying out the legal requirement to provide HIV/TB early intervention services in different ways within the existing dollars spent. While some States are using State funds or other Federal funds, most are using SAPT Block Grant funds for TB and HIV counseling and testing. As stated at the March 16th meeting, we know of no State that is using the SAPT Block Grant to provide treatment for TB or HIV. (Attached is a summary of what services a sample of States are providing with their HIV set-aside.)

check w/ Jurisdiction

Consequently, since we can assume that the current number of persons receiving treatment in slots supported with Federal funds are, where required by the law, being provided HIV/TB early intervention services, we contend that the $2,300 average cost per person estimate used for the basic SAPT Block Grant already takes into consideration the costs of such early intervention services. ONDCP has not previously objected to this basic assumption that has been used by the Department and ONDCP to estimate the average costs of treatment in formulating both the 1994 and the 1995 President's budget. Furthermore, until the State Systems Development Program (SSDP) is more fully implemented in all States, no other real data exist which could be used to derive any more accurate estimates.

For the FY 1995 Hard-Core Initiative, SAMHSA's estimate of an average cost of $4,300 per treated person (or $8,700 per treatment slot serving about 2,035 persons per year) was developed using the base average of $2,300 per person, and then inflating it, based on ONDCP guidance, for an increased intensity and duration of treatment and greater use of residential settings assumed to be necessary for treating the hard-core user. Since the base SAPT average cost of $2,300 per person included a factor for HIV/TB services, the Hard-Core average cost of $4,300 per person derived from the base figure must also account for such services.

Third, the cost of providing TB counseling and testing has been estimated by the Centers for Disease Control and Prevention (CDC) to cost approximately $35 per person. CDC estimated the cost of providing HIV counseling and testing at $100 per person. ONDCP agreed at the March 16th meeting that these costs are negligible, even if they are not factored into the basic cost, as we suggest they are. However, not everyone who receives services under the Hard-Core Initiative will require the complete array of TB and HIV counseling and testing services, so the average cost per person served for these activities would likely actually be much less.

Fourth, the cost of providing TB and HIV counseling and testing services is the same whether an individual is being served through the general Block Grant or through the Initiative. Thus, if it is taken into consideration in the determination of the average cost per person for the SAPT, as stated above, we would not expect any increased cost for the Hard-Core Initiative.

We are also very concerned that it would send a wrong and confusing signal to the States and other providers to require these HIV/TB services for persons presumed to be treated with general Block Grant funds, but not to require them for the hard-core user, who is even more at-risk and thus, in even greater need for these exact services.

Finally, it is important to point out that the President's *1994 National Drug Control Strategy* emphasizes in several places the need to link drug abuse treatment and HIV/TB early intervention services. For example, page 26 of the *Strategy* states,

> "The goal of expanding treatment also embraces the concept of a comprehensive, integrated approach to treatment services based on a public health model that views drug use, violence, infectious disease, and mental illness as closely related threats to health and welfare..... The AIDS epidemic – with its spread among drug users, threat to the general population, and demands on the primary health care system – emphasizes the difficulty caused by the separation of drug use treatment from the primary health care system..... The recent resurgence in the incidence of tuberculosis and the problem of HIV infection dramatically underscore the interrelationships between drug use and infectious diseases.
>
> "Treatment services should include a comprehensive assessment of drug use and overall health, appropriate medical intervention, and case management and patient matching to appropriate levels of care. In addition, services should include HIV testing and counseling, counseling for other sexually transmitted diseases, psychological counseling, life skills education, and assistance in obtaining other needed services.....
>
> "This strategy reflects an awareness that the social problems stemming from drug use do not fit neatly into separate categories, and neither can efforts to solve these problems... " (emphasis added).

It is clear to us that not proposing to extend the HIV/TB early intervention services to the Hard-Core Treatment Initiative would thus be inconsistent with the national recommendations of the President's *Strategy* and our commitment to serving the public and promoting the public health.

Attachments

State HIV/AIDS Activities in Response to the Substance Abuse Prevention and Treatment Block Grant Requirements

I. Background Information

The Public Health Service Act was amended by the ADAMHA Reorganization Act, Public Law 102-321, on July 10, 1992. In addition to authorizing the reorganization of ADAMHA, the ADAMHA Reorganization Act, incorporated several provisions which expanded the States' responsibility for controlling the spread of infectious disease. Section 1924, (b), delineates new requirements for early intervention services for HIV disease for individuals undergoing substance abuse treatment.

In any state with 10 or more cases of AIDS per 100,000 individuals (as reported by the Centers for Disease Control, CDC, January 1992), publicly funded substance abuse (SA) treatment programs must:

- Carry out one or more projects for individuals undergoing treatment for substance abuse which provide early intervention services relating to HIV disease at the sites at which the individuals are undergoing such treatment.

- Early intervention services relating to HIV are defined as:

  - Testing, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.
  - Appropriate pre- and post-test counseling
  - Providing appropriate therapeutic measures.

- Early intervention projects must be carried out only in geographic areas of greatest need.

- If 2 or more projects are carried out, 1 must be carried out in a rural area. (A waiver may be granted if the State can certify that the rate of AIDS cases is less than or equal to 2 such cases per 100,000 individuals in any rural area of the State or there are no rural areas in the State).

- Establishment of linkages - programs participating in early intervention projects are required to establish linkages with a network of related health and social services organizations.

- Entities receiving block grant funds for SA treatment are required to follow procedures developed by the State SA Agency. The State SA Agency must consult with the State Medical Director for SA services. Procedures must also be

developed in cooperation with the communicable disease officer of the State Department of Health.

- Payment of services - States must ensure that Block Grant payments are the "payment of last resort" meaning that entities which receive block grant funds are expected to collect reimbursement for the costs of providing HIV services from all sources (e.g. Title XVIII, Title XIX, private insurance, etc.) and from patients in accordance with their ability to pay.

- States must also ensure that these early intervention services relating to HIV are undertaken voluntarily and are not required as a condition for receiving SA services or any other services.

- Maintenance of effort - State are expected to establish a reasonable funding base for FFY 1991 as relates to the provision of HIV services at a level that is not less than the average level of such expenses maintained by the State for the 2-year period preceding the first fiscal year for which the State receives a grant. Depending upon historical funding patterns, States must also expend between 2 and 5 per cent of their block grants on HIV services.

The ADAMHA Reorganization Act required the Secretary of Health and Human Services to draft new regulations for the implementation of P.L. 102-321. 45 CFR Part 96, "Substance Abuse Prevention and Treatment Block Grants; Interim Final Rule", was published and took effect March 31, 1993. The HIV early intervention requirements are incorporated into this document. A Final Rule is currently being drafted for the Secretary's approval.

Early Intervention Services for HIV Disease

California

- 47 counties receive early intervention services funds for HIV disease. Most counties contract with their public health department for primary care services which are provided through Ryan White funds.
- Pre and post-test counseling, testing services and therapeutic services are made available through formal contracts with both public and private providers.
- In Los Angeles county, vans were purchased to provide mobile on-site pre and post-test counseling and diagnostic testing.
- Some counties have used early intervention services money to hire dedicated HIV counselors.

Colorado

- Statewide HIV Early Intervention Project- for clients admitted to publicly funded substance abuse treatment programs, services are provided to clients on-site. HIV services are delivered at or by the 32 publicly funded substance abuse treatment programs in all six (6) substate planning areas of the state. Based on state regulations, all treatment programs are required to ensure that pre-test counseling, evaluation of risk, offer of testing and post-test counseling are offered to all clients. Programs are also required to make HIV testing available to all clients who are at risk of HIV.

Connecticut

- Dedicated HIV Nurse/Counselors on-site at thirteen methadone outpatient clinics - Pre and post test counseling and referral services are provided.

Delaware

- Delaware is currently determining the area(s) of most need for HIV early intervention services and will utilize its block grant funding set-aside to provide at least one early intervention services for HIV disease project in the area(s) determined to be in most need.

District of Columbia

- An ambulatory clinic focused on early intervention is planned. Services will include pre and post-test counseling, HIV testing, case management and treatment.

Florida

- HIV Early Intervention projects have been established in 6 substate regions. Each project provides pretest counseling, testing (HIV testing, confirmation testing), post-test counseling and therapeutic measures. Counseling services are also provided. Specialized counseling is provided which includes bereavement issues, stress management, risk reduction/behavioral change strategies, nutritional strategies/health promotion and quality of life improvement.

Georgia

- Early intervention services for HIV disease are provided at six rural (Dalton, Brunswick, Albany, Thomasville, Valdosta, Waycross) and six urban (Atlanta, Augusta, Columbus, Decatur, Macon, Savannah) cities.

- SA treatment providers provide on-site pre and post-test counseling and behavior change counseling. Diagnostic testing is accomplished through referral to Department of Public Health HIV clinics.

- All HIV positive clients are referred for primary care to Department of Public Health HIV clinics except Fulton and Dekalb counties which utilize Grady Hospital. Primary care services include testing to diagnose the extent of the deficiency in the immune system and the provision of indicated therapeutical and medicinal intervention. In addition, directly observed medication services are provided.

Hawaii

- An early intervention services program on the island of Oahu and the island of Hawaii will provide screening, education and individual risk assessments; testing to confirm the presence of the disease, to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease; appropriate pre and post-test counseling, case management and appropriate medical follow-up. Transportation will also be provided or arranged when needed by clients.

Illinois

- Illinois Department of Alcohol and Substance Abuse (DASA) and the Illinois Department of Public Health (IDPH) are working cooperatively on the expansion of 35 counseling and testing sites throughout the State. A projected 8,850 diagnostic tests and 34,036 hours of pre and post test

Illinois (continued)

counseling will be delivered at these sites during the FY 1993 expenditure period.

- IDPH is facilitating training of the staff at these sites. Training focuses on pre and post-test counseling, the delivery of HIV antibody testing and referral services.

Louisiana

- The state has contracted with nurses to provide pre and post-test counseling statewide in 28 outpatient clinics.

Maryland

- Ujima Program- A program targeted to women in Baltimore City.
A mobile health van is used to deliver counseling and HIV testing to women in certain targeted areas of Baltimore.

- Primary care sites- Four (4) primary care sites are run by the state in Baltimore City, providing comprehensive services to city residents. Early intervention services for HIV disease are provided at these sites, including pre and post-test counseling, HIV testing and therapeutic measures.

- A rural program is operated in Carroll County, a residential program, which provides beds for TB clients and provides a range of early intervention services for TB and HIV clients.

Massachusetts

- ACT Now, an HIV/AIDS counseling and referral service, operates out of 42 sites. 6 of these sites are situated within block grant funded SA treatment programs. These 6 ACT Now projects also provide therapeutic services and prophylactic medication.

- 4 block grant funded treatment programs provide early intervention services with the set-aside funds to include pre and post-test counseling and referral services.

- At four substance abuse treatment programs, pre and post-test counseling is provided on-site.

Missouri

- Provides a variety of HIV services at the site at which clients receive substance abuse treatment. On site HIV testing and pre and post test counseling is provided in all publicly funded methadone programs. Service coordination

Missouri (continued)

and limited primary care are also provided. In addition, nine (9) comprehensive care programs also provide on-site HIV testing and pre and post-test counseling, including service coordination and limited primary care. All contract agencies are also mandated to provide on-site HIV risk assessment and pre and post-test counseling, upon request. Transportation to off-site HIV and testing locations is also provided at the majority of publicly funded treatment programs.

Nevada

- Washoe County Health Department - Contracted with this county health department to provide pre and post-test counseling, testing services and therapeutic services for their HIV-infected substance abusing clients.

- Clark County Health Department - Contracted with this county health department to provide pre and post-test counseling, testing services and therapeutic services for their HIV-infected substance abusing clients.

- Community Counseling Center of Las Vegas - Contracted with this counseling service to provide pre and post-test counseling. Linkages with Clark County Health Department have been established to provide needed therapeutic services.

New Jersey

- At 22 substance abuse treatment programs, early intervention services for HIV disease are provided to injection drug users (IDUs). 18 of these programs are outpatient methadone programs and 4 are residential programs or therapeutic communities.

- Services provided at these sites include pre and post-test counseling, testing and referral to primary care services.

New York

- State has contracted with the Department of Health which operates an AIDS Institute to provide the early intervention services for HIV disease stipulated by the regulations. The Department of Health has subcontracted with 5 providers to provide the services required by the regulations (i.e., pre and post test counseling, testing and therapeutic measures). The state also pays for HIV coordinators.

Pennsylvania

- Plans to operate programs at eight (8) sites in Philadelphia, Pittsburgh, Delaware County, Schuylkill County (a rural program), Lancaster, Bucks County, Lehigh County and Forest County. Services will include pre and post-test counseling, testing and appropriate therapeutic measures.

Puerto Rico

- Operates a central intake unit (CIU) where, in addition to psycho-social assessment, medical evaluations are completed. If HIV risk factors are identified, voluntary HIV testing is encouraged. Pre and post test counseling and referral to voluntary testing is provided on-site at the CIU.

- HIV positive patients are provided primary care services through referral to the office of AIDS Affairs and Sexually Transmitted Disease.

Texas

- Texas has required all treatment programs to (1) provide information to staff and clients including basic substance abuse/HIV information about risk factors, risk reduction strategies, routes of transmission, and HIV antibody counseling and testing; (2) provide risk assessments to all clients entering treatment; and (3) have a documentable procedure in place for making available, at the client's request, pre and post-test counseling and confidential HIV testing.

- In 1994 Texas plans to provide early intervention services for HIV disease at fifty-eight programs.

Virgin Islands

- The Virgin Islands' Division of Mental Health Alcoholism and Drug Dependency has plans in place to train substance abuse staff in HIV intervention services, specifically pre and post test counseling.

- Formal service agreements with public health programs are to be arranged by August 1993.

- Procedures for referral, coordination, and follow-up services are to be established by the fourth quarter of FY 1993.

Washington

- Special HIV Early Intervention Projects- Projects will be conducted at seven (7) methadone treatment sites that deliver publicly funded methadone treatment services to opiate addicted residents in four (4) counties in the state. The projects are targeted to areas with high concentrations of injecting drug users. Three (3) projects will be conducted in King County, two (2) in Pierce County, one (1) in Spokane County and one (1) in Yakima County. Services will include pre and post-test counseling; testing to diagnose the extent of the immune deficiency; testing to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from the disease; and therapeutic measures to intervene with the deterioration of the immune system and/or conditions arising from the disease.

ATTACHMENT

States With 10 or More Cases Per 100,000 Population of Acquired Immune Deficiency Syndrome
1992

State	Rate per 100,000	HIV Set-Aside
CA	25.4	7,393,962
CO	13.0	238,462
CT	17.1	263,227
DE	13.1	62,248
DC	126.4	77,748
FL	41.9	2,414,307
GA	21.5	1,156,824
HI	17.8	273,407
IL	13.9	1,781,675
LA	17.9	353,021
MD	20.2	430,573
MA	16.0	1,429,557
MO	12.8	911,213
NV	21.3	276,947
NJ	29.7	1,872,649
NY	45.3	1,645,851
PA	10.3	2,312,398
TX	17.9	3,468,007
WA	11.3	1,157,069
PR	50.9	680,749
VI	20.5	49,546
	TOTAL	28,249,440

Source: CDC HIV/AIDS Surveillance Bulletin, January 1992
and CSAT internal documents

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Divider Title: _____

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

April 11, 1994

MEMORANDUM FOR NANCY ANN MIN
CHRIS EDLEY

FROM: RICIA MCMAHON
ACTING CHIEF OF STAFF

SUBJECT: Response to SAMSHA's Additional Information on Substance Abuse Block Grant HIV and TB Services for the Hardcore Treatment Initiative

In reviewing the SAMHSA response, we offer the following comments:

- HHS contends that its average cost per person estimate for the Block Grant of $2,300 already takes into consideration the costs of early intervention services for HIV and TB.

  We are concerned that the base estimate doesn't take into account these mandated services. According to the HHS memo and its National Drug Treatment Requirements Table (See attachment 1), this estimate has been derived using SAMHSA survey data, such as NDATUS, ADSS, and the 1991 Household survey. Therefore, since the ADAMHA Reorganization Act passed subsequent to the release of the findings of these data instruments, it is unlikely that the base reflects adjustments to account for the mandates of the ADAMHA Reorganization Act.

  Further, according to the HHS Drug Treatment Slot Table, it appears that the only funding adjustment for the cost per slot is for inflation. Again, it appears that the base has not been adjusted to account for the HIV/TB early intervention services as required by law.

- HHS indicates that a review of at least 20 State applications for FY 1994 shows that the States are carrying out the legal requirement to provide HIV/TB early intervention services. This is commendable.

Further, in reviewing the 1992 data provided by the Centers for Disease Control, it is clear that 19 States, Puerto Rico and the Virgin Islands are required to provide early intervention services for HIV/TB since these areas have at least 10 cases of AIDS per 100,000 individuals. However, in reviewing the State back-up data provided in the package from HHS, it is evident that at least 8 (38%) of the 21 States are not currently in compliance with the law (e.g., Delaware is in the process of determining the areas of most need and D.C. is planning a clinic that will focus on early intervention services.) Moreover, it appears that there may be as many as 12 (57%) States of the 21 that are not completely in compliance. This is of great concern to us.

Furthermore, while it appears that many of these States are planning to do something for this population, the law requires that the publically funded substance abuse treatment programs in States with at least 10 AIDS cases per 100,000 provide early intervention services. The information provided by HHS suggests that this is not happening.

- During the formulation of the hardcore drug treatment initiative, HHS provided ONDCP with a table that estimated the cost to provide comprehensive drug treatment services for the hardcore population at $26,155 per slot (See attachment 2). Using this figure, HHS anticipated that only 24,000 additional persons would receive treatment. At ONDCP's insistence to increase the number of persons to be treated by this initiative, HHS agreed to lower its cost estimate for this population to $8,729, thus treating an additional 74,000 persons. This poses two questions:

  - -- How can HHS continue to state that the current hardcore drug treatment cost estimate of $8,729 is adequate to cover the cost of all the mandates?

  - -- What is the basis of the $26,155 estimate and what services are lost for the hardcore user under the current estimate of $8,729?

- HHS claims that the cost to provide the early intervention services for HIV/TB screening is marginal.

Since these cost estimates appear to be minimal, we assume that there will be no reduction in the estimate of 74,000 hardcore drug users to be treated. Again, our concern is that the President's Strategy (as well as the HHS National Drug Treatment Requirements Table) indicates that an additional 74,000 hardcore drug users

will receive treatment. (Please note that the estimate of 74,000 additional persons does not include under 21 alcohol only use nor comorbid use. It only includes treatment for drug users. See the attached HHS table.)

We need to ensure, whatever the outcome of this proposal, that we do not abandon the President's commitment to treat an additional 74,000 hardcore drug users.

If you should want to discuss this in more detail, please do not hesitate to contact me at 395-6732.

Attachments

c: Peter Edelman

NATIONAL DRUG TREATMENT REQUIREMENTS 1/

FY 1995 – President's Budget

DRUG ABUSE ONLY	FISCAL YEAR								
	1990	1988	1991	1992	1993	1994	1995	1996 2/	1997 3/
A. ESTIMATED DRUG ABUSERS									
A1. Marijuana Only	2,484,000	2,358,000	1,763,000	1,738,000	1,715,000	1,693,000	1,672,000	1,648,000	1,698,000
A2. Other Illicit Drugs	2,995,000	2,744,000	2,419,000	2,370,000	2,325,000	2,281,000	2,240,000	2,193,000	2,293,000
A3. Total Drug Abusers	5,479,000	5,102,000	4,182,000	4,108,000	4,040,000	3,974,000	3,912,000	3,841,000	3,991,000
B. TREATMENT GOAL									
B1. Marijuana Only	315,000	298,000	224,000	221,000	218,000	215,000	212,000	209,000	216,000
B2. Other Illicit Drugs	2,995,000	2,744,000	2,419,000	2,370,000	2,325,000	2,281,000	2,240,000	2,193,000	2,293,000
B3. Total Treatment Goal	3,310,000	3,043,000	2,643,000	2,591,000	2,543,000	2,496,000	2,452,000	2,402,000	2,509,000
C. FEDERAL CAPACITY (SAMHSA & NIDA)									
C1. (a) New Federal Slots / Hard Core Initiative	NA	NA	NA	NA	NA	NA	36,453		
(b) NET Federal Treatment Slot Growth	22,774	21,711	5,918	−3,354	6,199	−940	30,654		
C2. Prior Balance Federal Slots	47,086	69,860	91,571	97,489	94,135	100,334	99,394		
C3. Total Federal Treatment Slots	69,860	91,571	97,489	94,135	100,334	99,394	130,248		
C4. Public Throughput Rate	2.80	2.73	2.68	2.63	2.58	2.53	4/		
C5. Total People Served / Federal	195,608	249,999	261,271	247,575	258,862	251,467	311,462		
D. PUBLIC CAPACITY / NON-FEDERAL									
D1. Total Non-Federal Slots – Public	330,400	310,900	307,871	307,871	307,871	307,871	307,871		
D2. Public Throughput Rate	2.80	2.73	2.68	2.63	2.58	2.53	2.53		
D3. Total People Served / Public (Non-Fed)	925,266	848,782	825,094	809,701	794,307	778,914	778,914		
E. PRIVATE CAPACITY									
E1. Total Private Treatment Slots	155,000	156,520	157,640	157,640	157,640	157,640	157,640		
E2. Private Throughput Rate	2.80	2.62	2.57	2.52	2.47	2.42	2.42		
E3. Total People Served / Private	436,004	410,082	406,135	397,253	389,371	381,488	381,488		
F. TOTALS									
F1. Total Slots	556,000	589,000	563,000	560,000	566,000	565,000	596,000		
F2. Total People Served	1,557,000	1,508,000	1,491,000	1,456,000	1,443,000	1,412,000	1,472,000		
F3. Percent of Treatment Goal Achieved	47.0%	49.6%	56.4%	56.2%	56.7%	56.6%	60.0%		
F4. Remaining Treatment Need	3,922,000	3,563,000	2,991,000	2,863,000	2,807,000	2,662,000	2,449,000		

FOOTNOTES: (Also see Page 2)

1/ This table only includes SAMHSA and NIDA in the Federal slot Estimates. It excludes other Federal Agencies that provide substance abuse treatment. These other Federal resources include Dept of Veterans Affairs, Dept of Justice (e.g., Crime Bill), Dept of Housing and Urban Development, and Dept of Defense, among others.

2/ To be determined during the 1996 budget cycle.

3/ To be determined during the 1997 budget cycle.

4/ The "standard" throughput rate for Federal slots in 1995 is 2.53; however, the Hard Core Treatment Initiative estimates are based on a lower throughput factor of 2.035. In combination, all programs result in the number of persons served by Federal treatment slots as shown on line C5.

TOTALS MAY NOT ADD DUE TO ROUNDING

Attachment 1

FOOTNOTES:

LINE A1. FY 89–91 have been derived from the FY 91 Household Survey, adjusted for under–representation and under–counting. Outyears are calculated by adding 50,000 "New" Marijuana abusers, and removing 5% from the prior year treatment base (i.e., minus 5% of "Total People Served" in the previous year).

LINE A2. FY 89–91 have been derived from the FY 91 Household Survey, adjusted for under–representation and under–counting. Outyears are calculated by adding 100,000 "New" Other Illicit Drug users and removing 10% from the prior year treatment base.

LINE A3. This is the total number of people who need treatment, the sum of LINES A1 and A2.

LINE B1. The treatment goal for the Marijuana component has been established at 12.7% of the total who need treatment, Line A1, based on professional judgement.

LINE B2. Treatment goal for the "Other Illicit Drug" component has been established at 100% of the total who need treatment, Line A2, based on professional judgement.

LINE B3. This is the total treatment goal, the sum of LINES B1 and B2.

LINE C. Federal Capacity is defined as drug treatment slots funded by programs of the Substance Abuse and Mental Health Services Administration (SAMHSA), with oversight by the Center for Substance Abuse Treatment (CSAT), plus treatment slots created by Clinical Trials by the National Institute on Drug Abuse (NIDA).

LINE C1. (a) Actual or projected slots in the Hard Core Treatment Initiative; (b) Total of Hard Core slots, plus/minus other program increases or decreases.

LINE C3. This line represents the total number of treatment slots funded by Federal funds. Specific comments for each fiscal year are as follows:
FY 1989–FY1991: Calculation of "Actual" number of slots was derived from NDATUS in FY 89. FY 90–91 were calculated by dividing available funds by the annual "cost per treatment slot" for each program category (In FY 1995, $20,105 for residential slots, and $5,819 for all others except Hard Core).
FY 1992: Slots have been adjusted for 1992 Actual Cost and the effects of reallocation of the ADMS Block Grant in compliance with P.L. 102–321.
FY 1993: Slots have been adjusted for 1993 Actual Cost.
FY 1994: Slots have been calculated based on the FY 1994 Appropriation.
FY 1995: Slots have been calculated based on OMB funding guidance for FY 1995. (See specifics in the Drug Treatment Slot table, Page 3.)
FY 1996 and FY 1997: TO BE DETERMINED.

LINE C4. Public Throughput Rate: The number of (unique) individuals served by a public–pay slot. It accounts for patterns of capacity utilization including more than one treatment episode per client. Based on professional judgement, the rate declines .05 per year from FY 1990 through FY 1994 and remains "flat" from FY 1995 forward (2.53), except for the Hard Core Treatment Initiative (which is 2.035.)

LINE C5. This is the total number of individual persons served by Federally funded treatment slots (Line C4 times Line C3; except in FY 1995, see Footnote 4, Page 1.)

LINE D1. This represents the total Non–Federally funded treatment slots minus slots funded by the private sector (See Lines E1–E3). FY 89–91 totals have been derived from review of the NDATUS. From FY 92 forward, "no growth" is assumed, however, it is assumed that Non–Federal will keep pace with inflation.

LINE D3. This is the total number of individual persons served by Non–Federally funded treatment slots (Line D2 times Line D1), less the adjustment for private slots.

LINE E1. Total Private treatment slots equal the estimated percent of private capacity in total capacity. Only inflationary cost growth is assumed from FY 1992 forward.

LINE E2. Private Throughput Rate: The number of (unique) individuals served by a private–pay slot. It accounts for patterns of capacity utilization including more than one treatment episode per client. Like the Public throughput rate, the Private rate declines .05 per year from FY 1990 through FY 1994, then remains flat thereafter.

LINE E3. This is the total number of individual persons served by Privately funded treatment slots (Line E2 times Line E1).

LINE F1. Sum of Lines: C3 + D1 + E1.

LINE F2. Sum of Lines: C5 + D3 + E3.

LINE F3. Line F2 divided by Line B3.

LINE F4. Line A3 minus Line F2.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION 1/

Drug Treatment Slots

FY 1995 – President's Budget

FUNDING MECHANISM	1993 ACTUAL Dollars Available	1993 ACTUAL Cost per Slot	1993 ACTUAL Total Slots	1994 APPROPRIATION Dollars Available	1994 APPROPRIATION Cost per Slot	1994 APPROPRIATION Total Slots	1995 PRESIDENT'S BUDGET Dollars Available	1995 PRESIDENT'S BUDGET Cost per Slot 2/	1995 PRESIDENT'S BUDGET Total Slots	CHANGES (95 PRES. BUD OVER 94 APPROPRIATION) Dollars Available	%	Total Slots	%
CSAT:													
Block Grant 3/	$402,744,000	$5,507	73,137	$422,168,893	$5,855	74,849	$419,344,369	$5,819	72,060	-$2,824,524	-0.67%	-2,589	-3.5%
Demonstrations 4/	120,278,900	5,507	13,176	103,226,000	5,855	11,445	89,249,500	5,819	9,066	-13,976,500	-13.54%	-2,379	-20.8%
Cap Expansion Program 5/	14,601,000	5,507	2,651	9,729,000	5,855	1,720	6,515,000	5,819	1,120	-3,214,000	-33.04%	-601	-34.9%
Hard Core Treatment Initiative 6/							300,700,000	8,729	34,448	300,700,000		34,448	
Hard Core Treatment Demos 7/							17,500,000	8,729	2,005	17,500,000		2,005	
SAMHSA Total	$537,623,900		88,964	$535,123,893		87,814	$833,308,869		118,698	$298,184,976	55.72%	30,884	35.2%
Throughput Factor 8/			2.58			2.53						60,092	27.0%
People Served			229,527			222,169			282,261				
NIDA (NIH) Total 9/	$62,611,000	5,507	11,370	$65,469,000	5,855	11,580	$67,214,000	5,819	11,550	$1,725,000	2.63%	-30	-0.3%
P H S TOTAL	$600,234,900		100,334	$600,612,893		99,394	$900,522,869		130,248	$299,909,976	49.93%	30,854	31.0%
Throughput Factor			2.58			2.53						60,016	23.9%
People Served			258,861			251,467			311,462				

FOOTNOTES:

1/ This table also includes treatment slots in NIDA (see # 8 below), but for no other Federal Department or Agency.

2/ The cost per slot for all programs has been increased by 2.9% for inflation in FY 1995; however, the cost per slot for Hard Core treatment programs is increased by 50% over the non-residential treatment cost estimate used for other programs (i.e., from $5,819 to $8,729).

3/ Only 35.625% of each Block Grant dollar is used to support drug abuse treatment slots. (The Hard Core Treatment Initiative will be funded using the Block Grant mechnanism; however, these funds (excluding SAMHSA Set-Aside) will be scored 100% for treatment slot estimates.)

4/ This table consolidates all prior demonstration programs into one line (residential treatment components are scored at 100% of grant funding, all others at 50%).

5/ The Capacity Expansion Program is scored at 100% of grant funding. It will begin phasing out in 1995, as existing grants expire.

6/ The Hard Core Treatment Initiative is a new proposal in 1995. See CSAT/Drug Budget Summary for details. State allocations are scored 100% for slots.

7/ The Hard Core Treatment Demonstration is a new $35,000,000 proposal in 1995, and, like existing non-residential demos, it is scored at 50% for slots.

8/ The "standard" throughput rate for Federal slots in 1995 remains at the FY 1994 level of 2.53; however, the Hard Core Treatment Initiative estimates are based on a throughput factor of 2.035. In combination, all programs result in the number of persons served by Federal treatment slots as shown.

9/ This data provided by NIDA. Dollars and treatment slots reflect recalculations (for all years), based on Clinical Trial funding in lieu of NIDA Demonstrations. (Treatment demonstration funding was used to generate slots when NIDA was under ADAMHA, before re-organization, per P.L. 102-321.)

TOTALS MAY NOT ADD DUE TO ROUNDING

Impact on Treatment Capacity

Program Component	Amount of Funding	No. of Slots	No. of Persons
Services	$310,000,000	11,260	22,922
Demonstrations	$35,000,000	669	1,362
Total Package	$345,000,000	11,929	24,284

Assumptions: $26,155/slot; $12,848/person; 2.035 throughput; 5% set-aside

Source of Funding

Funding Components	$240 M Passback	$45 M For. Funds	$60 M Demo Base	Total Amount
Formula Grant	$240,000,000	$45,000,000	$25,000,000	$310,000,000
Demonstrations	$0	$0	$35,000,000	$35,000,000

Weighted Average Annual Cost per Slot

Treatment Modality	Cost/slot	Pop Distrib	Wt. Av. Cost/slot
Outpatient	$5,500	10%	$550
Outpatient/medical	$7,700	15%	$1,155
Intensive Non-Resid	$31,000	45%	$13,950
Residential	$35,000	30%	$10,500
			$26,155

Weighted Average Annual Cost per Person

Treatment Modality	Cost/slot	Throughput	Cost/Person	Pop Distrib	Wt. Av. Cost/Person
Outpatient	$5,500	3.0	$1,833	10%	$183
Outpatient/medical	$7,700	1.5	$5,133	15%	$770
Intensive Non-Resid	$31,000	10.0	$3,100	45%	$1,395
Residential	$35,000	1.0	$35,000	30%	$10,500
					$12,848

Attachment 2

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

March 22, 1994

MEMORANDUM FOR MATTHEW WELBES

FROM: BABETTE HANKEY

SUBJECT: HHS Draft Bill Substance Abuse and Mental Health Services Amendments of 1994

As previously discussed, please find below the ONDCP comments with regard to the HHS proposal. We have not commented on the section by section at this time since it will need major rewriting once the bill language is finalized.

On page 3 of the bill language, the definition should read as follows: "The term 'hardcore substance abuser' means an individual who uses illicit drugs or illicit drugs in combination with alcohol at levels sufficient to cause functional impairment.

Since the inception of the hardcore initiative, it has been the ONDCP position to treat hardcore users with polydrug, comorbid, and/or co-occurring disorders. This would include the treatment of alcohol provided that the user also has a drug problem. These funds should not be spent on alcohol only treatment.

However, we understand the point that SAMHSA raised during the meeting with regard to States that primarily have an alcohol problem. We would accept the compromise offered by OMB, that the States could request a waiver if they do not have sufficient clients to be treated as hardcore substance abusers, as defined above. Under this proposal, however, the States should be required to clearly define their needs in the needs assessment of their State plan.

On page 4, with regard to the section of Allocation of Grants for the Treatment of Hardcore Substance Abusers, we require further clarification on what is meant by abusers who are "unserved or underserved." Further, we would like to know how HHS plans to track these funds to ensure that they are expended in the areas as defined in this section.

Also on page 4, under (d) (2), we also believe that HHS should not define the groups that would receive particular emphasis. The purpose of this program, as presented to the President, is to expand the capacity of drug treatment for the hardcore drug user (or those who use illicit drugs in combination with alcohol). This program was intended to give the States the flexibility to best target their funds (within the hardcore population) where they are most needed. (This is consistent with the recommendations of the NPR.) Therefore, we would recommend deleting the section that begins with "with particular emphasis on juvenile .....) We do not want to force subsets of the hardcore population. Additionally, the proposal by HHS poses the question of how these subsets would be tracked.

On page 5, we would note that the 3% set-aside should not only be for evaluations, but also technical assistance. The technical assistance component is articulated in the Strategy. HHS has advocated that the States do not have ability nor funds to separately track the hardcore population. Since this was a new population and a new program, we allowed for a 3% set-aside to provide technical assistance to States and local service providers to develop flexible, low cost, high utility data systems for tracking hardcore addicts that also meet State and Federal needs for comparability across regions and States. (See page 54 of the Budget Summary.)

On page 6, HHS agreed during the meeting to include a separate breakout identifying the $35 million hardcore drug treatment demonstration. We would expect to see this in the next draft of the legislative proposal.

On page 8, we are concerned that the Secretary will evaluate <u>all</u> demonstration programs. This will dilute the funding available for prevention and treatment services. We do not believe that all demonstrations should be evaluated. Further, we suggest the evaluations be limited to no more than 10% of the total award.

On page 9, Section 8, Continuation of Projects, we are concerned that the Secretary can terminate any projects that she determines should be terminated. There should be some criteria that these programs fall into in order to be considered for termination. In light of the new general demonstration authority, this provision could be devastating to small, local providers. The existing grantees should have more of a commitment that they will be continued.

Finally, with regard to the issue of mandates, we do not believe that some of the existing mandates should be required for two reasons: (1) it is likely that the cost for the mandates are not included in the estimate of 74,000 hardcore persons to be

treated; and, (2) the proposal should allow the States the maximum amount of flexibility to provide additional capacity for this population. The latter is consistent with the recommendation of the NPR.

I will be on travel the rest of this week. Therefore, should you have any questions, please contact John T. Carnevale, Director of Planning and Budget, at 395-6736.

c: Ricia McMahon
John Carnevale
Ed Jurith
Jill Blickstein

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Drug Treatment: The Administration's Hard-Core Plan

David Broder goes astray in his assertion that the administration is not exploring every avenue "to make drug treatment available to everyone who needs it" [op-ed, Jan. 26]. He further says, "Few communities have the resources even to treat the drug addicts they jail."

There is clear evidence that the administration takes this problem very seriously. For example, President Clinton is about to propose the largest ever increase for drug treatment directed to the most intractable part of the problem—the chronic hard-core drug users—in his Fiscal Year 1995 budget. In that budget request, our administration will also ask Congress to allow us to maintain existing resources in the substance abuse services block grant to serve such "priority populations" as pregnant women and intravenous drug addicts.

Above and beyond that, the president is prepared to ask for significantly more funds in the treatment category to address the needs of these chronic hard-core drug addicts. This is the population that drug policy experts agree is the most challenging to significantly reduce drug abuse.

Those criminals who are addicts must get treatment. Evidence shows that drug treatment for prisoners cuts recidivism in half and is very cost-effective. The crime bill establishes a schedule for treatment of federal drug-addicted prisoners, requires drug testing of federal offenders on post-conviction release, and increases penalties for drug use and trafficking within federal prisons.

In fact, we can take the president's commitment to expand treatment options a step further. The administration's health care reform proposals include provisions to cover substance abuse treatment. For the first time, substance abuse treatment will be available to all Americans, and there will be no lifetime limits on preexisting conditions that deny coverage to those in need. These components—a chronic hard-core treatment strategy, and enhanced substance abuse treatment through health care reform—together create a comprehensive treatment network.

In the days ahead, as we unveil the national drug strategy, Mr. Broder and other journalists will have ample time to see for themselves the sincerity of the president's commitment. Once all the details are laid out, Mr. Broder will see clearly that getting serious about drug treatment is not a promise that will go unfulfilled.

LEE P. BROWN
Director
Office of National Drug Control Policy
Washington

Let Those Computers Go

Lally Weymouth argued that Clinton administration efforts to relax export restrictions on computers are "good news" for rogue states that "seek" such technology for nuclear weapons development [op-ed, Feb. 4]. In fact, the deregulation was an overdue recognition that the outmoded controls hamstring competitive U.S. companies while doing nothing to advance our nonproliferation agenda.

A newcomer to issues of export controls and nonproliferation might conclude on the basis of Mrs. Weymouth's article that computers are a magic wand for producing nuclear weapons. Wrong. In the words of the August 1993 Office of Technology Assessment report on nonproliferation, computers are "not required" and are of "minimal importance" in developing nuclear weapons. (By the way, they are of even less utility for chemical-biological weapons and missiles.)

But why trust the OTA? In April 1992, the 27 countries of the Nuclear Suppliers Group, in approving a landmark set of controls on "choke point" nuclear technologies, pointedly rejected controls on computers, which could not compete with specialized nuclear materials, oscilloscopes, isostatic presses, lasers and the like for a slot on the control list. If computers were as helpful in nuclear weapons development as the author suggests, Vanuatu might today hold the fate of our planet in its hands.

NSG countries recognized another factor to which the author is oblivious: Computers have become commodity items that slip effortlessly through the export control net. Taiwan, South Korea, Singapore and India, which administer no export controls whatsoever, all produce and export freely the "advanced, high-speed" computers that the author contends are so important for nuclear weapons development. So bring these countries into the international computer export control fold, right? First, try finding a State Department negotiator who doesn't mind getting laughed at.

The author's half-truths turn into outright untruths when she says that pinning out the Coordinating Committee for Multilateral Export Controls (COCOM) will put an end to U.S. veto power over European high-tech sales to developing countries of proliferation concern. Fact: The United States never had such a veto and never will. The COCOM veto applied only to the Soviet Union and its Communist allies.

Mrs. Weymouth's piece is a fine example of how the national press, in its quest to simplify matters for the lay person, fouls up complicated issues of export control policy. Regrettably, the victim of the distortions has been U.S. business, which loses as much as $37 billion per year in export sales on account of senseless controls.

ERIK C. WEMPLE
Washington

The writer is co-publisher of a newsletter on high-technology exports.

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DRAFT DRAFT DRAFT February 9, 1994
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PUBLIC HEALTH SERVICE
FISCAL YEAR 1995 LEGISLATIVE PROPOSAL

Hard Core ~~Substance Abuser~~ Drug User Program

Dedicate Certain Substance Abuse Prevention and Treatment Block Grant (SAPT) Funds for Treatment of Hard Core ~~Substance Abusers~~ Drug Use

Current Law: Subparts II and III of part B of title XIX of the Public Health Service Act outline the conditions under which States may receive Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, and set out the formula under which the funds are to be distributed.

Funds distributed to States must be spent on drug and alcohol abuse prevention and treatment activities. Under subpart II the States are obliged to expend funds on both drug and alcohol activities, to expend certain percentages of the grant for named populations in special need, and to fund particular activities, such as primary prevention. There is also a maintenance of effort requirement.

Subpart II also sets out the formula under which funds are distributed, and restricts or limits use of funds for certain activities, e.g. States may not spend any more Block Grant funds on activities within State prisons than they spent in 1991, and they may not spend any more than 5 percent of their allotment for administering the block grant.

Subpart III requires States to make their applications and plans available for public comment, and requires the States to conduct audits and carry out peer reviews of their programs.

Proposal: Authorize the Secretary to grant a portion of the funds appropriated for the SAPT Block Grant to States for special efforts to provide treatment services to hard core ~~substance abusers~~ drug users.

These funds would be allotted to the States (including the District of Columbia and the Territories) in the same proportion that they receive SAPT funds now under the formula in section 1933 of the Act.

The funds would be targeted to assist "hard core ~~substance abusers~~ drug users." Such persons are those who:

- abuse drugs ~~and/or alcohol~~ at levels sufficient to cause functional impairment;

- are victims of, or at greatest risk for, the negative consequences of drug ~~and/or alcohol abuse~~, including violence, justice system involvement, infectious disease, abuse, neglect, homelessness, educational dysfunction, unemployment, and other forms of socio-economic dislocation; and

These funds would be subject to the following provisions of the existing block grant legislation:

- section 1922(c), relating to the 5 percent set aside for pregnant women;

- section 1924, relating to tuberculosis services and early intervention services for HIV infection;

- section 1927, concerning priority placement for pregnant addicted women;

- section 1928, regarding improvement of referral systems, continuing education for counselors, and integration of the substance abuse system into the primary health care system in the State;

- section 1929, requiring a needs assessment with a focus on the incidence and prevalence of hard core drug ~~and alcohol~~ abuse in the State, especially substance abusers who are juveniles under court supervision, adults on parole or probation, women with dependent children, and/or living in rural and remote areas;

- section 1930, regarding maintenance of effort.

These funds would be subject to existing requirements in the legislation, modified as follows:

- section 1931(a)(2), but limiting funds for monitoring, evaluation and management of this program to two percent, in place of five percent;

- section 1932(a), (b)(1) and (2), and (c), regarding applications, but applications must include information on the incidence and prevalence of hard core substance abuse, the incidence of drug and alcohol-related emergency room admissions, drug and alcohol toxicology incidence data for arrestees, AIDS and TB incidence data, unemployment rates, rates of homelessness, high school drop-out rates, birth rates for alcohol and drug

3% + SAMHSA for technical assistance to the States

exposed infants, a description of how the State intends to distribute the funds and provide services.

The application for this program would be required to be submitted in conjunction with State applications for SAPT funds.

The funds would also be subject to the following general provisions which apply to both the SAPT and CMHS Block Grants - sections 1941 through 1948, and 1950 through 1952.

Funds available to the Secretary for data collection and technical assistance under sections 505 and 1948, currently five percent, would be limited to three percent for the new program.

The States would be required to submit reports of their activities under the program. The Secretary would determine the elements of the report but it would at a minimum have to include information on the population served, the specific services provided, the costs of the services provided, and the outcome for the individuals served.

The outcome information at a minimum would include the substance abuse status of the individuals at the time of leaving treatment, their educational level, their involvement with the criminal justice system, indications of their social stability, their psychiatric state, their employment status and whether they were positive for hepatitis, tuberculosis, HIV, or any sexually transmitted disease.

Rationale: This program is intended to direct some portion of SAPT block grant funds (for FY 1995, $310 million beyond the basic block grant request) to expand treatment for hard core substance abusers.

Statistics on substance abuse over the past five years have shown a decline in the number of casual users, but the number of hard core users has remained essentially the same. This is a population that requires comprehensive ~~substance abuse~~ treatment services over an extended period of time. ~~Because of its lifestyle, this population is most susceptible to drug-resistant tuberculosis and HIV, and is often in need of extensive primary health care.~~

Services for hard core ~~substance~~ users are expensive, and while States have been providing some treatment services for them under the existing grant programs, the additional funds under the proposed ~~targeted~~ program will allow ~~expansion of these efforts.~~ treatment services for this target population.

The SAPT is being used as a mechanism for the distribution of these funds because it assures that every State will receive funds to address the issue of hard core use, under an existing formula, and will permit States flexibility in deciding how to

use the funds. Distribution in this fashion has lower administrative costs, and the funds would get to the communities faster than under a direct project grant program.

This will be taken care of by Insert 1

While recognizing the cost to the State of administering the program and the need for technical assistance, data collection and evaluation, the limit on State use of funds for monitoring, evaluation and management has been reduced to two percent, and the Federal set aside to three percent in an effort to maximize funds available for services. This assures that 95 percent of the funds the Secretary dedicates to this initiative will be used directly for treatment services.

Many of the requirements of the SAPT Block Grant and their associated regulations will apply to the new program. The existing requirements pertaining to priority placement of pregnant women, and provision of tuberculosis services and early intervention services for HIV, are especially important for the hard core drug use population.

Restrictions on the use of these funds in State penal or correctional facilities would continue to apply. While the prison population constitutes a large portion of hard core users in the United States and represents a population for whom treatment can have a significant effect, treatment funds for this group should be provided by the Department of Justice. States would be free, however, to use funds in the new program to treat those on parole or probation. The States could also use the funds for treatment in lieu of incarceration.

Effect on Beneficiaries: This new program will provide an additional $310 million dollars to States for the treatment of approximately ~~70,100~~ 74,000 hard core ~~substance abusers~~ users.

Federalism Impact: None. The mandates and restrictions placed on these funds are basically the same as those placed on the SAPT block grant funds.

Authorization Level: (millions)

FY 1995	FY 1996	FY 1997
$ 310	-- Such Sums As Necessary --	

Contact Person: Joseph D. Faha, Director, Division of Legislation and External Affairs, SAMHSA, (301) 443-4640.

would be stressed, and SAMHSA will increase efforts to cooperation with other agencies in developing and co-funding programs designed to achieve their multiple goals for the same target populations.

FUNDING FOR HARDCORE SUBSTANCE ABUSE TREATMENT INITIATIVE

- A total increase of $345.0 million is requested for the treatment of hardcore addicts. Of this amount, $310.0 million will be distributed to the States through the block grant and $35.0 million will be distributed on a competitive basis.

- The additional $310 million will be awarded using a revised State block formula, focusing exclusively on hardcore drug abuse. States will have considerable latitude to flexibly use these new resources to meet local priorities for this population. States will be required to address hardcore indicators in their applications and plans, and to adhere to current provisions governing access and quality of care on the public health model. Monitoring, oversight, and reporting requirements will help guarantee that these funds are targeted on the hardcore population.

- Up to 2 percent of the States' allocation could be used to strengthen and extend State and local data collections systems to build their capabilities to determine need, track trends in prevalence, monitor service capacity, utilization, and outcomes for hardcore addicts. States would be able to build data and program monitoring systems and human resources. The hardcore initiative would also permit SAMHSA to use a 3 percent set-aside to provide technical assistance to States and local service providers to develop flexible, low cost, high utility data systems for tracking hardcore addicts that also meet State and Federal needs for comparability across regions and States.

- A total of $35.0 million would be redirected from existing CSAT demonstration programs and focused on projects to develop and test models for integrating service systems for persons with severe addictions into primary health and specialty substance abuse treatment systems. Health care reform will facilitate the rapid development of primary health care systems. Managed care systems have either avoided or excluded persons with severe addictive disorders, or have had little treatment success. Demonstrations are needed of different models of integrating substance abuse services into managed care systems, and the impact of different linkage systems on treatment outcomes.

CONSOLIDATION OF DEMONSTRATION AUTHORITIES FOR SUBSTANCE ABUSE TREATMENT AND SUBSTANCE ABUSE PREVENTION

- The first component of the proposal is the consolidation of the multiple Center demonstration authorities into a single one for each Center, to be accomplished through a legislative proposal. This will reduce the number of discrete grant announcements for drug control programs issued by SAMHSA, simplify application procedures for prospective CSAT and CSAP grants, and improve the efficiency of the grant review process. Priority populations and issue areas, such as individuals in the criminal justice system and the provision of services under Health Care Reform, will continue to be separately identified and supported within the consolidated program. Activity tables are included in the budget which project the distribution of funding among priority areas within the treatment and prevention demonstration programs.

FUNDING FOR WOMEN'S ACTIVITIES

- The 1995 budget will redirect $20.9 million from expiring PPW1 grants to fund initiatives which focus on women, including: $10.0 million to continue and expand prevention activities which focus on adolescent women; $4.0 million for intervention strategies specifically targeted on women in life transitions; $1.9 million to redesign the CSAP National Resource Center to become the National Women's Resource

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Divider Title: _____

II. Treating America's Drug Problem

Treating America's drug problem must start with an aggressive effort to finally break the cycle of hardcore drug use. Drug dependence is a chronic, relapsing disorder characterized by a strong desire or craving for drugs. Such dependence is difficult to extinguish once it has been established. Hardcore drug users often suffer extreme physical, psychological, emotional, economic, and social pain and are, in many ways, removed from society. Their addiction affects not only them, but their families, friends, and all of society. But even the chronic or hardcore user can successfully travel the path to recovery if that path is properly illuminated. It is the intention of this *Strategy* to finally take the steps that are needed to illuminate that path and to remove as many of the pitfalls as possible so that, in the end, the individual, familial, and societal costs of drug use are reduced and the dismal cycle of drug abuse is broken for as many as possible.

The *1994 National Drug Control Strategy* proposes an increase of $355 million to expand treatment opportunities for these hardcore users—the largest such effort to date. Providing treatment is both a compassionate and pragmatic course of action. According to the National Institute on Drug Abuse (NIDA), every dollar spent on drug treatment saves $7—$4 in reduced costs to the public and $3 in increased productivity.[1] Drug-using offenders are also responsible for a disproportionate amount of crime, and the frequency and severity of their criminal activity rises dramatically during periods of heavy or addicted use.

Although most recent concern with violence has understandably focused on the brutality attendant to drug trafficking and the weapons involved, there is long-standing evidence that heavy drug use itself spawns violent behavior. This was underscored by a recent PRIDE (Parents' Resource Institute for Drug Education) survey of over 10,000 middle and high school students in a large urban school district; the survey demonstrated that drug users were 3 to 20 times more likely than nonusers to carry guns to school. Preliminary analysis of survey data suggests similar correlations between drug users and gang activity, threatening behavior, and teen suicide.[2] A survey of hardcore drug users not in treatment in 1992 found that more than 50 percent were involved in illegal activity during the 30 days prior to their participation in the survey; 10 percent derived their income solely from illegal sources. Recent detailed studies of violent crime and homicide have found about 50 percent to be in some way drug related.[3]

Fortunately, entry into drug treatment has been shown to have an immediate impact on the levels of drug use and associated crime, while retention in drug treatment has an even greater impact. Major longitudinal studies have shown repeatedly that drug use and criminal activity decline upon entry into treatment and remain below pretreatment levels for up to 6 years after completion of treatment. Studies of opiate addicts found an average reduction in daily narcotics use of 85 percent during treatment and a 40-percent decrease in property crime. A related study of eastern seaboard cities found that the number of annual "crime days" (i.e., days criminally active) per treatment participant dropped from 307 days the year before treatment to about 21 days after 6 months in treatment—a 93-percent reduction. A recent study of methadone treatment participants in the Midwest found a 75-percent reduction in

criminal activity for all entrants and an 85-percent reduction for those who remained in treatment for 1 year.[4]

Treatment programs designed to deal directly with violence are showing promise. One example is the Violence Interruption Program of Chicago's Treatment Alternatives to Street Crime (TASC). The program attempts to break the cycle of drug use and violence among young male and female drug users and gang members through intensive training and counseling conducted in a day reporting program.

An example of a large-scale comprehensive program to link treatment of hardcore users and criminal justice is the Texas Criminal Justice Treatment Initiative. Begun in 1991 and still in the early stages of implementation, this prison-based effort incorporates assessment, treatment, and transition to the community with strong offender management to avoid relapse and recidivism.

The Administration will continue to support drug treatment as a means to reduce crime and violence by promoting strong linkages between treatment and the criminal justice system, supporting aggressive outreach to get hardcore users into treatment, ensuring strong management and monitoring to foster treatment retention, and demonstrating interventions designed specifically for those at risk of violence.

Final passage of the crime bill will help foster drug treatment, drug testing, graduated sanctions, and offender management programs as integral parts of the criminal justice response to drugs. The criminal justice system will be better linked to treatment services to ensure the safe and effective reentry of drug-using offenders into the community and to reserve prison space for those who represent a threat to public safety. Through TASC and TASC-like management programs, courts will be able to divert users into treatment, monitor treatment progress, and condition either pretrial release or probation on participation in drug treatment. In concert with corrections officials, courts can secure needed treatment for those who must be incarcerated and ensure proper transition and community treatment and supervision for those released from prison or jail programs of "coerced abstinence." These programs need to include swift and sure sanctions, including return to prison and mandatory treatment if an offender lapses into renewed drug use.

Just as the criminal justice system provides many opportunities to identify and offer treatment interventions to drug-using offenders, the justice system on a broader scale, provides multiple opportunities to link drug users to treatment services. Hardcore users often encounter noncriminal legal problems that end up in traffic, divorce, family, domestic, and other noncriminal courts. The *Strategy* supports efforts to identify and treat heavy drug-using adults and juveniles who come into contact with the justice system through both noncriminal and criminal courts.

TARGETING DRUG TREATMENT TO POPULATIONS MOST IN NEED

Expanded treatment capacity will be targeted to those areas and populations most in need and will include support for the provision of vocational and support services as well as training for treatment program staff. Certain populations have had limited opportunities training for treatment, have faced numerous practical obstacles to treatment entry and retention, or have been difficult to reach. Thus, while maintaining support for effective existing programs, the *Strategy* will target new and existing treatment resources to address the problems of underserved and priority populations such as low-income citizens, pregnant addicts, addicted women, adolescents within the criminal justice system, and injecting drug users.

As a related matter of national policy, the Administration will continue to press for a health care reform package that emphasizes preventive care, especially for women, young mothers, and children. A companion public health initiative will target prevention, education, and treatment initiatives for those communities most in need to help them reestablish a stable and productive environment for their citizens.

The Department of Health and Human Services (HHS) will work with State substance abuse agencies and service providers to increase outreach efforts and comprehensive treatment services to substance abusing women, including homeless women. HHS also will provide comprehensive treatment services to children of substance abusing women.

EXPANDING THE CAPACITY TO TREAT DRUG USERS

Recent estimates suggest that as many as 2.5 million users could benefit from treatment. Most (about 2.1 million) are addicted to cocaine, especially crack-cocaine, often in combination with other illegal drugs and alcohol. Finally, heroin—the nemesis of previous decades—now claims about 600,000 addicts and has been showing signs of a potential comeback.

Not every user needs long-term treatment. For some, testing and monitoring are enough;[5] for others, self-help groups have proven effective. But the majority of addicts and hardcore users need intensive, continuous, and often long-term help. Currently the treatment system does not have the capacity to provide treatment for all who need it. Today the capacity is available to treat roughly 1.4 million drug users—1.1 million fewer than the total in need of treatment. Although most people who need treatment do not actively seek it, if everyone who needs and could benefit from treatment were to seek it this year, the treatment system could only serve about 60 percent.

The budget proposed to carry out this *Strategy* will add capacity sufficient to treat an additional 140,000 hardcore users next year. This is a significant start, because the provision of intensive treatment to these addicts and hardcore users—offered in concert with targeted prevention and enforcement programs—will begin to reduce the total population in need of treatment. The long-term strategy is to provide additional resources at a rate and in a manner that will best enable the treatment system to expand the delivery of effective services.

BRINGING DRUG TREATMENT SERVICES INTO THE MAINSTREAM OF HEALTH CARE

Health care reform is important to the long-term National Drug Control Strategy, and significant benefits would be provided by the President's proposed Health Security Act. Ultimately substance abuse services should be fully incorporated into the Nation's health care system; this is envisioned, under the Health Security Act, by the year 2001.

Even in its early stages of implementation, the Health Security Act will improve access and remove obstacles to drug treatment. The Health Security Act will extend basic substance abuse benefits to many more Americans than are covered today. Persons with addictive disorders who have frequently been unable to secure health insurance because of preexisting conditions relating to their addiction will no longer be excluded. People who use treatment services will no longer face the lifetime limits common to many policies. The Act also includes, under companion public health initiatives, support for essential activities—such as transportation, outreach, patient education, and translation services—that will remove other barriers to treatment participation.

The substance abuse benefit under the Health Security Act is designed to encourage the most effective treatment in the least restrictive environment (e.g., community-based care rather than inpatient hospital care). To accomplish this, States are challenged to make full, coordinated use of all available treatment resources. The Administration will provide leadership and technical assistance to ensure successful implementation.

Specifically, through initial limits on the number of days and the number of visits and a benefit substitution approach, the Health Security Act will spur treatment programs to implement better assessment, treatment-patient matching, treatment progress monitoring, and transition planning. The Act uses 30 days of inpatient coverage as the annual coverage base and allows the substitution of 1 inpatient day for 2 days of intensive

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Divider Title: _____

SUPPLY AND DEMAND RESOURCES

The Anti-Drug Abuse Act of 1988 requires the Director of the Office of National Drug Control Policy (ONDCP) to report on spending for programs dedicated to supply reduction and demand reduction activities. The $1.0 billion increase in the FY 1995 request provides additional resources for both supply reduction and demand reduction programs. However, the bulk of the increase in total resources is for demand reduction programs, which increase by more than 18 percent, as compared with supply reduction programs, which increase by only 3 percent.

Of the total $13.2 billion request, $7.8 billion is for supply reduction programs and $5.4 billion is for demand reduction programs. The percentage of resources for supply reduction has fallen below 60 percent for the first time. The FY 1995 budget provides 59 percent of total budgeted resources for supply reduction and 41 percent for demand reduction programs. This reflects a dramatic shift in program emphasis in favor of treatment and prevention programs. It also demonstrates the Administration's commitment to closing the gap between funding for supply reduction and demand reduction programs.

MAJOR DRUG BUDGET INITIATIVES

Four major budget initiatives are included in the FY 1995 request. The first two initiatives focus on reducing the demand for illicit drugs through treatment and prevention programs. The third initiative provides resources to communities to confront the problems of drug use and its health and crime consequences, particularly for youth and hard-to-reach populations. The last initiative enhances international programs to give producer countries the means to attack the problems of drug production and trafficking at the sources.

1. Reducing Hardcore Drug Use Through Treatment. First, the FY 1995 budget request focuses on increasing funding for programs that diminish drug use by providing additional funding for those programs that are most effective in reducing drug use, particularly for the hardcore drug using population. As has been stated in the *Strategy*, hardcore drug use fuels the continued high demand for illicit drugs and is linked to the high level of crime that occurs, especially in inner cities. Further, studies link hardcore drug use and HIV/AIDS (human immunodeficiency virus/ acquired immune deficiency syndrome) transmission. Injecting drug users and their sexual partners account for nearly one-third of the reported AIDS cases and, in cities where the rate of HIV is high, women trading sex for crack-cocaine also have been identified as a growing source of HIV/AIDS transmission.

It is for these reasons that the *Strategy* makes the reduction of drug use by hardcore users its number-one priority.

The total 1995 funding request for drug treatment programs is $2.9 billion, an increase of $360 million (14 percent). Of this increase, $355 million is targeted specifically for programs to reduce hardcore drug use and includes the following elements:

- $310 million for the Department of Health and Human Services (HHS) Substance Abuse Prevention and Treatment Block grant;
- $35 million for a new treatment demonstration program at HHS for the hardcore population; and
- $10 million for the expansion of treatment services for American Indian and Alaska Native populations.

It is anticipated that these additional funds will provide treatment for up to an additional 74,000 hardcore drug users.[2]

Furthermore, it is expected that the enactment of the Crime Bill will provide substantially more resources for treatment of prisoners. It is estimated that funding provided by the Violent Crime Reduction Trust Fund could provide resources to treat as many as 65,000 additional hardcore drug users in prisons.

These initiatives will specifically support the following goals:

- Goal 1 by reducing the number of drug users. In this particular case, the number of hardcore drug users will be reduced significantly. The $355 million treatment initiative, coupled with resources expected from the Crime Bill, will enable as many as 140,000 additional hardcore drug users, both in and out of the criminal justice system, to receive drug treatment.

- Goal 2 by closing the treatment gap by 9 percent by 1996. The treatment gap will continue to close by like amounts thereafter if resources for treatment are maintained. The Administration will continue to support additional resources in the future to close the treatment gap as well as to provide adequate capacity so that all those who seek treatment can receive it.

- Goal 9 by targeting hardcore drug users. Drug-related crime and violence will be reduced.

2. Ensuring Safe and Drug-Free Schools by Improving Prevention Efficacy. Drug use and drug-related violence interfere with learning in schools. Accordingly, to create safe and drug-free environments, the FY 1995 request includes $660 million for school-based drug and violence prevention programs, an increase of $191 million over the FY 1994 level for two programs within the Department of Education: the Safe and Drug-Free Schools and Communities State Grant Program and the Safe Schools Program.

This initiative will ensure that children can attend schools that are free of crime and violence. Under the FY 1995 request, every student in grades K–12 will have the opportunity to receive violence and drug and alcohol use prevention education. Further, these new programs will allow for the procurement of metal detectors and the hiring of security personnel in school districts that demonstrate high levels of drug-related crime as well as other crime and violence problems.

It is estimated that more than 40 million youths are exposed to prevention programs annually; this initiative will provide more comprehensive programs than ever before. It specifically supports the following goals:

- Goal 1 by reducing the number of drug users. Once they are in safe learning environments, children can benefit from the prevention message. The 1992 Monitoring the Future Survey found drug use on the rise among students. This initiative seeks to reverse the recent increase in drug use among children.

- Goal 4 by helping communities develop effective prevention programs. By providing safe living and learning environments for youth, communities can ensure that every child in grades K–12 can participate in drug, alcohol, and violence prevention education.

[2] The 74,000 users targeted for treatment from the $355 million initiative are those most likely to require extensive residential treatment and aftercare. This distinguishes them from those users generally supported by the Substance Abuse Block Grant, who tend to receive treatment on a less costly out-patient basis. However, given the health and crime consequences associated with those most addicted, this initiative targets these users to reduce such consequences.

would be stressed, and SAMHSA will increase efforts to cooperation with other agencies in developing and co-funding programs designed to achieve their multiple goals for the same target populations.

FUNDING FOR HARDCORE SUBSTANCE ABUSE TREATMENT INITIATIVE

- A total increase of $345.0 million is requested for the treatment of hardcore addicts. Of this amount, $310.0 million will be distributed to the States through the block grant and $35.0 million will be distributed on a competitive basis.

- The additional $310 million will be awarded using a revised State block formula, focusing exclusively on hardcore drug abuse. States will have considerable latitude to flexibly use these new resources to meet local priorities for this population. States will be required to address hardcore indicators in their applications and plans, and to adhere to current provisions governing access and quality of care on the public health model. Monitoring, oversight, and reporting requirements will help guarantee that these funds are targeted on the hardcore population.

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FUNDING FOR WOMEN'S ACTIVITIES

- The 1995 budget will redirect $20.9 million from expiring PPWI grants to fund initiatives which focus on women, including: $10.0 million to continue and expand prevention activities which focus on adolescent women; $4.0 million for intervention strategies specifically targeted on women in life transitions; $1.9 million to redesign the CSAP National Resource Center to become the National Women's Resource

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Divider Title: _____

Hard Core Drug Treatment Initiative m:\shardata\dfm\kade\345

Impact on Treatment Capacity

Program Component	Amount of Funding	No. of Slots	No. of Persons
Services	$310,000,000	11,260	22,922
Demonstrations	$35,000,000	669	1,362
Total Package	$345,000,000	11,929	24,284

Assumptions: $26,155/slot; $12,848/person; 2.035 throughput; 5% set-aside

Source of Funding

Funding Components	$240 M Passback	$45 M For. Funds	$60 M Demo Base	Total Amount
Formula Grant	$240,000,000	$45,000,000	$25,000,000	$310,000,000
Demonstrations	$0	$0	$35,000,000	$35,000,000

Weighted Average Annual Cost per Slot

Treatment Modality	Cost/slot	Pop Distrib	Wt. Av. Cost/slot
Outpatient	$5,500	10%	$550
Outpatient/medical	$7,700	15%	$1,155
Intensive Non-Resid	$31,000	45%	$13,950
Residential	$35,000	30%	$10,500
			$26,155

Weighted Average Annual Cost per Person

Treatment Modality	Cost/slot	Throughput	Cost/Person	Pop Distrib	Wt. Av. Cost/Person
Outpatient	$5,500	3.0	$1,833	10%	$183
Outpatient/medical	$7,700	1.5	$5,133	15%	$770
Intensive Non-Resid	$31,000	10.0	$3,100	45%	$1,395
Residential	$35,000	1.0	$35,000	30%	$10,500
					$12,848

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Divider Title: _____

General Statement

	1993 Actual	1994 Appropriation	1995 Estimate	Increase or Decrease
CMHS	$384,880,000	$417,102,000	$417,102,000	—
CSAP	244,243,000	253,471,000	253,471,000	—
CSAT	1,350,609,000	1,417,357,000	1,702,357,000	+$285,000,000
Prog. Mgmt	57,820,000	61,296,000	61,296,000	—
B&F	952,000	952,000	—	-952,000
Total	$2,038,504,000	$2,150,178,000	$2,434,226,000	+$284,048,000
FTE	762	748	703	-45

The Substance Abuse and Mental Health Services Administration (SAMHSA) was established on October 1, 1992 pursuant to the ADAMHA Reorganization Act. The agency is responsible for fostering improvements in mental health, alcoholism, and other drug abuse prevention and treatment services throughout the country, primarily through categorical grants and block grants to States. The 1995 budget request includes a total of $2,434,226,000 and 703 FTEs, reflecting an increase of $284,048,000 and a reduction of 45 FTEs from the 1994 appropriation. This amount, which includes $45,000,000 proposed for transfer from the ONDCP Drug Forfeiture Fund, represents a net increase of 13.2%.

SAMHSA's mission is to provide national leadership in policy, services, and knowledge transfer for mental health, alcohol, and other drug abuse prevention and treatment throughout the country. In order to achieve this, SAMHSA conducts programs to: 1) reduce the incidence and prevalence of addictive and mental disorders and improve treatment outcomes for persons suffering from these disorders; 2) improve access to high quality and effective services; and 3) provide national leadership to ensure the most efficacious use of knowledge, based on science and service program evaluations, in preventing and treating addictive and mental disorders.

The 1995 President's Budget request proposes straightlined funding for most SAMHSA programs at the 1994 level of operations. The 1995 budgets for three major components, the Center for Mental Health Services, the Center for Substance Abuse Prevention, and Program Management are identical to the amounts appropriated by Congress for fiscal year 1994. Several new efforts to be undertaken within last year's funding levels are described in the Center narratives which follow.

The 1995 budget proposes one increase, $310,000,000 to fund a Hard Core Treatment Initiative, offset by a reduction of $25,000,000 in ongoing treatment demonstration activities. Of this amount, $45,000,000 is proposed to be transferred to SAMHSA from the ONDCP special forfeiture fund. Approximately $35,000,000 in substance abuse treatment demonstration funds will also be directed to demonstrations that focus on hard core users, for a total Initiative of $345,000,000. An additional $952,000 cut in building maintenance support reflects the proposed transfer to the District of Columbia of all buildings on the Saint Elizabeths campus other than those which continue to be required by the Federal government. The FTE reduction reflects a cut of 20 reimbursable FTEs from Saint Elizabeths Hospital and 25 FTEs from headquarters components to help meet the President's goal of reducing Federal employment.

Hard Core Treatment Initiative

A total of $345,000,000 is requested for a major program expansion to focus on treatment for hai core populations. Of this amount, $310,000,000 will be awarded to the States through the substanc abuse block grant mechanism for treatment services and $35,000,000 will be awarded on a competitiv basis for demonstrations addressing hard core treatment, and issues related to Health Care Refor

The Hard Core Treatment Initiative is expected to have a major impact on reducing substance abu throughout the country, and particularly in areas such as inner cities with an especially difficult dr problem. Secondary impacts of the program are anticipated reductions in violent crime, tuberculos and HIV/AIDS. Taken as a whole, the 1995 SAMHSA budget could support as many as 118,6 treatment slots, an increase of 30,884 (35%) over the 1994 budget due to this initiative. An estimat 60,092 additional individuals will receive treatment services through SAMHSA-funded progran These estimates assume a minimum annual treatment cost of $4,289 per hard core user[1], a figu considerably higher than that of a typical drug user, $2,300[2]. The higher cost represents the long and more intensive cost of treating these individuals.

The $310,000,000 will be awarded in the same proportion that States (including the District Columbia and the Territories) receive the base Substance Abuse Block Grant funds, but with exclusive focus on the treatment for hard core populations. States will have considerable latitude use these new resources to meet local priorities for hard core drug users. States will be required provide a needs assessment based on hard core indicators in their applications and plans, and adhere to current provisions governing access and quality of care on the public health mod Monitoring, oversight, and reporting requirements will help guarantee that these funds are target on the hard core population. A legislative proposal will be submitted to Congress authorizing t targeted program. The budget request also proposes that $82,200,000 not be obligated u September 19, 1995, in order to prevent excessive outlays during the fiscal year.

Up to two percent of the States' allocation could be used to strengthen and extend State and lo data collections systems to build their capabilities to determine need, track trends in prevalence, a monitor service capacity, utilization, and outcomes for hard core addicts. The Hard Core Treatm Initiative also includes a 3 percent set-aside to provide technical assistance to States and local serv providers, and to develop flexible, low cost, high utility data systems for tracking hard core addi that also meet State and Federal needs for comparability across regions and between States.

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[1] Slot cost of $8,729 divided by throughput of 2.035

[2] Slot cost of $5,819 divided by throughput of 2.53

Substance Abuse and Mental Health Services Administration
Substance Abuse Block Grant Distribution

State/Territory	1993 Appropriation	1993 Actual [1/]	1994 Appropriation	1995 Base Sub Abuse Block Grant	1995 $310 Million Hard Core [2/]	1995 Total Estimate
Rhode Island	5,824,784	4,952,784	5,824,784	4,330,917	1,164,592	5,495,509
South Carolina	13,054,088	12,829,637	13,886,098	14,119,501	3,796,761	17,916,262
South Dakota	2,984,646	1,887,213	2,984,646	2,128,516	572,362	2,700,879
Tennessee	16,919,528	15,342,812	18,140,637	18,445,552	4,960,044	23,405,596
Texas	70,164,653	70,164,653	75,181,608	76,445,289	20,556,284	97,001,572
Utah	8,500,272	8,500,272	8,562,656	8,706,580	2,341,216	11,047,796
Vermont	3,110,892	1,900,825	3,110,892	2,163,655	581,811	2,745,466
Virginia	24,233,472	24,233,472	25,632,420	26,063,259	7,008,460	33,071,719
Washington	23,188,841	23,188,841	24,807,591	25,224,557	6,782,934	32,007,501
West Virginia	6,545,009	5,489,633	7,036,752	7,155,029	1,924,001	9,079,029
Wisconsin	18,674,361	18,674,361	19,761,129	20,093,282	5,403,122	25,496,404
Wyoming	1,261,466	1,261,466	1,391,414	1,414,801	380,443	1,795,244
American Samoa	180,808	180,808	188,749	195,511	52,573	248,084
Guam	514,720	514,720	537,326	556,574	149,664	706,238
N. Mariana Islands	167,557	167,557	174,916	181,182	48,720	229,902
Puerto Rico	13,614,985	13,614,985	14,212,957	14,722,073	3,958,794	18,680,867
Palau	58,456	58,456	61,024	63,210	16,997	80,207
Marshall Islands	172,929	172,929	180,525	186,992	50,282	237,274
Micronesia	409,385	409,385	427,365	442,673	119,036	561,709
Virgin Islands	990,912	520,912	990,912	425,560	114,434	539,994
Total Intrastate/Territory Allotments	1,073,983,550	1,051,772,767	1,118,251,650	1,118,251,650	300,700,000	1,418,951,650
Set-Aside	56,525,450	56,525,450	58,855,350	58,855,350	9,300,000	68,155,350
Total	$1,130,509,000	$1,108,298,217	$1,177,107,000	$1,177,107,000	$310,000,000	$1,487,107,000

1/ The FY 1993 actual reflects net transfers by the States of $22,210,873 to the MH Block Grant, as allowed by Section 205 (b), P.L. 102-321.

2/ These funds will be used exclusively to provide treatment for hardcore users. States will have considerable latitude and flexibility to use these new resources to meet local priorities for the hardcore population. To focus these new funds on treatment services, they will not be subject to several of the existing mandates of the current block grant.

Funds are allocated to each State according to a statutory formula based on the State's population, the State's total taxable resources, and a "cost of services index" for each State, with award levels subject to a residual "hold-harmless" provision. The State is eligible to receive the greater of the amount calculated by the formula or 79.6 percent of the 1992 ADMS allotment. Territories are to receive a share of 1.5 percent of the total available for block grant awards.

Rationale for the Budget Request

The 1995 request continues funding for this activity at the 1994 level plus an additional $310,000,000 to focus states on priority treatment services to hard core users. The request continues to provide support for the 18 FTEs providing direct technical assistance to States which are supported by the block grant set-aside funds. Thirteen States and Territories participated in the SSDP in 1992; four participated in 1993; fourteen will participate in 1994; and, twenty-nine more will be added in 1995, which will complete the first cycle of needs assessments for all States and Territories.

The new funds of $310,000,000 would be allotted to the States (including the District of Columbia and the Territories) in the same proportion that they receive base Substance Abuse Block Grant funds; however, the additional $310,000,000 will have an exclusive focus on the treatment of hard core populations. States will be required to address hard core indicators in their applications and plans, and to adhere to current provisions governing access and quality of care on the public health model. Monitoring, oversight, and reporting requirements will help guarantee that these funds are targeted on the hard core population, and that they will be used to meet the treatment needs of persons where abuse poses significant health and safety threat to themselves and to society.

Up to two percent of the States' allocation from the additional $310,000,000 could be used to strengthen and extend State and local data collections systems to build their capabilities to determine need, track trends, in prevalence, monitor service capacity, utilization, and outcomes for hard core addicts. States would be able to build data and program monitoring systems and add human resources. The Hard Core Treatment Initiative would also permit SAMHSA to use a three percent set-aside to provide technical assistance to States and local service providers to develop flexible, low cost, high utility data systems for tracking hard core addicts that also meet State and Federal needs for comparability across regions and States. The latter will focus mainly on providing additional resources for the State Systems Development Program (the SSDP).

Two legislative changes will impact the Substance Abuse Block Grant program in 1995. The "hold harmless" provision will terminate, thus changing State allocation percentages, and the provision permitting transfers to and from the Mental Health Block Grant will expire. Since the latter usually resulted in a new flow of grant dollars out of the substance abuse area, more funds are expected to be available nationwide in 1995.

A total of $1.6 billion is requested for drug-related activities, including $437.3 million for prevention and $1.2 billion for treatment. This represents an increase of $287.3 million, including an increase of $345.0 million to fund treatment services focusing on hard core populations, offset by a decrease of $60.0 million in ongoing treatment demonstration activities. Overall funding for demonstration activities is reduced by $25.0 million which is redirected to the block grant. In addition, $7.5 million of block grant set-aside funds earmarked in 1994 for State grants are restored to CSAT and OAS in 1995 for technical assistance and data collection activities, increasing total drug funding by an additional $2.3 million.

- Consolidation of Demonstration Authorities for Substance Abuse Treatment and Substance Abuse Prevention

  The first component of the proposal is the consolidation of the multiple Center demonstration authorities into a single one for each Center, to be accomplished through a legislative proposal. This will reduce the number of discrete grant announcements for drug control programs issued by SAMHSA, simplify application procedures for prospective CSAT and CSAP grantees, and improve the efficiency of the grant review process. Priority populations and issue areas, such as individuals in the criminal justice system and the provision of services under Health Care Reform, will continue to be identified and supported within the consolidated program. Activity tables are included in this budget which project the distribution of funding among priority areas within the treatment and prevention demonstration programs.

- Funding for Hard Core Treatment Initiative

  A total of $345,000,000 is requested for the treatment of hard core addicts. Of this amount, $310,000,000 will be awarded to the States through the block grant and $35,000,000 will be awarded on a competitive basis.

  The additional $310,000,000 will be awarded using the current State block formula, but with an exclusive focus on treatment of hard core populations. States will have considerable latitude to flexibly use these new resources to meet local priorities. States will be required to address hard core indicators in their applications and plans, and to adhere to current provisions governing access and quality of care on the public health model. Monitoring, oversight, and reporting requirements will help guarantee that these funds are targeted on the hard core population.

  Up to two percent of the States' allocation could be used to strengthen and extend State and local data collections systems to build their capabilities to determine need, track trends, in prevalence, monitor service capacity, utilization, and outcomes for hard core addicts. States would be able to build data and program monitoring systems and human resources. The Hard Core Treatment Initiative would also permit SAMHSA to use a 3 percent set-aside to provide technical assistance to States and local service providers to develop flexible, low cost, high utility data systems for tracking hard core addicts that also meet State and Federal needs for comparability across regions and States.

  A total of $35,000,000 would be redirected from existing CSAT demonstration programs and focused on projects to develop and test models for integrating service systems for persons

with severe addictions into primary health and specialty substance abuse treatment systems. Health care reform will facilitate the rapid development of primary health care systems. Managed care systems have either avoided or excluded persons with severe addictive disorders, or have had little treatment success. Demonstrations are needed of different models of integrating substance abuse services into managed care systems, and the impact of different linkage systems on treatment outcomes.

- Funding for Women's Activities

A total of $20,939,000 will be used to fund initiatives which focus on women, including: $10,000,000 to continue and expand prevention activities which focus on adolescent women; $4,000,000 for intervention strategies specifically targeted on women in life transitions; $1,939,000 to redesign the CSAP National Resource Center to become the National Women's Resource Center and expand its perspective to include women of all ages and conditions; $3,000,000 to develop and implement a women's education campaign to prevent alcohol and other drug use during pregnancy; and, $2,000,000 to train health providers to instruct female patients on the risks of combining alcohol and other drugs and prescription drugs.

- Treatment Slots

The 1995 Budget will fund up to 118,698 treatment slots. This represents an increase of up to 30,884 slots above the 1994 appropriation. This increase reflects an additional 36,453 slots for the Hard Core Treatment Initiative, offset by a reduction of 5,569 slots resulting from inflation and the redirection of funding to the Hard Core Treatment Initiative. These slots will result in the treatment of up to an additional 60,092 persons, reflecting an additional 74,182 persons funded from the Hard Core Treatment Initiative offset by a reduction of 14,089 from other programs. Estimates for the Hard Core Treatment Initiative may vary depending on the mix of treatment modalities to be offered by the States through the block grant and by SAMHSA in the new hard core demonstration grants.

- Block Grant Transfers

Section 205 (b) of P.L. 102-321 authorizes States to request the transfer of funds between the Mental Health and the Substance Abuse block grants. A total of $22,210,783 was transferred from the Substance Abuse to the Mental Health Block Grant in 1993. This will result in a reduction in funding for the Drug Control Budget in 1993 once the 1993 estimates are adjusted to reflect actual expenditure experience. This provision is also in place for 1994 but is discontinued for subsequent years.

Substance Abuse Block Grant Components
(dollars in thousands)

	1993 Actual	1994 Appropriation	1995 Estimate
Federal Set-Aside ..	$56,525	$51,323 *	$58,855
Prevention Activities	107,398	112,578	111,825
Treatment Activities	402,744	422,169	419,344
State Administration	26,850	28,145	27,956
Sub-Total	593,517	614,215	617,980
Comorbid Sub Abuse	161,098	168,868	167,738
Under 21 Alcohol ..	48,866	51,223	50,880
Sub-Total	209,964	220,091	218,618
Hard Core Treatment Initiative **	0	0	300,700
Hard Core Set-Aside	0	0	9,300
Sub-Total	0	0	310,000
Total	**$803,481**	**$834,306**	**$1,146,599**

* Excludes earmark of $7,532,000 for State allotments.
** Does not include the $35,000,000 Hard Core Treatment Demonstration.

Substance Abuse Block Grant Set-Aside Funds by Activity
(dollars in thousands)

	1994 Appropriation	1995 Estimate
SABG Set-Aside	$51,323 *	$58,855
Hard Core Trmt Initiative Set-Aside	0	9,300
Total Set-Aside	51,323	68,155
Activities:		
Data Collection	23,190	25,690
Technical Assistance	16,362	30,694
Sub-Total	39,552	56,384
Prevention Earmark	11,771	11,771
Total Set-Aside	**$51,323**	**$68,155**

* Excludes earmark of $7,532,000 for State allotments.

Federal Treatment Slot Summary
PHS Budget Summary

	1993 Actual	1994 Appropriation	1995 Estimate	Increase/ Decrease
SAMHSA				
Drug Abuse Slots:				
Block Grant	73,137	74,649	72,060	- 2,589
Demonstrations	13,176	11,445	9,065	- 2,380
Capacity Expansion ...	2,651	1,720	1,120	- 600
Subtotal	88,964	87,814	82,245	- 5,569
(Persons Served) ..	(229,527)	(222,169)	(208,080)	- (14,089)
Hard Core Treatment Initiative & Hard Core Demonstration:				
Slot Estimate	0	0	36,453	+ 36,453
(Persons Served) ..	(0)	(0)	(74,182)	+ (74,182)
Total Slots	88,964	87,814	118,698	+ 30,884
Persons Served ...	229,527	222,169	282,261	+ 60,092
NIDA				
Drug Abuse Slots:				
Clinical Trials	11,370	11,580	11,550	- 30
Persons Served ...	29,335	29,297	29,221	- 76
**Total PHS Slots ..... **	**100,334**	**99,394**	**130,248**	**+ 30,854**
**Persons Served ..... **	**258,861**	**251,467**	**311,482**	**+ 60,016**

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13

Divider Title: _____

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

NOV 17 1993

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

Dear Mr. Panetta:

The enclosed document outlines ONDCP's budget priorities for FY 1995 to support the principal objectives of the President's Interim Drug Control Strategy. This Interim Strategy charts a new, realistic course that will reinvigorate our efforts to prevent drug use before it starts, extend a hand to those who have started, punish those who profit from the misery and tragedy that flows from drug trafficking, and work with those countries, especially the major source and transit countries, that demonstrate the political will and program commitment to combat the drug trade. This proposal presents the funding plan for key initiatives to ensure that the objectives of the Interim Strategy are achieved.

The budget initiatives proposed in the enclosed document put more emphasis than in the past on demand reduction programs, youth drug and violence prevention, and source country programs. A total of $988 million is requested for three major initiatives that are briefly described below. When fully implemented, these initiatives will have a tremendous impact on the most difficult aspect of the drug problem, hard-core drug use and its damaging consequences.

Treatment Infrastructure Service Expansion

The Treatment Infrastructure Service Expansion initiative requests $715 million to provide expanded treatment capacity and more treatment for hard-core drug addicts, both inside and outside the criminal justice system. It will add nearly 51,000 slots and will provide resources so that nearly 126,000 additional persons can receive treatment services they need.

Youth Crime, Violence and Prevention

Drug use is behind much of America's problem with crime and violence. The Youth Crime, Violence, and Prevention initiative requests $200 million to ensure that every child from kindergarten through the twelfth grade will have the opportunity to live productive lives free of crime and violence. This effort provides additional funding for the Safe and Drug-Free Schools and Communities program and for a new initiative to combat teenage drinking.

Source Country Counterdrug Enhancement

The Interim Strategy calls for a controlled shift of emphasis away from the transit zones to the source countries, focusing on programs to achieve democratic institution-building, dismantle organizations, and interdict drugs. The recently signed Presidential Decision Directive (PDD) signals the President's dissatisfaction that source country resources were cut by Congress below their FY 1994 request level. Accordingly, the proposal includes a $73 million initiative in this area to restore and enhance resources for the Bureau of International Narcotics Matters in FY 1995.

These initiatives, along with expected funding from the Crime Bill, will give the Administration the resources it needs to implement its drug control priorities, as articulated in the Interim Strategy. I look forward to working with you in the weeks ahead on this very important issue. Should your staff need any additional information, they should contact John Carnevale, Director of Planning and Budget at 467-9880.

Sincere regards,

Lee P. Brown
Director

Enclosure

Executive Office of the President
Office of National Drug Control Policy

I. OVERVIEW

Background

The Office of National Drug Control Policy (ONDCP) establishes the policies, objectives, and priorities for the National Drug Control Program (the Program). ONDCP provides the President's primary Executive Branch support for drug policy development and program oversight. It advises the President on national and international drug control policies, strategies, and funding levels, and works to ensure effective coordination of drug programs within the Federal government.

A policy statement delineating the major focus of this Administration's National Drug Control Strategy was released in October 1993. The the "Interim Strategy" set forth the Administration's plan to conduct domestic and international drug policy, but did not identify budget resources or provide goals and objectives to implement it. This document defines the resource requirements to implement the President's plan.

The Interim Drug Strategy gives new direction to national efforts to confront the problems caused by illicit drug use and trafficking. It views drug policy as a cornerstone of domestic policy in general, and links it with efforts to spur economic growth, reform health care, curb youth violence, and empower communities. It is distinguished from past Strategies in several key ways:

- It shifts the focus away from the easier part of the drug problem, reducing casual or intermittent drug use, to the most difficult aspect, reducing hard-core drug use and its consequences.

- It views the drug problem not in isolation, but as inextricably linked to other domestic policy issues such as the health of the economy, violence, health care, and family and community stability.

- It recognizes drug dependence as a chronic, recurring disorder requiring treatment and continuing aftercare, and targets all heavy drug users for intensive treatment and supervision to reduce their drug use and its consequences.

- It proposes an aggressive drug treatment strategy to reduce the number of hard-core drug users by expanding treatment capacity in general and for special populations, such as those in the criminal justice system and pregnant drug users.

- It proposes to give all drug users access to treatment services through Health Care Reform and other related initiatives.

- It recognizes the need for grassroots level efforts rather than top down Federal-to-local programs to deal with the drug problem.

- It supports Community Empowerment (local efforts based on strategic, comprehensive plans) as the best way to coordinate government efforts across program and jurisdiction lines. It promotes Community Policing as a necessary first step to halt the cycle of community decay caused by drug use and trafficking and the violence it spawns.

- It supports efforts to reduce ready availability of the guns that play a significant role in drug-related violence. It supports the Brady Bill and proposes to do more by enacting a ban on all domestic assault weapons.

- It views alcohol use, especially underage drinking, as part of the overall drug problem and focuses drug prevention on high-risk populations to deter first-time drug use.

- It recognizes that drug policy must be an integral part of our overseas foreign policy and pursued on a broad front of institution building, dismantling organizations, and source-country interdiction.

The Four Tracks to Successful Implementation

The Interim Strategy proceeds on four basic tracks. The first track is to *concentrate on demand reduction efforts*. This requires that we mount an aggressive drug treatment strategy, with heavy or addicted drug use as our primary focus. By increasing treatment capacity so that those who need treatment can receive it, the Interim Strategy seeks to promote drug treatment programs that are shown to work. It also seeks to link habilitation, social, and vocational services to drug treatment, to ensure that heavy drug users receive the support and learn the skills they need to prevent relapse and recidivism. Finally, health care reform will provide direct substance abuse treatment benefits for inpatient and residential treatment, intensive non-residential treatment, outpatient treatment, and follow-up services. However, until it is enacted, we must not relax our efforts to expand treatment capacity and provide more comprehensive treatment services for those who are in need.

The second track is to *reduce drug-related violence, and control and prevent crime.* This requires we pursue a comprehensive approach to criminal violence, involving law enforcement, educators, substance abuse treatment specialists, and religious and community leaders. Emphasis will be on community policing efforts to involve police officers working with community residents to help resurrect and maintain neighborhoods and lay the foundation for constructive involvement by government, the private sector, and neighborhood residents. And to help curb school violence, we will also seek to address the impact of drugs and violence on our youth. We will teach our school children the skills needed for the positive resolution of conflict, and balance the need for swift, appropriate punishment with the need to set every young person on the right track to productive living. We will push hard to take guns out of the hands of criminals and children.

The third track is to *streamline government and empower communities*. This requires that we seek ways to make communities more active in combating drug trafficking and use, focus Federal efforts to eliminate duplication and waste by government agencies, and review the appropriate roles of Federal, State and local governments in controlling drugs. We will review existing interdiction organizations, resources, and methods; aggressively pursue improvements to our intelligence systems; improve our data collection and research efforts to help Federal, State and local, as well as private organizations obtain the best and most up-to-date information possible about the drug problem; establish performance standards for drug treatment providers; and seek to empower communities to resist drug trafficking and use and repair the damage it has done.

The fourth track is to *provide international leadership and support for international drug control actions*. We will support counternarcotics programs in those source countries that demonstrate the political will to stand against the drug trade, focusing on those programs that work and eliminating those that do not. We will emphasize assistance to international and regional institutions that conduct or support counternarcotics programs. The Interim Strategy calls for a controlled shift of emphasis away from the transit zones to the source countries, focusing on programs to achieve democratic institution-building, dismantle organizations, and interdict drugs.

Conclusion

This Administration is committed to reducing the demand for drugs through comprehensive and aggressive prevention and treatment initiatives, with particular emphasis on heavy drug use and addiction and on seriously at-risk populations. On the supply side, the Interim Strategy calls for a shift in emphasis from the transit zone to source countries to attack the production of drugs and suppress the traffic in drugs aimed at the United States. What is now required is a sufficient resource commitment to fund these priorities and begin a credible program effort.

II. FY 1995 DRUG CONTROL FUNDING PRIORITIES

Overview

The Interim Strategy charts a new, more realistic course that will reinvigorate our efforts to prevent drug use before it starts, extends a hand to those who have started, punish those who profit from the misery and tragedy that flows from drug trafficking, and work with those countries, especially the major source and transit countries, that demonstrate the political will and program commitment to combat the drug trade. This proposal presents the funding plan necessary to implement the most critical elements of the Interim Strategy.

The successful implementation of the Interim Strategy requires a budget that places increased emphasis on demand reduction programs, source country programs, and local law enforcement (Community Policing). This means that some programs that received priority in the past will not receive priority in this Strategy.

Some of the required resources can be reallocated from existing, lower priority programs. For example, the controlled shift in interdiction from a focus on transit zones to one on source countries will result in some reductions in transit zone program funding. In other areas, Administration-supported action on the FY 1994 budget promises to fund key priorities in the Interim Strategy that will carry over into the FY 1995 budget. For example, the Crime Bill will likely result in funding for more *cops on the street*, assuming that such priorities will be funded in FY 1995. However, in other key Interim Strategy program areas, resource enhancements must be provided if critical services are to be provided.

Implementation of the National Performance Review and new program initiatives such as Community Empowerment and National Service program promises to implement key Interim Strategy priorities for Streamlining Government and Empowering Communities. No new initiatives above and beyond what is already covered by these efforts are proposed for FY 1995 in these areas.

There are certain program areas identified in the Interim Strategy that must be funded if the Strategy is to succeed. In some instances, these are top priority Interim Strategy priorities that are not currently funded by other ongoing Federal efforts. In other areas, the existing resource level is inadequate to provide a meaningful, credible effort. This budget proposal identifies $988 million for three major initiatives, which are requested over the FY 1994 enacted levels:

A. **Treatment Infrastructure and Service Expansion** ($715 million): This initiative will provide new funds for expanded capacity to target the treatment needs of hard-core drug users, both inside and outside the criminal justice system, principally for long-term residential treatment. A total of $500 million is proposed for targeted treatment services expansion for those outside the criminal justice system, $150 million for treatment and monitoring targeted at those already within the criminal justice system, $15 million for offender management programs, $35 million for vocational and educational services, and $15 million for training to provide more staff to treat this population. This initiative will add nearly 51,000 new treatment slots

through capacity expansion, and will provide resources so that 126,000 additional persons can receive treatment.

B. **Youth Crime, Violence, and Prevention** ($200 million): Drug use fuels much of America's problem with crime and violence. This initiative provides an additional $180 million for the Safe and Drug-Free Schools and Communities Program. This new reauthorization proposal takes a comprehensive, integrated approach to drugs and violence prevention by recognizing the relationships between drug use and violent behavior. Additionally, $20 million is targeted for a new teenage drinking prevention program component to be carried out jointly by the Center for Substance Abuse Prevention, the Department of Education, and the Department of Transportation. This Youth Crime, Violence, and Prevention initiative ensures that our children will be able to attend school free of crime and violence, and gives them the tools to resist the temptation to use alcohol and other drugs.

C. **Source Country Counterdrug Enhancement** ($73 million): The Interim Strategy calls for a controlled shift of emphasis from the transit zones to the source countries, focusing on democratic institution-building, dismantling drug trafficking organizations, and interdiction closer to the source of production. The recently signed Presidential Decision Directive signals the President's disapproval over the Congressional reductions to source country programs to levels below the FY 1994 request and directs OMB and ONDCP to minimize the effects of these cuts. This initiative proposes increase the FY 1994 request level for the Bureau of INM by $25 million. This requires that $48 million be added to the FY 1994 enacted level plus an additional $25 million for new Andean program efforts.

When fully implemented, these initiatives will have a tremendous impact on the most difficult aspect of the drug problem, hard-core drug use and its damaging consequences. By taking action now, the Administration can achieve its goal of reducing drug use and drug-related crime and violence.

Each of these initiatives is discussed below.

A. TREATMENT INFRASTRUCTURE AND SERVICE EXPANSION

This Administration will make it a priority to add to our Nation's capacity so that those who need treatment can receive it.

Unless we can increase treatment capacity, the physical and psychological debilitation often caused by substance abuse and a drug-using lifestyle will overwhelm our health care system. . . .

Treatment must be made available to those who need and want it. . . . We must begin to focus more directly on ways to reduce the population of heavy users. . . . Habilitation and social services must be linked with treatment services, both during and after treatment.

The Interim Strategy.

The Interim Strategy identified the hard-core drug user as the principal challenge for drug policy. Hard-core drug use has not been reduced by past anti-drug efforts, especially in our inner cities and among the disadvantaged, and recent hospital emergency-room data suggest that problems resulting from heroin and cocaine use are on the rise. According to the statistics from the Drug Abuse Warning Network (DAWN), cocaine and heroin medical emergencies reached 119,800 and 48,000 in 1992, respectively, the highest levels since data from this survey were first reported. Further, we continue to see high levels of drug use among the arrestee population, with cocaine being the most commonly abused drug.

Hard-core users fuel the overall demand for drugs and are the most difficult and intractable aspect of the drug problem. For example, one study conducted by RAND for ONDCP found that although heavy users constitute only about 20 percent of all cocaine users, they account for roughly two-thirds of total cocaine consumption.

Hard-core drug use appears to fuel the continued high level of crime in our inner cities. Decades of research has established that drug users are much more criminally active during periods of heavy use. One study, for example, found that 573 substance abusers in Miami were responsible for nearly 14,000 serious crimes and over 50,000 additional, petty criminal acts in one year. Drug users themselves report greater involvement in crime and are more likely to have criminal records than non-drug users. Jail and prison inmates report very high rates of drug use, with more than 25 percent reporting they were under they were under the influence at the time they committed the offense that led to their incarceration.

As drug use increases, so does the number of crimes a person commits. According to a draft study prepared by HHS for ONDCP on the procurement habits of hard-core drug users, half of the hard-core users surveyed in the study reported having used illegal income to procure drugs, mostly from property crime and drug-related activities.

The relationship of drugs to violence is well established by empirical work. Paul Goldstein, for example, conducted studies of the drug market on the lower east side of New York City and found that about one-half of all violence was drug and alcohol related. This violence was attributable to the effects of using drugs or to factors internal to the drug trade (e.g.,

fights between rival dealers). Goldstein finds little evidence that drug-related violence is economic related: that is, drug users do not generally commit violent or predatory acts to obtain money for drugs. In fact, his work supports the HHS procurement study finding that drug users core commonly commit property crime to obtain income to support their habits.

Hard-core drug use and HIV/AIDs are highly related. Injecting users and their sexual partners account for nearly one third of reported AIDs cases and, in cities where the rate of HIV seropositivity is high, women trading sex for crack has also been identified as a growing source of HIV/AIDs transmission.

It is for these reasons that the Interim Strategy makes the reduction of drug use by hard-core users its number one priority. To the extent we are able to place hard-core users into treatment, we can expect drug-related crime to be reduced immediately during the course of treatment and (with the provision of follow-up supervision and support) for an extended period of time afterward. To do otherwise would sentence our inner cities to more crime. The proposed $715 million initiative contains the following elements:

- Targeted Treatment Services Expansion ($500 million): to provide funds so that 62,000 additional hard-core users outside the criminal justice system can receive long-term treatment, with emphasis on residential treatment. The Capacity Expansion Program would be repealed and replaced by this new program to be administered by the Center for Substance Abuse Treatment (HHS).

- Criminal Justice Targeted Treatment ($150 million): to expand prison-based treatment and transitional services programs so that 64,300 additional addicts can receive treatment. This program would be administered by CSAT in coordination with the Department of Justice.

- Offender Management Programs ($15 million): to ensure public safety and foster treatment effectiveness by providing essential assessment, monitoring, and supervision of offenders in community treatment and in transition from institutional treatment to the community. We envision funding or enhancing TASC or TASC-like programs in areas where heavy drug users are concentrated, under a program administered by DOJ in coordination with CSAT.

- Vocational and Educational Services ($35 million): to provide habilitation and rehabilitation services to addicts to enhance their long-term employability. This program would be administered by CSAT in collaboration with the Department of Labor.

- Treatment Staff Training ($15 million): to train more staff to cope with the increased demand for substance abuse treatment services. This program would be administered by CSAT.

Together, these components of the Treatment Infrastructure and Service Expansion Initiative will provide a focused effort to address hard-core substance abuse. Resources will be

allocated directly to communities, most likely urban areas, with disproportionately high rates of substance abuse, and will link to Empowerment Zones where appropriate.

The Substance Abuse Block Grant provides general funding nationwide to support substance abuse treatment, but does not target high treatment need areas. We are assuming level funding for this program in FY 1995.

Expected Outcome: This initiative will add nearly 51,000 more treatment slots to treat and provide related supervision and support 126,000 more persons. Given its targeted focus, it will have a tremendous impact on the drug problem and related violence that has devastated our urban areas.

B. YOUTH CRIME, VIOLENCE, AND PREVENTION

Our drug prevention programs must send a strong "no use" message and educate individuals about the risks and dangers of illegal drug and alcohol use. . . .

Violence against students and teachers in our Nation's schools has now reached epidemic proportions. If any place in our community is gun-free and drug-free, it must be our schools.

The Interim Strategy.

Drug use is behind much of America's problem with crime and violence. The proposed Safe and Drug-Free Schools and Communities Program will extend the current school-based prevention programs to include activities to prevent violence and drug use by youth. The Interim Strategy highlights the need that our children be taught skills for the positive resolution of conflict. However, for those who somehow do not get the message that drug use and violence will not be tolerated, the Strategy provides for swift and appropriate punishment

In general, we have seen tremendous progress in reducing drug use by our youths. The University of Michigan's High School Senior Survey has registered annual declines in drug use by seniors since the mid-1980s in all major categories of illicit drugs. Presumably, prevention efforts have contributed to this progress. However, there is evidence that the prevention message may be becoming stale. The most recent University of Michigan survey reported that drug use--especially cocaine, hallucinogens, and marijuana--is on the rise for eighth graders. More dramatically, fewer eighth graders in 1992 associated great risk of harm with cocaine or crack use than did eighth graders in 1991. These findings do not bode well. We must reinvigorate our existing prevention programs, focusing hard on their currency and relevancy. Otherwise, we stand to lose a new generation of our youth to drug abuse.

The seriousness of the drug/violence connection cannot be understated. The National Crime Victimization Survey Supplement reports that crimes in schools contribute to fears among students. It reported that 9 percent of students had experienced a victimization while at school. Sixteen percent report that a student attacked or threatened a teacher. Twenty-two percent of public school students are indicated some fear of attack at school (compared to 13 percent for private schools).

A preliminary study done by the Atlanta-based PRIDE organization found a strong link between high levels of marijuana use and violence; the higher the use, the more violent the student. Further, this study found that 45 percent of those who used marijuana 1-7 times a week responded in the positive to the following question: "Have you threatened to harm another student or teacher using a weapon?

An analysis of prevention programs done by Abt Associates for ONDCP shows that successful programs share three important characteristics: 1) they are comprehensive in approach; 2) they are positive in focus; and 3) they are carefully tailored to a clearly defined target population. To be continuously successful, prevention programs must reflect or

accommodate the changes in the population they target. We must constantly update and expand prevention efforts and better target these efforts to in effect "cap" the pipeline into drug use.

The Director of ONDCP has consistently expressed his support for drug prevention programs. The DFSCA program is a key component of the overall prevention effort. However, Congress has cut the funding for the DFSCA program by nearly $130 million. Given the threatened increase in drug use among our younger school age population, and the continued crime and violence that plague our schools, it is imperative that funding be provided to increase existing program efforts. Accordingly, to address the problems confronting our youth, this $200 million initiative contains two elements:

- Safe and Drug-Free Schools and Communities Program ($180 million): under the new SDFSC legislative proposal, the scope of the DFSCA program is broadened to include violence and drug prevention strategies. This budget initiative provides an additional $180 million so that comprehensive, coordinated prevention efforts for drugs, violence, and alcohol can be implemented. This will facilitate the success of Goal 6, "That all schools are free of drugs and violence by the year 2000 and will maintain a disciplined environment conducive to learning."

- Targeted Teenage Drinking Prevention Program ($20 million): this provides resources to establish a prevention campaign specifically for alcohol prevention to be carried out by SAMHSA, the Department of Education, and the Department of Transportation. The use of alcohol begins early. According to the High School Senior Survey many eighth graders regularly use alcohol (26 percent); this initiative seeks to reverse this unacceptably high level of use.

Expected Outcome: This initiative ensures our children will be able to attend school free of crime and violence, and gives them the tools to resist the temptation to use drugs and alcohol. This initiative ensures that every student in grades K-12 will have the opportunity to receive drug, violence, and alcohol prevention programs. It is estimated that over 40 million youths are exposed to prevention programs annually; this initiative will provide more comprehensive programs for these youth.

C. SOURCE COUNTRY COUNTERDRUG ENHANCEMENT

To improve our national responses to organized international drug trafficking, there will be a controlled shift of emphasis from the transit zones to the source countries, focusing on democratic institution-building of law enforcement and judicial institutions.

We will concentrate drug control assistance in major producer and transit countries that have demonstrated their political will to reduce drug trafficking. Assistance programs will focus on improving judicial and policy systems, interdiction efforts, and other programs to attack the drug-trafficking infrastructure.

The Interim Strategy.

Our interdiction effort has been successful in forcing traffickers to abandon direct shipments to the United States. It has also forced them to adopt more costly and difficult concealment tactics, shipping, and delivery methods, and dramatically increase production to ensure their supply. Traffickers' most favored transportation method--private aircraft into the Caribbean and Central America--has recently been dramatically reduced indicating another shift away from preferred methods. In the future, we believe the traffickers will be more vulnerable in the source countries to increased host country intelligence-cued law enforcement operations.

In 1992, we and our allies seized an estimated 338 metric tons of cocaine--more than we estimate is consumed by Americans annually. These seizures of cocaine resulted in the loss of billions of dollars in potential profits, making our interdiction effort very painful financially to the traffickers.

Interdiction operations have produced valuable intelligence and exposed operations. Interdiction contributed to about 43,000 drug arrests and detentions in Latin America in 1992. We have also used interdiction operations to train host nation police forces in how to plan, coordinate, and execute sophisticated counter-narcotics operations. Consequently, Mexico has taken over full responsibility for planning and executing its interdiction operations, and Colombia has begun planning and executing such operations. Bolivia is starting to plan and execute operations on her own. Peru is the weakest in this area, but its capability to conduct counter-drug operations is growing.

The Interim Strategy calls for a controlled shift of emphasis from the transit zones to the source countries -- in response to the shift in air smuggling by traffickers. A recently signed Presidential Decision Directive (PDD) ensures that certain resources, such as Customs' P-3 assets, be used more intensely to augment interdiction and intelligence in the source countries. Given the reduced threat in the transit zone, there is less need for detection and monitoring operations there; there is also less need for some border control air program efforts, such as helicopter operations.

The PDD also signals the President's dissatisfaction that source country funding was reduced by Congress below the FY 1994 President's Budget request level and directs OMB and ONDCP to minimize the effects of these cuts. Most notable among the cuts to the Andean Program in FY 1994 was the $48 million cut to the Bureau of International Narcotics Matters

(INM). The Department of State has assigned INM responsibility for developing, implementing, and monitoring U.S. international drug control programs. INM provides bilateral and multilateral assistance in Latin America for numerous activities such as enforcement efforts, training, judicial reform, crop control, prevention and treatment, and interdiction. Additionally, INM supports programs in other parts of the world focused on opium cultivation and heroin production and trafficking. Given the growing threat heroin poses to the U.S., and the President's intent to strengthen our source country effort, funding for source country programs must be restored and enhanced.

The source-country counterdrug enhancement initiative, which totals $73 million, contains two elements:

- INM Program Restoration ($48 million): the PDD directs OMB and ONDCP to partially restore and minimize the effects of these cuts in FY 1994. Implicit in this directive is the full funding and support for this program in FY 1995. This initiative proposes to restore resources in the FY 1995 program to the FY 1994 Presidential request level.

- INM Program Enhancement ($25 million): proposes to plus up by $25 million the FY 1994 request level for the Bureau of INM. This is needed to supported the expansion of source country programs over and above the shift in source country interdiction efforts from the transit zone.

By way of background, Congressional cuts to the President's FY 1994 counter-drug budget request -- INM ($48 million), DoD ($300 million), Foreign Military Financing ($36 million), Economic Support Funds ($71 million) -- will, if not at least partially restored, severely and adversely impact implementation of the President's international strategy as outlined in the Interim Strategy and the PDD. Restoration of $48 million in INM funds, along with a program enhancement of $25 million is absolutely essential to allow continuation of priority ongoing programs and permit some very modest enhancement of selected source country programs as required by the PDD.

Expected Outcome: INM resources enable producing and trafficking countries to engage in efforts to reduce the availability of illicit drugs. Such efforts were key to the proven success in reducing drug demand the late 1980's (according to ONDCP's White Paper on the price and purity of cocaine reported source country supply reduction efforts caused domestic U.S. cocaine prices to rise and drug use (as measured by DAWN) to decline). Country-specific results follow:

Colombia: Restoration and enhancement of the INM budget will allow necessary increases in support of expanded Colombian National Police operations throughout Colombia. It will help Colombia to sustain its extensive efforts to locate and arrest Pablo Escobar and to intensify its activities against the Cali cartel.

Colombia also needs the additional funds to continue efforts to gain control over sovereign airspace and to expand its capabilities to conduct night and day "end-game" operations throughout Colombia. Additional funds are also needed to support

Colombian efforts to interdict maritime shipments moving through Colombian ports with greater frequency.

Peru: Restoration and enhancement of the INM's budget will prevent the termination of U.S. law enforcement presence east of the Andes mountains and the termination of a new initiative to form and deploy mobile Peruvian law enforcement teams in Eastern Peru. This initiative, if funded, will reduce by half the cost of conducting interdiction and law enforcement operations east of the Andes. Given DoD's $300 million budget cut and Congress' refusal to give Peru Foreign Military Financing, additional funding for Peru for this specific area is absolutely essential to implement the President's new strategy.

This is also true for institution building and sustained development in Peru. Additional funding is required to help compensate for a $21 million or 65% cut in Economic Support Funds for Peru. The monies are needed to support judicial reform, expand demand reduction, and allow selective alternative development.

Bolivia: Bolivia is now going through a transition period in which they are assuming greater responsibility for planning and conducting law enforcement and interdiction operations. Restoration and enhancement of the INM budget will allow this effort to continue and will help make up for a projected cut of $10 million dollars or 66% in Foreign Military Financing and a $25 million or 50% cut in Economic Support Funds. Bolivia is now having major successes in attacking trafficker organizations and badly needs additional funding to sustain its police air and river operations.

Bolivian political will is very high under the new government and major new initiatives are underway to attack coca cultivation and expand alternative development in the Chapare growing area. Without additional funding, considerable initiative and infrastructure will be lost both in the Chapare and in drug transit and processing areas to the north.

III. PROGRAM LINKAGES

This Administration will set a new tone in reducing drug use by "reinventing" Federal drug control programs.

The Federal approach must be one that empowers communities. Empowering communities means supporting local efforts that are based on comprehensive, strategic plans and that involve the private sector, build on existing community institutions, and coordinate government efforts across program and jurisdiction lines.

The Interim Strategy.

There is a dire need for better cross-agency coordination with regard to drug programs, as well as more flexibility for communities to allocate resources to best meet their particular situations. This is highlighted in the Interim Strategy and repeatedly mentioned in the Vice President's National Performance Review. There are many programs that are similar, and perhaps even duplicative; however, there has been little direction and coordination of programs among the various drug control Departments and agencies to date.

The Interim Strategy has a new focus to confront the drug crisis. It targets scarce resources to areas of greatest need, as well as the most efficient and effective programs. It commits to reducing drugs and crime in our communities by focusing on targeted treatment, youth prevention, and crime and violence reduction by empowering communities and providing them with the proper tools.

To reduce drug use, as well as the crime and violence plaguing our communities, the Departments and agencies must commit to work together in targeting their scarce resources to those areas with the greatest need. This effort should encompass the Empowerment and Enterprise zones, as well as target other high need areas.

ONDCP, in collaboration with OMB, has held several joint Department/Agency meetings in order to discuss the merits, both political and technical, of grant "consolidation". This consolidation will take a two tier approach. Due to time constraints, the first tier will be proposed for the FY 1995 budget. It will link several cross-agency grant programs to allow for more effective targeting of resources. The second tier will be addressed subsequently this Spring with a view to developing specific proposals for the FY 1996 budget. This effort will involve specific proposals to consolidate existing grant and demonstration programs into larger discretionary grant programs, continuing to build infrastructure in support of the drug Strategy, Health Care reform, Empowerment Zone legislation, and the Crime bill.

FY 1995 Program Linkages

For the FY 1995 Budget request, we are proposing to link several existing drug programs, across-agencies to provide greater flexibility to communities, better use of scarce resources, and allow for the design of programs that work for the targeted population. The linkages will focus on the themes of the Interim Strategy: Targeted Treatment Expansion; Youth Prevention; and, Crime and Violence initiatives. The Department of Labor will be a key player in the "consolidation" because in order to successfully treat users, as well as provide incentives to youth and others to stop the crime and violence, alternatives such as gainful employment must be offered.

The linkage proposal will be included in the February Strategy. Examples of the programs that are likely to be candidates for cross-agency linkages are listed below. ONDCP will continue to work with OMB in coming to resolution on sound, finite, cross-agency proposals.

- Youth Program Linkages: High risk youth (HHS), Youth Gang (HHS and Justice), National Service, Job Corps (Labor) and Safe and Drug-Free Schools (Education.)

- Special Treatment Populations Linkages: Pregnant and Postpartum Women (HHS), Crack babies (HHS), Critical Populations (HHS), and Job Training Partnership Act/JTPA (Labor).

- Community Prevention Linkages: Community Empowerment, Drug Elimination grants (HUD), Community Policing grants (Justice), and Community Partnerships.

- Early Childhood Program Linkages: Head Start (HHS), Grants for infants and families (Education), Emergency Protection (HHS) and Early childhood education (Education.)

New funding from expiring grants, as well as existing funding would fall under the umbrella of eligible funding to be linked. The programs would be jointly administered by the responsible Departments and agencies by Cooperative Agreements, Memorandum of Understanding, Interagency agreements, and the like. The grants would be targeted to those areas with the need for comprehensive services, and most likely would target those communities that already receive multiple "separate" grants. This would enable the communities to use the majority of the funds to provide services by greatly reducing their administrative burden.

After the linkages have been formed, the next step (Tier II) will be to look at appropriate program that can be consolidated. This broader "consolidation" would merge existing programs, that are very similar, and consolidate them into large discretionary grant programs.

The benefits of such a consolidation are clear: administrative savings; greater flexibility for communities to design solutions: more effective concentration of limited resources; and, programs that work for the target population.

Clinton Presidential Records
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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

14

Divider Title: _____

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

SEP 15 1993

Mr. Dennis P. Williams
Deputy Assistant Secretary for Budget
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Williams:

Pursuant to 21 U.S.C., section 1502(c)(3), I have completed my review of the Fiscal Year 1995 drug-related budget submissions from the Administration for Children and Families (ACF), the Health Care Financing Administration (HCFA), Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the Centers for Disease Control (CDC), National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). While I understand that these submissions reflect preliminary agency level budget requests and do not reflect the recommended levels determined by the Secretary, I have determined, for both budgetary and policy reasons, that the budgets, in toto, are not adequate in this interim submission.

I would note, however, that I will reevaluate the request when the Department provides its submission in the Fall. In that submission, I would encourage the Department to address how Health Care Reform would contribute to drug treatment and prevention resources and augment the resources identified in the present PHS submission. The ways in which Health Care Reform will provide for drug treatment are an important dimension to be reflected in the Fall submission. In the absence of any information regarding this matter in this Summer submission, however, ONDCP can only evaluate the information supplied by PHS. In addition, the Fall submission should carefully indicate how adequate treatment and prevention resources will be available during the transition from the present system to the new one.

The reasons for this determination are spelled out below. Additional details are provided in the enclosed documents.

I would urge the Department to address the issues raised in this certification in its Fall budget submission so that the Office of National Drug Control Policy (ONDCP) can certify the budget as adequate at that time.

1. TREATMENT

a. The PHS budget request for drug treatment slots would provide the same number of slots that were requested in President's FY 1994 request to Congress. But, because of a decrease in the number of persons to be treated per slot, SAMHSA would treat a total of only 1,420,000 persons, 29,000 fewer persons than the 1994 level. Additionally, the funding increases proposed for the Block grant do not take into consideration the various mandates placed on the States as a result of the ADAMHA Reorganization Act. Undoubtedly, the impact of the new State mandates on the number of slots and the number of persons being treated will be even greater.

I would request that in the Fall submission the Department provide estimates of the cost impact of the new mandates and request adequate funding to offset them, either by increasing the Block Grant or by further increasing the categorical grants, such as the Capacity Expansion Program, or both.

b. The PHS submission for SAMHSA indicates that more funds would be put into treatment only if they were taken from the supply reduction agencies. As you know, the supply reduction agencies are also facing fiscal constraints for FY 1995, and they have to propose adequate funding levels within the resources at their disposal. I am not in a position at this time to recommend reductions in their budgets.

c. The President and I are committed to expanding the Nation's capacity to treat people, especially hard to treat populations. In order to meet this commitment to treatment, I support the new criminal justice block grant program you have recommended and would propose restructuring the Capacity Expansion Program into a formula grant program, that targets areas of greatest need. I would encourage the Department to revisit the budget request to include an adequate funding level for both of these programs in the Fall submission.

d. Despite recent changes in regulations, the FDA budget request does not provide for increased monitoring and oversight of methadone maintenance programs. They should be addressed in the Fall budget submission.

e. The HCFA, HRSA and IHS budgets do not reflect any combined efforts directed at injecting drug users (IDUs), AIDS, and sexually transmitted diseases (STDs). It is particularly significant that only CDC targets the prevention and treatment of STDs -- an important link between drug use and the transmission of HIV. Information should be included in the Fall submission that would indicate how these areas will

be addressed and how the efforts will be coordinated among the agencies involved in this area, including CDC.

2. PREVENTION

a. I am concerned about the reduction in the ACF budget for the Youth Gang and Emergency Protection programs. While I support the idea of consolidating programs so that services can be better targeted, I also believe that these new consolidated programs should include a drug component and this component should be highlighted and scored as "drugs" in the budget submission. The ACF request did not provide an estimate of the drug-related level.

b. Head Start program funding has nearly doubled since 1993; however, the level of funding scored as drug-related has remained the same. I would recommend that the Department revisit the drug scoring of this program and provide a detailed justification for the funding level that is recommended in the Fall submission.

c. SAMHSA is proposing a new Women in Transition Program. Please explain in the Fall submission the extent to which the Center for Mental Health Services (CMHS) will be involved. It appears that this program should be coordinated with both the Center for Substance Abuse Prevention (CSAP) and CMHS. Additionally, please indicate what data are available that support the need for prevention services for this population.

e. With regard to the increases in the communications program, the Department should work with the Department of Education on the Cooperative Agreements for Public Education initiative. Since recent data show increases in drug use among the eighth grade population, this program should also target the seventh graders in order to provide prevention services as early as possible.

f. The Centers for Disease Control has recently conducted an evaluation on outreach efforts to IDUs. I would like any results that you can provide to me with the Fall submission.

3. RESEARCH

a. The SAMHSA request should include adequate funding for the High School Senior Survey, the Household Survey, DAWN, NDATUS, etc. In addition, I am not prepared at this time to support a reduction in the frequency of collecting and analyzing such data.

b. The NIDA budget request does not provide justification for the day-to-day research efforts. We are concerned about the utility of Federally funded research in clinical settings and would like detailed explanation in the Fall submission

with regard to these efforts. NIDA indicated in its submission that a listing of the ongoing research and development projects had been forwarded to my office; however, we have not received this submission to date.

Further, the Department should include funding in its Fall submission for medications development for cocaine and combined cocaine/heroin use.

Finally, the NIDA budget does not include expansion of outreach efforts for IDUs and other heavy users not in treatment. Since the treatment of heavy users is a priority, this should be included in the Fall submission.

Should your staff have any questions about the points raised in this certification, or any questions about the details provided in the enclosed document, they should feel free to contact Bruce Carnes, Director, Office of Planning, Budget and Administration.

Sincerely,

Lee P. Brown
Director

Enclosure

c: The Honorable Donna Shalala
Dr. Elaine Johnson
Dr. Camille Berry

TREATMENT INITIATIVE BACKGROUND

I. Administration's Treatment Initiative

- The President's FY 1995 budget request includes an initiative in the amount of $355 million for the treatment of chronic, hardcore drug users. The initiative is comprised of the following elements:
  - -- $310 million for the Dept. of HHS Substance Abuse Prevention and Treatment Block Grant;
  - -- $35 million for a new treatment demonstration program at HHS for the chronic, hardcore user population; and
  - -- $10 million for the expansion of treatment services for the American Indian and Alaska Native populations.
- There are two sources of funds for this initiative:
  - -- $310 million is requested in HHS' direct appropriation; and
  - -- $45 million is proposed for transfer from ONDCP's Special Forfeiture Fund to HHS.
- The Treatment Initiative is identified in the 1994 Strategy as the Administration's number one drug priority. A total of 74,000 new users will receive treatment under this proposal, if enacted as proposed by the Administration.

II. Administration's Legislative Proposal

- In March 1994, the Administration transmitted legislation to Congress requesting the reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA) for three years.
- Included in this legislation is authorization language for the Administration's new Treatment Initiative.
- The Administration's Bill authorizes appropriations of $310 million for FY 1995 and "such sums" as may be necessary for FYs 96-97 for the Treatment Initiative for chronic, hardcore drug users.
- Chronic, hardcore users are those users who--

  "abuses alcohol or other drugs at levels sufficient to cause functional impairment, and who is at greatest risk of suffering the negative consequences of substance abuse

(including violence, incarceration, infectious disease, abuse, neglect, homelessness, education dysfunction, unemployment, and other forms of socioeconomic dislocation)."

- Treatment would be provided to those users illicit substances or illicit substances used in combination with alcohol (comorbid).

- However, the proposed bill would allow "alcohol only" treatment for the $310 million so long as a State applies to the Secretary of HHS for a waiver and the Secretary determines that amounts are not needed in relation to other hardcore drug users.

- The Bill would eliminate other requirements that normally apply to funds appropriated to the Substance Abuse Prevention and Treatment Block Grant:

  -- None of the new funding ($310 million) is to be spent on prevention.

  -- States may use a total of five percent of new funding for monitoring and evaluation (2 percent) and technical assistance (3 percent).

  -- Pregnant women would be given priority in treatment, but the 5 percent set-aside for pregnant women would not apply to these new funds.

- The Bill establishes demonstration authority, which enables at least $35 million to be used for demonstrations of models of chronic, hardcore treatment interventions

III. Waxman's Legislative Proposal

- The House Full Committee on appropriations recommended a $60 million increase over the FY 1994 level. However, none of the additional funds are technically for the hardcore initiative since the Administration's proposal has yet to be authorized.

- The House Committee also did not recommend funding for the chronic, hardcore demonstration program due to the lack of an authorization.

- Cong. Waxman will propose a bill to reauthorize SAMHSA. It does not propose a separate authorization for the hardcore user initiative, but it does authorize the use of block grant funds for "SERIOUS ADDICTIVE DISORDERS."

- A "serious addictive disorder" is a term that applies to drugs and alcohol and covers a broad array of circumstances

involving a significant adverse effect on an individual. There is no distinction between illicit drug addiction and alcohol addiction.

- The Waxman bill would eliminate a provision in current law requiring that at least 35 percent of funds be used for alcohol treatment and at least 35 percent be used for drug treatment. This effectively allows funds to be used for any type of substance abuse (theoretically, alcohol only).

- The Waxman bill seems to maintain most other set-asides and mandates. This includes the 20 percent set-aside for prevention programs (we wanted to eliminate this in our hardcore user treatment initiative).

- The Waxman bill does provide treatment for some special populations (e.g., residential treatment programs for pregnant and postpartum women).

June 30, 1994

Existing Block Grant Mandates

1. 20% prevention set-aside.
2. Approximately 30% for alcohol only treatment.
3. 5% set-aside for administration.
4. Treatment on demand for IV users and pregnant women, as well as a 5% set-aside for pregnant women.
5. Childcare services for women in treatment.
6. HIV screening and TB testing.
7. Interim methadone maintenance.
8. Prenatal Services.

Hardcore Initiative

1. Priority for pregnant women.
2. 2% set-aside to strengthen and extend State and local data collection systems.
3. 3% set-aside for SAMHSA to provide technical assistance.
4. HIV screening and TB testing.
5. No prevention set-aside.
6. No 5% set-aside for pregnant women.
7. No specific predetermined allocation for drug or alcohol activities.
8. Funding must be used to treat those with drug and polydrug (including alcohol) addictions. If a State has met the need of treating this population, it can request a waiver from the Secretary of HHS to use the funds for alcohol only treatment.

Remember that the base of the block grant has nearly $837 million for State allocations.

EXECUTIVE OFFICE OF THE PRESIDE

05-Jul-1994 02:52pm

TO: William L. Dorotinsky

FROM: James E. Duke
Office of Mgmt and Budget, TCJ

SUBJECT: Text of Hard Paper Requested by Edley For Today's

Hard-Core Drug Treatment

Initiative Funding:	FY 1995 Request	House Mark	Senate Mark
Substance Abuse Block Grant	$ 1,430	$ 1,227	$ --
President's Initiative (non-add)			
Hard-Core Treatment	$ 310	$ 0	$ --
Special Forfeiture Fund	45	0	20

Special Forfeiture Fund Mark Contained In Treasury Postal Appropriat

House appropriators added $60 million to Block Grant over FY 1994, but provided no funding for the President's Hard-Core Treatment Initiative, citing a lack of a SAMHSA reauthorization providing for a hard-core program. The substance abuse block grant funds treatment for all substance abuse conditions including alcohol only addictions. Without full funding 65,000 hard-core drug addicts may not receive treatment.

ONDCP Position:

Hard-Core Treatment #1 Priority. The treatment of hard-core users [those who often commit crime to support the abuse and create a significant burden upon the Nation's health care system] is the Drug Czar's highest priority. Funds provided for the President's "Hard-Core Initiative" should be fully funded and targeted only to hard-core users.

Co-morbid Treatment Necessary. Most hard-core drug abusers also abuse alcohol and successful treatment regimens typically address both the abuse of illicit drugs and co-morbid licit alcohol abuse. ONDCP recognizes the co-morbid character of hard core addiction and supports the use of hard-core treatment funding when it addresses poly drug and co-morbid alcohol abuse, and provides priority to hard-core treatment.

Dilution Of Grants Is Unsatisfactory. ONDCP favors a hard-core treatment set-aside and objects to hard-core treatment funds being absorbed into a block grant without a prohibition of alcohol only abuse treatment. ONDCP supports alcohol abuse treatment only within the context of underage drinking.

"Priority" To Hard-Core Treatment - A Fall Back Position. ONDCP strongly supports hard-core treatment funding through a supplemental grant program. Should such treatment funding be rolled into a block grant, ONDCP would want assurances that amounts designated for hard-core treatment would go there first with a waiver required from the Secretary for other uses.

HHS Position:

The Same As ONDCP With Exception.

A Supplemental Hard-Core Treatment Grant Not Politically Feasible. HHS points out that current Congressional sentiment supports an expansion of the block grant, and believes that as a consequence maximum funding will be obtained within that frame work.

Note: Hill staffers argue that smaller states suffer if funding is reduced to accommodate hard-core treatment. [Some sta have the same hard-core problem as other states]. Therefore, th grant will likely continue to receive priority for funds.

Analysis:

ONDCP's position on what constitutes hard-core abuse for purposes of the President's initiative is a long standing one. They specifically exclude alcohol only abuse, viewing it as a diluter of funding and a public health problem outside their purview. Further, ONDCP views the hard-core initiative as a policy initiative for which ONDCP ought to hold policy sway.

HHS's position is simply pragmatic. It sees addiction regardless of substance(s) used as a public health issue and recognizes the power of Members of Congress who are protective of block grant funds and supportive of few restrictions. Given budget cap restrictions, Members view any carve out for hard-core drug treatment as a competitor for block grant funding. To fund hard-core treatment at the expense of the block grant would have the effect in Congress' view, of shifting away from some States to others.

The SAMHSA reauthorization will likely contain language to authorize funding for "serious addictive disorders". We have a copy of a discussion draft from Waxman's staff which does so.

Recommendation:

Support a position which adds substantial funding for hard-core drug treatment to the block grant. The SAMHSA reauthorization language should provide an authorization which contains: 1) a clear definition of hard-core substance abuse; and 2) some targeting/priority mechanism for hard-core treatment within the block grant. For example, States would be able to use hard-core treatment funds for alternative treatment programs only <u>after</u> they have satisfied treatment requirements for hard-core addicts <u>and</u> received a waiver from the Secretary of HHS.

Note: As a clear way to measure of the number hard-core addicts has y developed, some surrogate for counting would need to be employed [e.g. room mentions, or drug-related crime].

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D. C. 20201

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

DATE: June 30, 1994

TIME: 2:40 p.m.

TO : Jose Cerda

COMPANY : _____

FAX NUMBER: 456-7028 TELEPHONE NUMBER _____

Number of pages being transmitted (including this one) _____

FROM: Peter Edelman

OFFICE OF THE SECRETARY
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201
(202) 690-7000 FAX NO. (202) 690-7595

COMMENTS: Per our conversation. This is the "Draft" Waxman Bill

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTTEE ON ENERGY AND COMMERCE

512 House Annex I
300 New Jersey Ave., S.E.
Washington, D.C. 20515
Phone: (202) 226-7620
Fax: (202) 225-7092

HENRY A. WAXMAN
CHAIRMAN

****

From the desk of:

Lisa Barclay
Phil Barnett
Rapley Forbes
Julia Fortier
Joe Molica
Bill Schultz
Greg Wetstone

****

Attention: BRIAN

Organization:

Date:

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Message:

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690-6960

F:\PMG\SAMHSA\WAXMAN.001

HLC

"DISCUSSION DRAFT"

June 27, 1994

10:45 a.m.

103D CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. WAXMAN introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to concentrate Federal resources for the treatment of substance abuse on expanding the availability of treatment to individuals with serious addictive disorders involving alcohol or drugs, and to revise and extend the program for the Substance Abuse and Mental Health Services Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "*[Serious Addictive Disorders Emergency Substance Abuse Treatment Act of 1994]".

TITLE I—FORMULA GRANTS UNDER TITLE XIX OF PUBLIC HEALTH SERVICE ACT

SEC. 101. MENTAL HEALTH.

Section 1920(a) of the Public Health Service Act (42 U.S.C. 300x-9(a)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $278,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

SEC. 102. SUBSTANCE ABUSE.

(a) PURPOSE OF GRANTS; TREATMENT OF SERIOUS ADDICTIVE DISORDERS.—Section 1921 of the Public Health Service Act (42 U.S.C. 300x-21) is amended—

(1) in subsection (b), by striking to "to prevent and treat substance abuse" and inserting the following: "to prevent substance abuse and to treat cases of substance abuse that are serious addictive disorders"; and

(2) by adding at the end the following subsection:

"(c) SERIOUS ADDICTIVE DISORDERS.—

"(1) IN GENERAL.—For purposes of this subpart, the term 'serious addictive disorder', with respect to the abuse of alcohol or drugs, means that the extent of such abuse by an individual significantly predisposes the individual to any of the following: Acts of violence; incarceration under the criminal justice system; infectious diseases; abuse and neglect; homelessness; unemployment; termination of participation in programs of education or training; or any other circumstance involving a significant adverse effect on the individual.

"(2) REFERENCES.—With respect to the expenditure of a grant under subsection (a), each reference in this subpart to the treatment of substance abuse, including a reference to the treatment of the abuse of a particular substance, shall be considered to be a reference to the treatment of serious addictive disorders.".

(b) STRIKING OF CERTAIN ALLOCATION REQUIREMENT.—Section 1922 of the Public Health Service Act (42 U.S.C. 300x-22) is amended—

(1) by striking subsection (a); and

(2) by redesignating subsections (b) and (c) as subsections (a) and (b), respectively.

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(c) PRIMARY PREVENTION PROGRAMS.—Section 1922(a)(1)(B) of the Public Health Service Act, as redesignated by subsection (b) of this section, is amended by inserting before the semicolon the following: "(which may include activities under any State program for reducing or discouraging the use of substances with significant adverse health effects)".

(d) MISCELLANEOUS PROVISIONS.—Subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.) is amended—

(1) by striking "is the collection of data in this paragraph is carrying out" in section 1935(b)(1)(B) and inserting "is carrying out"; and

(2) by striking the final subparagraph in the first paragraph of the first subsection of section 1931 (and by adding "or" after the semicolon at the end of the fourth subparagraph of the paragraph, and by striking "; or" at the end of the paragraph (as so amended) and inserting a period).

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 1935(a) of the Public Health Service Act (42 U.S.C. 300x–35(a)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $1,500,000,000 for fiscal year 1995, and such

sums as may be necessary for each of the fiscal years 1996 and 1997".

TITLE II—PROGRAMS UNDER TITLE V OF PUBLIC HEALTH SERVICE ACT

SEC. 201. PROGRAMS OF CENTER FOR MENTAL HEALTH SERVICES.

(a) CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.—Section 565(f)(1) of the Public Health Service Act (42 U.S.C. 290ff–4(f)(1)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $100,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(b) CERTAIN DEMONSTRATION PROJECTS.—Section 520A(e)(1) of the Public Health Service Act (42 U.S.C. 290bb–32(e)(1)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $50,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(c) DEMONSTRATION PROJECTS REGARDING POSITIVE TEST RESULTS FOR HIV.—Section 520B(j) of the

Public Health Service Act (42 U.S.C. 290bb-33(j)) is amended by inserting before the period the following: ", $5,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(d) PROJECTS FOR ASSISTANCE WITH TRANSITION FROM HOMELESSNESS.—

(1) IN GENERAL.—Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc-35(a)) is amended to read as follows:

"(a) IN GENERAL.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this part (subject to paragraph (2)), there are authorized to be appropriated $80,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(2) AUTHORITY REGARDING RELATED CATEGORICAL PROGRAM.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary may obligate not more than 10 percent for carrying out section 506.".

(2) FUNDING OF RELATED CATEGORICAL PROGRAM.—Section 506(e) of the Public Health Service Act (42 U.S.C. 290aa-5(e)) is amended to read as follows:

"(a) *[RULE OF CONSTRUCTION].—*[No amounts are authorized to be appropriated under this section.]".

SEC. 502. PROGRAMS OF CENTER FOR SUBSTANCE ABUSE TREATMENT.

(a) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1(r)(1)) is amended—

(1) *[in subsection (l), by striking "such agreements" and inserting "the funding agreements required in this section"]; and

(2) in subsection (r)(1)—

(A) by striking "and" after "1993,"; and

(B) by inserting before the period the following: ", $100,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(b) DEMONSTRATION PROJECTS OF NATIONAL SIGNIFANCE.—

(1) NATURE OF PROJECTS.—Section 510(b) of the Public Health Service Act (42 U.S.C. 290bb–8(b)) is amended—

(A) in paragraph (6), by striking "and" after the semicolon at the end;

(B) by redesignating paragraph (7) as paragraph (8); and

(C) by inserting after paragraph (6) the following paragraph:

"(7) projects to provide, in accordance with section 511, treatment services to individuals under the supervision of State or local criminal justice systems; and".

(2) FUNDING.—Section 510(e) of the Public Health Service Act (42 U.S.C. 290bb-3(e)) is amended—

(A) in paragraph (1), in the first sentence—

(i) by striking "and" after "1993,"; and

(ii) by inserting before the period the following: ", $125,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997"; and

(B) in paragraph (2), by inserting before the period the following: "and not less than $35,000,000 for treatment services under this section for individuals with serious addictive disorders (as defined in section 1921(c))".

(8) FUNDING FOR CERTAIN PROGRAM.—

(A) Section 510(e) of the Public Health Service Act (42 U.S.C. 290bb–3(e)) is amended by adding at the end the following paragraph:

"(3) AUTHORITY REGARDING MODEL COMPREHENSIVE PROGRAM IN NATIONAL CAPITAL AREA.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary may obligate such amounts as the Secretary determines to be appropriate for carrying out section 571.".

(B) Section 571 of the Public Health Service Act (42 U.S.C. 290gg) is amended by striking subsection (b).

(c) TREATMENT IN STATE AND LOCAL CRIMINAL JUSTICE SYSTEMS.—Section 511 of the Public Health Service Act (42 U.S.C. 290bb–4) is amended—

(1) by striking each of subsections (a) and (d);

(2) by striking "511." and all that follows through "(b) ELIGIBILITY.—" and inserting "511. (a) ELIGIBILITY.—";

(3) by redesignating subsection (c) as subsection (b), respectively;

(4) in subsection (a) (as redesignated by paragraph (2) of this subsection), by striking "In awarding grants under subsection (a), the Director shall"

and inserting the following: "In awarding grants under section 510(b)(7) (relating to treatment for individuals under criminal justice supervision), the Director of the Center for Substance Abuse Treatment shall";

(5) in subsection (b) (as redesignated by paragraph (3) of this subsection), by striking "awarding grants under subsection (a)" and inserting "awarding grants described in subsection (a)"; and

(6) by adding at the end the following subsection:

"(c) RULE OF CONSTRUCTION.—No amounts are authorized to be appropriated under this section. For grants described in subsection (a), section 510(c) is the exclusive authorization of appropriations [under this part].".

(d) TRAINING IN PROVISION OF TREATMENT SERVICES.—Section 512(d) of the Public Health Service Act (42 U.S.C. 290bb–5(d)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $9,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

SEC. 203. PROGRAMS OF CENTER FOR SUBSTANCE ABUSE PREVENTION.

(a) COMMUNITY PROGRAMS.—Section 516(c) of the Public Health Service Act (42 U.S.C. 290bb–22(c)) is amended to read as follows:

"SUBSTANCE ABUSE PREVENTION DEMONSTRATION PROJECTS OF NATIONAL SIGNIFICANCE

"SEC. 516. (a) IN GENERAL.—The Director of the Center for Substance Abuse Prevention shall make awards of grants, cooperative agreements, and contracts to public and nonprofit private entities for the purpose of establishing demonstration projects that will improve the provision of prevention services for substance abuse.

"(b) NATURE OF PROJECTS.—In carrying out subsection (a), the Director shall make awards for the following projects:

"(1) Projects providing assistance to communities to develop comprehensive long-term strategies for the prevention of substance abuse.

"(2) Projects for evaluating the success of different community approaches toward the prevention of substance abuse.

"(3) Projects to assist business organizations in establishing employee assistance programs to provide appropriate service for employees of the organization

regarding substance abuse, including education and prevention services and referrals for treatment.

"(6) Projects linking community-based prevention activities with primary health care systems, including health plans.".

(b) MODEL PROJECTS FOR HIGH RISK YOUTH.—Section 517(h) of the Public Health Service Act (42 U.S.C. 290bb–23(h)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $58,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(c) EMPLOYEE ASSISTANCE PROGRAMS.—Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–21 et seq.) is amended by striking section 518.

SEC. 203. DEMONSTRATIONS AND EVALUATIONS REGARDING SYSTEMS OF CARE.

Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following section:

"DEMONSTRATIONS AND EVALUATIONS REGARDING SYSTEMS OF TREATMENT

"SEC. 506A. (a) IN GENERAL.—The Secretary, acting through the Administrator, may make awards of

grants, cooperative agreements, and contracts to public and nonprofit entities to demonstrate and evaluate projects for improving systems for providing substance abuse and mental health services.

"(b) REQUIREMENT REGARDING INTEGRATED SYSTEMS.—The Secretary may make a grant under subsection (a) only if the project involved provides for an integrated system of delivering substance abuse and mental health services.

"(c) CERTAIN AUTHORITIES.—With respect to the system for which an award under subsection (a) is provided, the purposes for which the Secretary may authorize the award to be expended include the following:

"(1) Integrating the provision of the services of the system with the provision of primary health services.

"(2) Establishing linkages between the system and health plans.

"(3) Evaluation of programs of oversight and case management in order to determine the extent to which the services of the system are provided in a cost-effective manner.

"(d) FUNDING.—Of the amounts appropriated under section 510, 516, and 520A for a fiscal year, the Secretary

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Substance Abuse and Mental Health Services Administration
Rockville MD 20857

DRAFT

July 25, 1994

TO: Counselor to the Secretary on Drug Policy

FROM: Director, Division of Legislation and External Affairs

SUBJECT: SAMHSA Reauthorization - House Discussion Draft

The following are SAMHSA's comments on a House Discussion Draft bill for reauthorization of SAMHSA. Our comments are given by section of the bill. These comments include suggested language for a "FINDINGS" section and a change to Section 1928 (of the PHS Act) with respect to priorities for Block Grant funding for the States.

Add a "FINDINGS" section:

"Whereas, each year there are more deaths and disabilities from substance abuse than any other preventable cause: 100,000 people die as a result of alcohol and illicit drug abuse and related AIDS deaths account for at least 19,000 deaths;

Whereas, one-half to two-thirds of homicides and serious assaults involve alcohol and about half of men arrested for homicide and assault test positive for illicit drugs;

Whereas, every American pays nearly $1,000 annually to cover the costs of unnecessary health care, extra law enforcement, auto accidents, crime and lost productivity resulting from substance abuse;

Whereas, the National Drug Control Strategy involves the expansion of prevention and treatment services to address the needs of the Nation with regard to the consequences of substance abuse, targeting resources to outreach, education, and treatment to those most severely impaired addicts;

Whereas, as many as one third of American adults will suffer a diagnosable mental disorder sometime in their life, and 20 percent have a mental disorder at any given time;

Whereas, many children and adolescents lack the benefits of coordinated systems of care from local school, welfare, justice, and mental health systems, which must work together on their behalf;

Whereas establishing effective treatments for the developmental, emotional, and behavioral symptoms of childhood mental disorders is an urgent task;

Whereas, many adults with diagnosable mental and substance use disorders, including older people, rural Americans, women, children, ethnic and racial minorities, homeless people and those with HIV/AIDS, lack access to community-based treatment and support services;

Whereas, new scientific findings and advances in treatment methodologies have proven that serious mental illness and serious emotional disturbance in children can be successfully overcome, making those who have suffered with such disorders productive and contributing individuals, challenges remain regarding access and stigma,

Congress reauthorizes the Substance Abuse and Mental Health Services Administration to implement, through systems building and services delivery, the newest scientific findings with regard to mental illness and serious emotional disturbance for children to eliminate the stigma of mental illness and to carry out the goals of the National Drug Control Strategy so as to decrease illicit drugs use and its negative consequences and, generally enrich the lives of all persons with or effected by addictive and mental disorders.

Sec. 1 Short Title

The term "serious substance abuse disorder" should replace "serious addictive disorder" where ever it appears throughout the discussion draft. This term is more in keeping with the definition that is used.

Sec. 101 Mental Health Block Grant

No comment

Sec. 102 Substance Abuse Block Grant

(a)(1) we believe that the wording should be changed to show that the purpose of the grant is "to prevent substance abuse and to treat individuals with serious substance abuse disorders; and"

(2) As discussed in an earlier memo to you, the definition is reasonable though we believe the term should be changed as indicated earlier.

(b) We agree with the repeal of the requirement that States must spend at least 35 percent of their allotment on alcohol activities and 35 percent on drug related activities. This permits the States greater flexibility in the use of their funds.

(c) This provision would allow the primary prevention set aside to be used by any Department of the State including Corrections for reducing or discouraging the use of substances which are harmful to one's health. This means the funds could be used for asbestus removal, removal of other carcinogens, etc. Federal funds for primary substance abuse prevention have gone down over the past few years while surveys indicate that youth are seeing less and less harm in taking drugs.

We assume that the primary purpose of the provision is to allow the set aside to be used for tobacco enforcement. We are currently developing a proposed approach to paying for the tobacco provision in the Block Grant. We will provide further comments on this, so that satisfactory legislative language can be developed.

(d)(2) SAMHSA does not support the removal of the restriction on the use of Block Grant funds to support clean needle exchange programs.

(e) No comment

We suggest a change to section 1928 - ADDITIONAL AGREEMENTS by adding:

"(e) PRIORITIES - A funding agreement for a grant under section 1921 is that the State involved will target funds to communities with the highest prevalence of substance abuse or the greatest need for treatment services with respect to such abuse as identified in the Needs Assessment required under section 1929, and will assure thereby both availability and accessibility of appropriate treatment services to the most severely impaired individuals."

This change ensures State accountability with regard to targeting Block Grant funds to communities with the highest prevalence of substance abuse or the greatest need for treatment services with respect to substance abuse as identified in the Needs Assessment required under section 1929. It is intended to assure both availability and accessibility of appropriate treatment services to the most severely impaired individuals.

Sec. 201 Programs of the Center of Mental Health Services

(a),(b) and (c) No comment

(d) SAMHSA supports the continued authorization of PATH except that we request that the House consider four amendments we proposed to PATH in the Administration's proposal. They were:

1) Allow for a waiver for territories against the matching requirement. The territories receive minimal funds and do not have the resources to continuously match the Federal contribution.

2) Permit the States to use the funds for their own programs. Current law only allows the funds to be used by subdivisions of the States and non-profit private entities. Some States are funding their own programs by funneling the funds through a third party. This would allow current practice while reducing administrative costs.

3) Amend section 522(d) so that it would require the State to give special consideration to entities with a demonstrated effectiveness in working with veterans with a serious mental illness.

4) Amend section 522(f) to clarify that it is the State that is prohibited from using more than 4 percent of the funds for administrative expenses. In its current form the language would suggest that providers ar limited to using 4 percent for administrative expenses as well.

More importantly we are concerned with the implications of this section in the discussion draft on the ACCESS program. The "Access to Community Care and Effective Services and Supports (ACCESS)" is a 5 year demonstration program designed to contribute to ending homelessness among persons with serious mental illness and substance use disorders. ACCESS promotes linkages and cooperation among Federal, state and local governments and among agencies that provide housing, mental health, substance abuse, health care, and income supports and entitlement to provide integrated services to such persons.

This section repeals the authorization of appropriation for section 506 - Demonstrations for the Homeless - funding it instead with a 10 percent tap on PATH.

We expect that you have received from Jerry Britten a 2-page document, developed with assistance from CMHS staff, explaining in further detail the adverse consequences of this proposed language. A copy of the document is attached and designated "A". If you have any questions, please do not hesitate to call.

Sec. 202 Programs of the Center for Substance Abuse Treatment

(a) We ask that the House consider our request to include aftercare services in the list of allowable expenses for the program.

(b)(2) The authorization of appropriation needs to be increased to $175 million to cover existing programs that would be authorized under this authority.

(c) and (d) No comment

Sec. 203 Programs of the Center for Substance Abuse Prevention

We request that the House consider expanding the list of at risk groups to include other groups that the Secretary would determine. This would permit us to serve homeless youth and youth with disabilities.

The authorization level is below the Senate mark for the High Risk Youth program of $66,520,000.

Sec. 204 Demonstrations and Evaluations Regarding Services of Care

We support the provision and the flexibility it offers the Administrator to determine where the grants should be managed.

We also ask that the House consider the Administration's proposed changes to section 303 of the PHS Act that would address the issue of students evading their obligations under the program by declaring bankruptcy. This loophole has already been addressed in the National Health Service Corps program. A copy of the proposed language is attached and designated "B".

The Capacity Management Program should be repealed but the Administration is interested in continuing current grants through FY 1995 which would be their final year. Thus we need an authority that would permit us to do that.

For your information we have also attached, designated as "C", the recommended editorial changes to the discussion draft bill which correspond to the above stated comments. Thank you for the opportunity to comment on the discussion draft.

Joe Faha

Attachments

cc: Bill Corr
Judy Lewis
Frank Sullivan

JL 22 94

SAMHSA REAUTHORIZATION

ISSUE: Do not restrict authority for funding of the ACCESS project.

The House draft of the SAMHSA Reauthorization Act would eliminate the authority used for the ACCESS demonstration program in order to increase funding for the PATH program, a formula grant program that provides resources to States for mental health and substance abuse services for homeless persons. Demonstration projects, such as ACCESS, could be funded through a 10% set-aside in the PATH appropriation. The resulting reduction in funds would effectively eliminate the ACCESS project. While additional funding for the provision of mental health services for homeless persons is a worthwhile goal, accomplishing it at the expense of the ACCESS project before it is completed would be ill-advised.

BACKGROUND: Access to Community Care and Effective Services and Supports (ACCESS) is a five-year service demonstration project, now completing its first year, designed to implement and evaluate strategies to integrate services for homeless persons with mental illness or mental illness and substance abuse disorders. ACCESS promotes linkages and cooperation among Federal, state and local governments and among agencies that provide housing, mental health, substance abuse, health care and income supports and entitlements.

The ACCESS program, which made initial awards in FY 1993 totalling $18.5 million[1], $17 million to 18 sites in 9 states and $1.5 million for the evaluation of the program, was the primary recommendation of the Federal Task Force on Homelessness and Severe Mental Illness. The program was similarly embraced by the Administration in the recently released Interagency Council on the Homeless report , *Priority Home!: The Federal Plan to Break the Cycle of Homelessness* as a building block to help move toward an integrated system of housing and services.

PROBLEMS WITH DE-FUNDING ACCESS:

- **Cancels a multi-state and community service delivery project mid-stream.** Money the federal government has already spent on the project would be wasted. Local linkages that have already been forged would be jeopardized. For example, 16 of the 18 communities that receive ACCESS funds also receive funds through HUD's Shelter Plus Care (S+C) program. S+C funds rental assistance, but the community must provide services. In several cases, ACCESS funds the services.

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[1] The remainder of the $21.4 available for homeless service demonstrations was used for the following: $1.6 million supports a dually diagnosed collaboration with the Center for Substance Abuse Treatment; $700,000 supports the National Resource Center on Homelessness and Mental Illness; and $500,000 supports a one-year services demonstration on homeless runaway and homeless mentally ill youth.

- **Moves away from improving access to comprehensive services linked with housing.** Homeless people with mental illness need easy access to treatment, comprehensive support services, and housing. Access to comprehensive and integrated services is a priority for the Clinton Administration and Secretary Shalala. ACCESS represents an initial laboratory from which we will learn and be better equipped to expand the concept of service integration, not only among providers that serve homeless persons but also the service community generally. The concept of linkages with comprehensive support services and housing also is emphasized in the congressional Speakers Task Force on Homelessness Report. Eliminating ACCESS would send the false message that such linkages are no longer important to the Administration or of Congress.

- **Moves away from improving access to mainstream programs.** There is broad consensus that targeted homeless programs are not effective alone; that we must improve access to mainstream programs by homeless persons. ACCESS embraces this principle and has already made progress in helping to identify and resolve issues in accessing mainstream programs. For example: 1) new initiatives have been developed with SSA to increase enrollment in SSI; 2) discussions have taken place with DOEd to improve linkages with adult education programs; and 3) discussions have taken place with HUD about improving linkages with housing through activities such as mutual TA. This concept also is emphasized in the Federal Plan and the Speakers Task Force Report.

- **Breaks a long tradition of leadership.** The ACCESS program is the latest in a long tradition of projects for homeless mentally ill persons that have provided leadership in developing service protocols and advancing knowledge of homeless mentally ill persons. Case management, outreach and mobile vans, now mainstays in the service field, were first tested in a demonstration environment. Demonstration programs like ACCESS allow us to test innovative service strategies that are unlikely to implemented by block or formula programs that are usually oriented toward conventional services.

- **Spreads scarce resources.** The PATH program must distribute funds to the States, which then further distribute the funds to communities within the States. ACCESS provides selected communities with a significant investment of resources. This concentration of resources allowing them to design more comprehensive service systems (nearly 80% of the funds pay for services) than would otherwise be possible. The expertise and knowledge they generate allows more effective implementation of these strategies in other communities.

SEC. 13. NONDISCHARGEABILITY IN BANKRUPTCY OF PAYBACK FOR MENTAL HEALTH CLINICAL TRAINEESHIPS.

(a) General Rule.--Section 363(d) is amended by adding at the end the following:

"(6) Any obligation of an individual under paragraph (3) may be released by a discharge in bankruptcy under title 11, United States Code, only if the discharge is granted after the expiration of the seven-year period beginning on the first date that payment under that paragraph is required, and only if the Bankruptcy Court finds that the nondischarge of the obligation would be unconscionable.".

(b) Effective Date.--The amendment made by subsection (a) applies to bankruptcy proceedings in which a discharge has not been granted before 31 days after the date of enactment of this Act.

(c) Conforming Amendments to Bankruptcy Code.--

(1) Section 523(a) of title 11, United States Code, is amended--

(A) by striking "or" at the end of paragraph (11),

(B) by adding "or" at the end of paragraph (12), and

(C) by adding at the end the following:

"(13) that under provisions of the Public Health Service Act is not to be discharged.".

(2) Section 1328(a)(2) of title 11, United States Code, is amended by striking "or (8)" and inserting ", (8), or (13)".

690-6960

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DISCUSSION DRAFT

June 27, 1994

10:45 a.m.

103d CONGRESS
2d SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. WAXMAN introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to concentrate Federal resources for the treatment of substance abuse on expanding the availability of treatment to individuals with serious addictive disorders involving alcohol or drugs, and to revise and extend the program for the Substance Abuse and Mental Health Services Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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SECTION 1. SHORT TITLE.

This Act may be cited as the "[Serious Substance Abuse Disorders Emergency Substance Abuse Treatment Act of 1994]".

TITLE I—FORMULA GRANTS UNDER TITLE XIX OF PUBLIC HEALTH SERVICE ACT

SEC. 101. MENTAL HEALTH.

Section 1920(a) of the Public Health Service Act (42 U.S.C. 300x-9(a)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $378,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

SEC. 102. SUBSTANCE ABUSE.

(a) PURPOSE OF GRANTS; TREATMENT OF SERIOUS SUBSTANCE ABUSE DISORDERS.—Section 1921 of the Public Health Service Act (42 U.S.C. 300x-21) is amended—

(1) in subsection (b), by striking to "to prevent and treat substance abuse" and inserting the following: "to prevent substance abuse and to treat cases involving substance abuse serious addictive disorders"; and

(2) by adding at the end the following sub section:

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"(c) SERIOUS SUBSTANCE ABUSE DISORDERS.—

"(1) IN GENERAL.—For purposes of this subpart, the term 'serious substance abuse disorder', with respect to the abuse of alcohol or drugs, means that the extent of such abuse by an individual significantly predisposes the individual to any of the following: Acts of violence; incarceration under the criminal justice system; infectious disease; abuse and neglect; homelessness; unemployment; termination of participation in programs of education or training; or any other circumstance involving a significant adverse effect on the individual.

"(2) REFERENCES.—With respect to the expenditure of a grant under subsection (a), each reference in this subpart to the treatment of substance abuse, including a reference to the treatment of the abuse of a particular substance, shall be considered to be a reference to the treatment of serious substance abuse disorders.".

(b) STRIKING OF CERTAIN ALLOCATION REQUIREMENT.—Section 1922 of the Public Health Service Act (42 U.S.C. 300x-32) is amended—

(1) by striking subsection (a); and

(2) by redesignating subsections (b) and (c) as subsections (a) and (b), respectively.

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(c) PRIMARY PREVENTION PROGRAMS.—Section 1922(a)(1)(B) of the Public Health Service Act, as redesignated by subsection (b) of this section, is amended by inserting before the semicolon the following: "(which may include activities under any State program for reducing or discouraging the use of substances with significant adverse health effects)".

(d) MISCELLANEOUS PROVISIONS.—Subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x-21 et seq.) is amended—

(1) by striking "in the collection of data in this paragraph is carrying out" in section 1935(b)(1)(B) and inserting "is carrying out"; and

(2) by striking the final subparagraph in the first paragraph of the first subsection of section 1931 (and by adding "or" after the semicolon at the end of the fourth subparagraph of the paragraph, and by striking "; or" at the end of the paragraph (as so amended) and inserting a period).

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 1935(a) of the Public Health Service Act (42 U.S.C. 300x-35(a)) is amended—

(1) by striking "and" after "1993."; and

(2) by inserting before the period the following: ", $1,600,000,000 for fiscal year 1995, and such

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sums as may be necessary for each of the fiscal years 1996 and 1997".

TITLE II—PROGRAMS UNDER TITLE V OF PUBLIC HEALTH SERVICE ACT

SEC. 201. PROGRAMS OF CENTER FOR MENTAL HEALTH SERVICES.

(a) CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.—Section 565(f)(1) of the Public Health Service Act (42 U.S.C. 290ff-4(f)(1)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $100,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(b) CERTAIN DEMONSTRATION PROJECTS.—Section 520A(e)(1) of the Public Health Service Act (42 U.S.C. 290bb-32(e)(1)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $50,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(c) DEMONSTRATION PROJECTS REGARDING POSITIVE TEST RESULTS FOR HIV.—Section 520B(j) of the

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Public Health Service Act (42 U.S.C. 290bb-33(j)) is amended by inserting before the period the following: ", $5,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(d) PROJECTS FOR ASSISTANCE WITH TRANSITION FROM HOMELESSNESS.—

(1) IN GENERAL.—Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc-35(a)) is amended to read as follows:

"(a) IN GENERAL.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this part (subject to paragraph (2)), there are authorized to be appropriated $80,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(2) AUTHORITY REGARDING RELATED CATEGORICAL PROGRAM.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary may obligate not more than 10 percent for carrying out section 506.".

(2) FUNDING OF RELATED CATEGORICAL PROGRAM.—Section 506(e) of the Public Health Service Act (42 U.S.C. 290aa-5(e)) is amended to read as follows:

"(e) [RULE OF CONSTRUCTION].—[No amounts are authorized to be appropriated under this section.]".

SEC. 202. PROGRAMS OF CENTER FOR SUBSTANCE ABUSE TREATMENT.

(a) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb-1(r)(1)) is amended—

(1) [in subsection (l), by striking "such agreements" and inserting "the funding agreements required in this section"]; and

(2) in subsection (r)(1)—

(A) by striking "and" after "1993,"; and

(B) by inserting before the period the following: ", $100,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(b) DEMONSTRATION PROJECTS OF NATIONAL SIGNIFICANCE.—

(1) NATURE OF PROJECTS.—Section 510(b) of the Public Health Service Act (42 U.S.C. 290bb-3(b)) is amended—

(A) in paragraph (5), by striking "and" after the semicolon at the end;

(B) by redesignating paragraph (7) as paragraph (8); and

(C) by inserting after paragraph (6) the following paragraph:

"(7) projects to provide, in accordance with section 511, treatment services to individuals under the supervision of State or local criminal justice systems; and".

(2) FUNDING.—Section 510(a) of the Public Health Service Act (42 U.S.C. 290bb-3(a)) is amended—

(A) in paragraph (1), in the first sentence—

(i) by striking "and" after "1993,"; and

(ii) by inserting before the period the following: ", $125,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997"; and

(B) in paragraph (2), by inserting before the period the following: "and not less than $35,000,000 for the treatment services under this section for individuals with serious substance abuse disorders (as defined in section 1921(c))".

(3) FUNDING FOR CERTAIN PROGRAM—

(A) Section 510(a) of the Public Health Service Act (42 U.S.C. 290bb–3(a)) is amended by adding at the end the following paragraph:

"(3) AUTHORITY REGARDING MODEL COMPREHENSIVE PROGRAM IN NATIONAL CAPITAL AREA.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary may obligate such amounts as the Secretary determines to be appropriate for carrying out section 571.".

(B) Section 571 of the Public Health Service Act (42 U.S.C. 290gg) is amended by striking subsection (b).

(c) TREATMENT IN STATE AND LOCAL CRIMINAL JUSTICE SYSTEMS.—Section 511 of the Public Health Service Act (42 U.S.C. 290bb–4) is amended—

(1) by striking each of subsections (a) and (d);

(2) by striking "511." and all that follows through "(b) ELIGIBILITY.—" and inserting "511. (a) ELIGIBILITY.—";

(3) by redesignating subsection (c) as subsection (b), respectively;

(4) in subsection (a) (as redesignated by paragraph (2) of this subsection), by striking "In awarding grants under subsection (a), the Director shall"

and inserting the following: "In awarding grants under section 510(b)(7) (relating to treatment for individuals under criminal justice supervision), the Director of the Center for Substance Abuse Treatment shall";

(5) in subsection (b) (as redesignated by paragraph (3) of this subsection), by striking "awarding grants under subsection (a)" and inserting "awarding grants described in subsection (a)"; and

(6) by adding at the end the following subsection:

"(c) RULE OF CONSTRUCTION.—No amounts are authorized to be appropriated under this section. For grants described in subsection (a), section 510(c) is the exclusive authorization of appropriations [under this part].".

(d) TRAINING IN PROVISION OF TREATMENT SERVICES.—Section 512(d) of the Public Health Service Act (42 U.S.C. 290bb-6(d)) is amended—

(1) by striking "and" after "1993,"; and

(2) by inserting before the period the following: ", $3,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

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SEC. 301. PROGRAMS OF CENTER FOR SUBSTANCE ABUSE PREVENTION.

(a) COMMUNITY PROGRAMS.—Section 516(e) of the Public Health Service Act (42 U.S.C. 290bb-22(e)) is amended to read as follows:

"SUBSTANCE ABUSE PREVENTION DEMONSTRATION PROJECTS OF NATIONAL SIGNIFICANCE

"SEC. 516. (a) IN GENERAL.—The Director of the Center for Substance Abuse Prevention shall make awards of grants, cooperative agreements, and contracts to public and nonprofit private entities for the purpose of establishing demonstration projects that will improve the provision of prevention services for substance abuse.

"(b) NATURE OF PROJECTS.—In carrying out subsection (a), the Director shall make awards for the following projects:

"(1) Projects providing assistance to communities to develop comprehensive long-term strategies for the prevention of substance abuse.

"(2) Projects for evaluating the success of different community approaches toward the prevention of substance abuse.

"(3) Projects to assist business organizations in establishing employee assistance programs to provide appropriate service for employees of the organization

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regarding substance abuse, including education and prevention services and referrals for treatment.

"(4) Projects linking community-based prevention activities with primary health care systems, including health plans.".

(b) MODEL PROJECTS FOR HIGH RISK YOUTH.—Section 517(h) of the Public Health Service Act (42 U.S.C. 290bb-23(h)) is amended—

(1) by striking "and" after "1993."; and

(2) by inserting before the period the following: ", $68,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(c) EMPLOYEE ASSISTANCE PROGRAMS.—Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb-21 et seq.) is amended by striking section 518.

SEC. 208. DEMONSTRATIONS AND EVALUATIONS REGARDING SYSTEMS OF CARE.

Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following section:

"DEMONSTRATIONS AND EVALUATIONS REGARDING SYSTEMS OF TREATMENT

"SEC. 506A. (a) IN GENERAL.—The Secretary, acting through the Administrator, may make awards of

grants, cooperative agreements, and contracts to public and nonprofit entities to demonstrate and evaluate projects for improving systems for providing substance abuse and mental health services.

"(b) REQUIREMENT REGARDING INTEGRATED SYSTEM.—The Secretary may make a grant under subsection (a) only if the project involved provides for an integrated system of delivering substance abuse and mental health services.

"(c) CERTAIN AUTHORITIES.—With respect to the system for which an award under subsection (a) is provided, the purposes for which the Secretary may authorize the award to be expended include the following:

"(1) Integrating the provision of the services of the system with the provision of primary health services.

"(2) Establishing linkages between the system and health plans.

"(3) Evaluation of programs of oversight and case management in order to determine the extent to which the services of the system are provided in a cost-effective manner.

"(d) FUNDING.—Of the amounts appropriated under section 510, 515, and 520A for a fiscal year, the Secretary

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may obligate not more than $50,000,000 for carrying out this section.".

TITLE III—OTHER PROGRAMS

SEC. 301. NATIONAL RESEARCH INSTITUTES.

Reauthorize NIDA, NIAAA, NIMA.

SEC. 302. MISCELLANEOUS PROVISIONS.

Title VI of the Stewart B. McKinney Homeless Assistance Act is amended by striking section 612.