DRUG ABUSE PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1979

HEARING

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 525

TO AMEND THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972, AND FOR OTHER PURPOSES

MARCH 2, 1979

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FRIDAY, MARCH 2, 1979

U.S. SENATE,
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:08 a.m., in room 4232, Dirksen Senate Office Building, Senator Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Present: Senator Riegle.

Staff present: Craig Polhemus, counsel, Nancy Olson and Ruth Kane, professional staff members, and Robert Hunter, minority counsel.

Senator RIEGLE. The subcommittee will come to order.

I want to welcome everyone who is here today at the subcommittee's third day of hearings concerning the reauthorization of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Today's hearing focuses primarily on the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1979, which I have introduced along with Senator Williams, the chairman of the full Labor and Human Resources Committee.

We have quite an extensive witness list today, and will be covering a lot of ground, so I will be brief. Our Federal drug policy is struggling to adjust to new drug abuse patterns, new budget restraints, and new organizational structures. I believe it is especially important that Federal management techniques are designed to get the most out of every prevention and treatment dollar.

Our witnesses today face the problems of dealing with limited resources and almost unlimited needs on a daily basis. Former Senator Harold Hughes, the first chairman of this subcommittee, is noted for his lifelong commitment to alcoholics, drug abusers, and the other Americans who most need our understanding and support. I am extremely glad that Senator Hughes has agreed to testify, and he will be here just a little bit later in the morning, and we will be pleased to hear what he has to say at that time.

Our other witnesses represent the administration, the General Accounting Office, and professionals in the areas of prevention and treatment. In addition, we are fortunate to have with us a young man who has gone through the hell of drug addiction. He will be testifying to us first this morning about his personal experiences, so that we can be in a position to have that kind of understanding of the problems that he has faced, and we, as a Nation, must face,

and be better able to deal with. I appreciate that he is willing to share his experiences with us.

He will be appearing anonymously as John Doe, and I would ask that the television cameras, and the photographers that are here, not photograph this witness directly, only from the rear, if at all, so that the witness is not directly identified as he speaks.

In summary, I would like to thank Senator Williams for joining with me in introducing the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1979. This bill brings the legislative authority for both the National Institute on Drug Abuse and the White House drug abuse policy mechanism up to date. I hope that today's hearings will help us shape this legislation so that it will meet the needs of the Nation's millions of drug abusers to the risks and temptations of drug abuse in all its forms.

[The text of S. 525 follows:]

96TH CONGRESS
1ST SESSION

S. 525

To amend the Drug Abuse Office and Treatment Act of 1972, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 1 (legislative day, FEBRUARY 22), 1979

Mr. RIEGLE (for himself and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Human Resources

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A BILL

To amend the Drug Abuse Office and Treatment Act of 1972, and for other purposes.

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

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1979".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to

be made to a section or other provision of the Drug Abuse Office and Treatment Act of 1972.

SEC. 2. Section 101 is amended—

(1) by inserting "(in cooperation with employers, employee associations, social service organizations, and associations of concerned individuals)" after "programs" in paragraph (8); and

(2) by inserting at the end thereof the following new paragraphs:

"(11) Shifts in the usage of various drugs and in the Nation's demographic composition require a Federal strategy to adjust programs and techniques in order to meet new needs and priorities on a cost-effective basis.

"(12) Drug and alcohol abuse indicate the need for prevention and information programs designed to reach the general population and members of particularly vulnerable groups such as youth, older Americans, and families of drug abusers.".

Sec. 3. Title II is amended to read as follows:

"TITLE II—DRUG ABUSE POLICY COORDINATION

"§ 201. **Concentration of Federal effort.**

"(a) The President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, shall establish a system for making recommendations with respect to policies for, objectives of, and establishment of priorities for, Federal drug abuse functions and shall coordinate the performance of such functions by Federal departments and agencies. Recommendations under this subsection shall include recommendations for changes in the organization, management, and personnel of Federal departments and agencies performing drug abuse functions in order to implement the policies, priorities, and objectives recommended under this subsection.

"(b) To carry out subsection (a), the President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, shall—

"(1) review the regulations, guidelines, requirements, criteria, and procedures of Federal departments and agencies applicable to the performance of drug abuse functions;

"(2) conduct, or provide for, evaluations of (A) the performance of drug abuse functions by Federal departments and agencies, and (B) the results achieved by such departments and agencies in the performance of such functions; and

"(3) seek to assure that Federal departments and agencies, in the performance of drug abuse functions, construe drug abuse as a health problem requiring treatment and rehabilitation through a broad range of community health and social services.

"(c) Federal departments and agencies engaged in drug abuse functions shall submit to the President, through the Domestic Council or through such other mechanism as may be set forth by Executive order, such information and reports as may reasonably be required to carry out the purposes of this title.

"**§ 202. Designated drug representative.**

"(a) The President shall designate a single officer or employee of the Domestic Council, or of such other mechanism as may be established by Executive order to carry out the purposes of this title, to direct the activities required by this title. The officer or employee so designated shall serve as the President's representative on drug abuse functions and the location of such designee in the Executive Office of the President or elsewhere shall not be construed as affecting access by the Congress, or committees of either House, (1) to information, documents, and studies in the possession of, or conducted by or at the direction of, such designee, or (2) to personnel involved in carrying out the purposes of this title.

"(b) The President may direct the officer or employee designated under subsection (a) of this section to represent the Government of the United States in discussions and negotiations relating to drug abuse functions.

"§ 203. Officers and employees.

"In carrying out the purposes of this title, the President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to perform the functions vested in him by this title. At the discretion of the President, any officer or employee engaged in carrying out the purposes of this title may be allowed and paid travel expenses, including per diem in lieu of subsistence, in the same manner as is authorized by section 5703 of title 5, United States Code, for individuals employed intermittently.

"§ 204. Employment of experts and consultants.

"In carrying out the purposes of this title, the President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, may procure services as authorized by section 3109 of title 5, United States Code, and may pay a rate for such services not in excess of the rate in effect for grade GS–18 of the General Schedule. The President, acting through the Domestic Council or through such other mechanism as may be set forth by

Executive order, may employ individuals under this section without regard to any limitation, applicable to services procured under such section 3109, on the number of days or the period of such services, except that, at any one time, not more than six individuals may be employed under this section without regard to such limitation.

"§ 205. Acceptance of uncompensated services.

"In carrying out the purposes of this title, the President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, is authorized to accept and employ in furtherance of the purpose of this Act voluntary and uncompensated services notwithstanding the provisions of section 3679(b) of the Revised Statutes (31 U.S.C. 665(b)).

"§ 206. Notice relating to the control of dangerous drugs.

"Whenever the Attorney General determines that there is evidence that—

"(1) a drug or other substance, which is not a controlled substance (as defined in section 102(6) of the Controlled Substances Act), has a potential for abuse, or

"(2) a controlled substance should be transferred or removed from a schedule under section 202 of such Act, he shall, prior to initiating any proceeding under section 201(a) of such Act, give the President, through

the Domestic Council or through such other mechanism as may be set forth by Executive order, timely notice of such determination. Information forwarded to the Attorney General pursuant to section 201(f) of such Act shall also be forwarded by the Secretary of Health, Education, and Welfare to the President through the Domestic Council or through such other mechanism as may be set forth by Executive order.

"§ 207. **Statutory authority unaffected.**

"Nothing in this title shall be construed to limit the authority of the Secretary of Defense with respect to the operation of the Armed Forces or the authority of the Administrator of Veterans' Affairs with respect to the furnishing of health care and related services to veterans.

"§ 208. **Annual report.**

"The President, acting through the Domestic Council or through such other mechanism as may be set forth by Executive order, shall submit to the Congress, prior to March 1 of each year, a written report on the activities conducted to carry out the purposes of this title. The report shall specify the objectives, nature, and results of such activities, and shall contain an accounting of funds expended under this title.

"§ 209. **Appropriations authorized.**

"For purposes of carrying out this title, there is authorized to be appropriated such sums as may be necessary for each fiscal year ending prior to October 1, 1982.".

SEC. 4. This title shall become effective on October 1, 1979, or upon enactment, whichever is later.

SEC. 5. (a) Section 302 is amended by striking out "Director of the Office of Drug Abuse Policy" and inserting in lieu thereof "representative designated under section 202 of this Act".

(b) Section 304 is amended by striking out "Director of the Office of Drug Abuse Policy" and inserting in lieu thereof "President, through the Domestic Council or through such other mechanism as may be set forth by Executive order".

(c) The first sentence of section 409(a) of the Drug Abuse Office and Treatment Act of 1972 is amended—

(1) by striking out "and" after "1978"; and

(2) by inserting "and such sums as may be necessary for each succeeding fiscal year ending prior to October 1, 1982," after "1979,".

SEC. 6. Section 409(e) is amended—

(1) by inserting "with attention to assuring representation of minority and poverty groups, women, youth, and the aged," after "affected by drug abuse" in paragraph (3);

(2) by inserting the following before the semicolon in paragraph (4): ", and set forth in detail the changes in emphasis among such functions resulting from shifts in demographic and drug abuse patterns within the State";

(3) by striking out "and" at the end of subparagraph (5)(A);

(4) by striking out "by" after "drug dependence by women and" in subparagraph (5)(B);

(5) by inserting the following after "drug dependence by women": ", youth, older individuals, residents of urban and rural areas";

(6) by inserting the following at the end of subparagraph (5)(B): "(C) provide assurances satisfactory to the Secretary that, insofar as practicable, the survey conducted pursuant to subparagraph (A) is coordinated with and not duplicative of the alcohol abuse and alcoholism survey conducted pursuant to section 303 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970;";

(7) by inserting "(A)" after "in the State" in paragraph (7);

(8) by inserting the following before the semicolon in paragraph (7): ", (B) to review and comment on the plan prior to its submission to the Secretary, and (C)

to submit to the Secretary as an appendix to the plan such comments as such political subdivisions believe are relevant to approval of the plan under paragraph (f)";

(9) by inserting "(A)" after "(9)";

(10) by inserting after subparagraph (9)(A) the following new subparagraph:

"(B) provide that the Comptroller General of the United States or his duly authorized representatives shall have access for the purpose of audit and examination to the records specified in subparagraph (A);";

(11) by inserting "and of the extent to which other State programs and political subdivisions throughout the State are concerned and dealing effectively with the problems related to drug abuse and drug dependence" after "under the plan" in paragraph (10);

(12) by striking out "and" at the end of paragraph (12);

(13) by redesignating paragraph (13) as paragraph (17); and

(14) by inserting after paragraph (12) the following new paragraphs:

"(13) contain, to the extent feasible, a complete inventory of all public and private resources available

in the State for the purpose of drug abuse and drug dependence treatment, prevention, and rehabilitation, including but not limited to programs funded under State and local laws, occupational programs, voluntary organizations, education programs, military and Veterans' Administration resources, and available public and private third-party payment plans;

"(14) provide assurance that the State agency will coordinate its planning with local drug abuse planning agencies, with State and local alcoholism and alcohol abuse planning agencies, and with other State and local health planning agencies;

"(15) provide assurance that State certification, accreditation, or licensure requirements, if any, applicable to drug abuse and drug dependence treatment facilities and personnel take into account the special nature of such programs and personnel, including the need to include nonmedical aspects of treatment and the need to acknowledge previous experience when assessing the adequacy of treatment personnel;

"(16) provide assurance that the State agency—

"(A) will foster and encourage the development of drug abuse and drug dependence prevention, treatment, and rehabilitation programs and

services in State and local governments and in private businesses and industry;

"(B) will make available to all business concerns and governmental entities within such State information and materials concerning such model programs suitable for replication on a cost-effective basis as are developed pursuant to section of this Act; and

"(C) will furnish technical assistance as requested to such business concerns and governmental entities; and".

SEC. 7. Section 410(a) is amended—

(1) by inserting the following after "development" in paragraph (1): ", demonstration, and evaluation";

(2) by inserting "and detoxification" before "techniques" in paragraph (5);

(3) by inserting the following before the semicolon in paragraph (5): ", including supportive services to prevent relapse into drug abuse or drug dependence"; and

(4) by inserting the following before the period in paragraph (6): ", with particular emphasis on replicating effective prevention and treatment programs in areas of the greatest need for such programs".

SEC. 8. Section 410(b) is amended by adding at the end thereof the following new sentence: "For each succeeding fiscal year ending prior to October 1, 1982, there are authorized to be appropriated (1) such sums as may be necessary for grants and contracts under paragraphs (3) and (6) of subsection (a) for drug abuse treatment programs, and (2) such sums as may be necessary for grants and contracts under such subsection for other programs and activities.".

SEC. 9. Section 413(a) is amended—

(1) by striking out "Civil Service Commission" and inserting in lieu thereof "Office of Personnel Management";

(2) by striking out "Director" and inserting in lieu thereof "President (acting through the Domestic Council or through such other mechanism as may be set forth by Executive order), with the Secretary (acting through the National Institute on Drug Abuse),";

(3) by inserting "and in accordance with the provisions of subpart F of part III of title 5, United States Code, as amended by the Civil Service Reform Act of 1978" after "other Federal agencies and departments"; and

(4) by inserting "and their families" after "Federal civilian employees".

SEC. 10. Section 413(b) is amended to read as follows:

"(b)(1) The Secretary, acting through the National Institute on Drug Abuse, shall be responsible for fostering and encouraging similar drug abuse prevention, treatment, and rehabilitation programs and services in State and local governments and in private industry.

"(2) Consistent with such responsibility, the Secretary, acting through the National Institute on Drug Abuse, shall develop a variety of model programs suitable for replication on a cost-effective basis in different types of business concerns and State and local governmental entities, taking into account the number of employees, geographical location, proximity to other concerns and entities, and availability of existing services from public agencies and private organizations. With respect to small business concerns, the Secretary, acting through the National Institute on Drug Abuse, shall consult with the Small Business Administrator in the development of model programs affecting such concerns.

"(3) With respect to business concerns and governmental entities which employ individuals represented by labor organizations, such model programs shall be designed to operate through the collective bargaining process.

"(4) The Secretary, acting through the National Institute on Drug Abuse, shall disseminate information and materials to single State agencies designated pursuant to section

409 of this Act, and shall provide technical assistance to such agencies as requested.

"(5) To the extent feasible, model programs developed pursuant to this section shall be capable of coordination with model programs developed pursuant to section 201(b) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.".

SEC. 11. (a) Title IV is amended by adding at the end thereof the following new section:

"**§ 414. Admission of drug abusers to social services.**

"(a) Drug abusers who are suffering from personal, emotional, or social conditions shall not be discriminated against in admission or care, solely because of their drug abuse or drug dependence, by any private or public social service, mental health, intermediate care, rehabilitation, or other service-related facility which receives support in any form from any program supported in whole or in part by funds appropriated to any Federal department or agency.

"(b) The Secretary shall issue regulations not later than twelve months after the enactment of this section for the enforcement of the policy of subsection (a) with respect to the admission and care of drug abusers in facilities covered by this section. Such regulations shall include procedures for determining (after opportunity for a hearing if requested) if a violation of subsection (a) has occurred, notification of failure

to comply with such subsection, and opportunity for a violator to comply with such subsection. If the Secretary determines that a facility which receives support of any kind from any program administered by the Secretary and subject to such regulations has violated subsection (a) and such violation continues after an opportunity has been afforded for compliance, the Secretary may suspend or revoke, after opportunity for a hearing, all or part of any support of any kind received by such facility from any program administered by the Secretary. The Secretary may consult with the officials responsible for the administration of any other Federal program from which a facility covered by subsection (a) receives support of any kind, with respect to the suspension or revocation of Federal support for any facility found to violate such subsection.".

(b) The table of sections at the beginning of title IV is amended by adding at the end thereof the following new item:

"414. Admission of drug abusers to social services.".

SEC. 12. Section 502 is amended by inserting at the end thereof the following new subsection:

"(d) On the request of any State, the Secretary shall make available technical assistance for the purposes of developing and improving systems for data collection; program management, accountability, and evaluation; certification, ac-

creditation, or licensure of treatment facilities and personnel; monitoring compliance to Federal requirements of hospitals and other facilities; and developing demonstration projects or implementing through such State's insurance regulatory process a requirement that will constitute significant progress toward coverage of drug abuse and drug dependence by health insurance plans equivalently with other chronic health conditions. Insofar as practicable, such technical assistance shall be provided in such a manner as to improve coordination between activities funded under this Act and under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.".

SEC. 13. Section 503(a) is amended—

(1) by striking out "to create, develop, and test" and insert in lieu thereof the following: ", investigations, experiments, demonstrations, and studies, into";

(2) by inserting "the creation, development, and testing of" after "(1)", "(2)", and "(3)", respectively;

(3) by striking out "and" at the end of paragraph (2);

(4) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; and"; and

(5) by inserting after paragraph (3) the following new paragraph:

"(4) the social, behavioral, and biomedical etiology, treatment, mental and physical health consequences, and social and economic consequences of drug abuse and drug dependence.".

SEC. 14. Section 503(b) is amended—

(1) by striking out "and" after "1978,"; and

(2) by inserting before the period a comma and the following: "and such sums as may be necessary for each succeeding fiscal year ending prior to October 1, 1982".

SEC. 15. Section 503 is further amended by adding at the end thereof the following new subsection:

"(c) In carrying out the program described in subsection (a) of this section, the Secretary, acting through the Institute, is authorized to—

"(1) collect and make available through publications and other appropriate means, information as to, and practical application of, the research and other activities under the program;

"(2) make available research facilities of the Public Health Service to appropriate public authorities, and to health officials and scientists engaged in special study;

"(3) make grants to universities, hospitals, laboratories, and other public or nonprofit institutions, and to

individuals for such research projects as are recommended by the National Advisory Council on Drug Abuse, with particular emphasis on investigating poly-drug abuse (including the relationship between abuse of alcohol and other drugs);

"(4) secure from time to time and for such periods as he deems advisable, the assistance and advice of experts, scholars, and consultants from the United States or abroad;

"(5) promote the coordination of research programs conducted by the Institute, and similar programs conducted by other agencies, organizations, and individuals, including all National Institutes of Health research activities which are or may be related to the problems of individuals suffering from drug abuse or drug dependence or the drug abuse or dependence of members of their families;

"(6) for purposes of study, admit and treat at institutions, hospitals, and stations of the Public Health Service, persons not otherwise eligible for such treatment;

"(7) provide to health officials, scientists, and appropriate public and other nonprofit institutions and organizations, technical advice and assistance on the ap-

plication of statistical methods to experiments, studies, and surveys in health and medical fields; and

"(8) adopt, upon recommendation of the National Advisory Council on Drug Abuse, such additional means as he deems necessary or appropriate to carry out the purposes of this section.".

SEC. 16. Section 217(e)(1) of the Public Health Service Act is amended—

(1) by inserting the following before the period in the third sentence: ", including officers or employees of State and local drug abuse agencies"; and

(2) by inserting at the end thereof the following new sentence: "Appointed members may serve after the expiration of their terms until their successors have taken office.".

SEC. 17. (a) The Drug Abuse and Treatment Act of 1972 is amended by striking out the title of the Act each place it appears and inserting in lieu thereof the following new title of the Act: "Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1972".

(b) Whenever reference is made in any other Federal law, regulation, ruling, or order to the Drug Abuse Office and Treatment Act of 1972, the reference shall be considered to be made to the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1972.

Senator RIEGLE. At this time I ask to come to the witness table our John Doe witness, who will describe some of his personal experiences. He will be accompanied by Mr. Mark Bertler, who is the project director of the Coalition of Runaway Services, from Lansing, Mich., and Mr. Ken Skalitzky, who is here representing a rehabilitation project from Kent County, Mich.

So would the three of them please come to the witness table at this time?

Let me welcome all of you to the committee, and give you a minute to relax. This setting, I know, is a little intimidating, or can be, but you are with friends here, and we are pleased to have you come and share your thoughts with us. So if I may, let me call on our expert witness, who is sitting in the middle, and let me say to you that we very much appreciate the fact that you are here. I think the way you can help us the most, and the way that you can help other people right now, is to give us an insight into some of the problems that you have experienced, and some of the things that you have seen, so other people can have an understanding, so that they can really know things about what drug abuse means, that they cannot any other way, unless they hear from someone who has experienced it.

So, why do you not go ahead, and the microphones can be moved over so that everyone in the room can hear you. Why do you not just take your time, and when you are ready, tell us what you would like us to hear?

STATEMENTS OF JOHN DOE; MARK BERTLER, PROJECT DIRECTOR, COALITION OF RUNAWAY SERVICES, LANSING, MICH., AND KEN SKALITZKY, PROJECT REHAB-SUNRISE PROGRAM, KENT COUNTY, MICH.

Mr. BERTLER. I am trying to pry my witness.

Senator RIEGLE. I understand. Take your time. There is water there. Take a glass of water.

Mr. DOE. Well, in the beginning it was like sniffing toil, glue, gasoline.

Senator RIEGLE. How old were you when you started using these different kinds of things that you mentioned?

Mr. DOE. I would say around 13.

Senator RIEGLE. About 13?

Mr. DOE. Yes, and I am 17 now.

Senator RIEGLE. You are 17 now?

Mr. DOE. Yes.

Senator RIEGLE. Could you say again what you got started with? What was the first drug?

Mr. DOE. It was sniffing toil and glue.

Senator RIEGLE. What was the other thing?

Mr. DOE. Toil.

Senator RIEGLE. Then what happened next?

Mr. Doe Well, I met—I got help from the Project, and at first—well, it did not work for me, because I did not want it to work.

Senator RIEGLE. You mean you did not want help initially?

Mr. DOE. Yes. I guess I broke away for a while, because I would not see anybody, and then I was in trouble again for—I was in trouble again for taking something that did not belong to me, and I

was put in juvenile, and in those times before, I was getting into drugs again, smoking pot, taking chemicals.

Senator RIEGLE. Can you tell us why you decided to do that? Why does a young person who is 13—I am sure some of your friends were also doing this—but what prompted you to get started in to using drugs of this sort?

Mr. DOE. To use it, it was not much to do, and we thought it would be fun, and did things, it was just to have fun, show that we were big to each other, and that is all that came up. When I was in juvenile, they came to see me again, Project Rehab, they helped a lot, they came there and talked to me, and that is about how it was.

Senator RIEGLE. Did your family know that you were doing this?

Mr. DOE. Yes, they knew. My dad, he tried talking to me about it, and one day I just—he caught me, he talked to me about it. I told him I wanted help, and that is when I started getting help.

First I went down to juvenile court, and I was supposed to go to a court anyhow, in the future, but they just took me down, and I was placed in juvenile court with the promise from somebody to help get me off the drugs, and at Project Rehab, they did.

Senator RIEGLE. Were there many other people in the age range of 13 that you knew were also using drugs?

Mr. DOE. Yes.

Senator RIEGLE. How many, would you say? Was it a lot of your friends, and kids in school?

Mr. DOE. Yes.

Senator RIEGLE. How did you get the drugs?

Mr. DOE. Well, from people around there, just people that lived around there. There is a lot of people into it.

Senator RIEGLE. So it was not hard to get the drugs?

Mr. DOE. No; it is not hard.

Senator RIEGLE. How did you get the money to pay for these?

Mr. DOE. Process of B&E, breaking and entering.

Senator RIEGLE. So, in other words, you just got the money however you could. If you had to steal the money you just did that?

Mr. DOE. Yes.

Senator RIEGLE. Do you think now, looking back on this, was there a point that you got hooked on drugs, so that instead of just being fun, and something that you were doing to kind of show off, that it became something that you needed to do?

Mr. DOE. Yes; like after we would get up, and they would go right to it. As soon as we could get away. Sometimes we do it before school. So you could make it through school, and then after school, or we would not even go to school. We would do the drugs. Like if you wake up and you did not have it, you are really nervous, and you had to have it, and it was not very good.

Senator RIEGLE. How long did it take before you reached that stage, that you found you really needed to do this every day, a year or so?

Mr. DOE. No; it did not take that long.

Senator RIEGLE. It did not take that long?

Mr. DOE. Because it was most of the sniffing that took effect faster. In the morning you would get really nervous, you had to have it, so you would go out and try to get it, and you could get it.

Senator RIEGLE. So this addiction then really came about quite quickly?

Mr. DOE. Yes.

Senator RIEGLE. What was it like after you started using these drugs, when you would—you know, after you would get up in the morning and use them, and so forth, and go to school. Did it affect your behavior? How were you different?

Mr. DOE. Oh, well, in the morning, at first, you really were not feeling too good at all. You were sick, and your head was always spinning, and then I thought if I did not get it together it would make me feel better, and in a way it did. I do not know. I would just act goofy, really, after doing it. Things would go by different. I do not know. I just think I was like flying sometimes, and I would not pay attention to anything.

Senator RIEGLE. So you were just kind of spaced out when you were in school?

Mr. DOE. Yes.

Senator RIEGLE. How many of your school mates, in say classes that you were in, do you think were in the same shape that you were in?

Mr. DOE. Some of the students that did go to school, I did not know many from the school yard.

Senator RIEGLE. Pardon?

Mr. DOE. I did not know many from the school that I was going to at that time. But other kids from the neighborhood, because I was in a different type of school, for help to them. It was like an easier type of work for me.

Senator RIEGLE. I would like you to describe, if you would, some of the things that you specifically were involved in, or that you saw happen, with yourself or other young people like yourself who were really doing whatever they had to to get the money to pay for these drugs. When you say beatings, were you beating up other kids in school?

Mr. DOE. No; B&E, breaking and entering.

Senator RIEGLE. I beg your pardon. How long was that taking place?

Mr. DOE. Well, mostly like every day. Some of us would get caught, and like some of it bothers for a while, but everybody forgets about it, and they would do it again.

Senator RIEGLE. Were you not afraid when you broke into somebody's house, that they would hurt you, or something of that sort?

Mr. DOE. No. Well, not really. I cannot say that I was.

Senator RIEGLE. How many times did you do that?

Mr. DOE. It was plenty of times.

Senator RIEGLE. Many times?

Mr. DOE. Yes.

Senator RIEGLE. You would have been what, 14, at this time?

Mr. DOE. I think around that.

Senator RIEGLE. Were there other people with you when you would do this, would there be a group of you doing this, or would you be doing it by yourself?

Mr. DOE. Two to three people.

Senator RIEGLE. Did you ever get to the point where you were prepared to do something violent against somebody else, or did it never come to that?

Mr. DOE. Well, we planned one, once, to a cottage, and we planned that one out, so that is the only one I can think of. The other ones you would walk down the street and see a house, and nobody home, so you would go there.

Senator RIEGLE. Let me ask you now, one of the two of the fellows sitting beside you have been working with you and assisting you, is that right?

Mr. SKALITZKY. Yes, Mr. Chairman, that is myself.

Senator RIEGLE. Why do you not fill out the picture of what you saw as a staff person trying to assist in this area, when you first came in contact with this young man? What was the profile that you saw, how would you describe the situation?

Mr. SKALITZKY. My name is Ken Skalitzky, and I am the Sunrise supervisor from Project Rehab, and Mr. Doe's testimony is not much different from other characters, or clients that we have, that come in to our program.

Mr. Doe was initially referred to the program because of the Juvenile Court program, which is their program, in trying to assist individuals in getting treatment before they are actually put into a boys' training school for punishment. It is like a last ditch effort to get help for these individuals, and so his case was referred to the program for treatment because of his toil use. Toil is the street name for a substance called toluene, which is available in the Grand Rapids area, because of our history as a furniture capital.

Senator RIEGLE. Tell us something about that, toluene, am I saying that right?

Mr. SKALITZKY. Yes, Mr. Chairman. Toluene is a petroleum by-product. It is used in many cleaning substances, it is also used in the glue processing, it was one of the main ingredients in what we know as airplane glue. The toil has since been removed, but the glue does contain substances which does cause intoxication. It is also present in approximately 32 household items that are readily available on a daily basis.

For example, hair spray, nail polish remover, any kind of paint or varnish, paint thinner. Many products in the home, that are readily available.

Senator RIEGLE. And these products, they can get high from these products?

Mr. SKALITZKY. Yes, Mr. Chairman. It is not always deliberate the first time. If someone gets into a situation with very little ventilation, and all of a sudden they feel kind of dizzy, it is like floating, and you may be familiar with varnish in a closet, for example, I am sure you experienced something similar to that.

However, it easily becomes past this point, because of peer pressure, and because of the feelings of euphoria that it does cause. So an individual who is having a difficult time can certainly escape from that time just by going on a trip.

Senator RIEGLE. How many young people like our witness today, in the early teens, have you come across in the Grand Rapids area, say that are using products like this product tol, which is a street name for this particular——

Mr. SKALITZKY. I would say, Mr. Chairman, approximately, there is about 300 people that we are aware of on a daily basis who are into very heavy inhalant abuse at this point.

Senator RIEGLE. That is just inhaling abuse?

Mr. SKALITZKY. Yes, sir.

Senator RIEGLE. Would that be—are you saying of all ages, or are you saying——

Mr. SKALITZKY. That would be of all ages. Of teenagers, about half of them. Unfortunately, the toil population, the individuals who choose to use toil, come from a low socioeconomic background. The toil is readily available.

Senator RIEGLE. Anybody that wants to get that can get that?

Mr SKALITZKY. It is very readily available in factories, or around factories, it has to be stored outside, because it is highly inflammable. It comes in barrels. They tell me that all they need, is a hammer and nail, and jug, to get it out.

Senator RIEGLE. Are there dealers in it who try to make it readily available?

Mr. SKALITZKY. Yes, Mr. Chairman.

Senator RIEGLE. Tell us about how you get hold of these things.

Mr. DOE. There is one down by the Grand River, some people—I went there once, but we just go down there, follow the river, and you have to go over a bunch of fences and stuff, and then we bring jugs along, first they take the barrel and throw it down the river, and they stash it someplace, so they could come back.

Senator RIEGLE. So you steal this barrel with this substance in it?

Mr. DOE. Yes. Then they take jugs back, and they fill them up, and they would sell them to kids on the street, and put them in pop bottles from the jugs, sell the jugs at a time, gallon jugs.

Senator RIEGLE. How old would the people be who were selling this? Were they your age?

Mr. DOE. Older. Around 18 and 19.

Senator RIEGLE. Eighteen or 19?

Mr. DOE. Yes.

Senator RIEGLE. So if you wanted to buy some of this from them, they would have it in a jug, or they would have it in a pop bottle, what would they charge for that?

Mr. DOE. Well, 16 ounce bottle probably would be about 50 cents.

Senator RIEGLE. Fifty cents for a 16 ounce bottle?

Mr. DOE. That would last a couple of days.

Senator RIEGLE. That would last a couple of days?

Mr. DOE. Yes.

Senator RIEGLE. How would you actually use it? Once you have the container, what is the process?

Mr. DOE. You can take a cloth rag.

Senator RIEGLE. A what?

Mr. DOE. A cloth rag, and you soak it, and keep it between your hand, tight, and you breathe through your hand, like this [indicating].

Senator RIEGLE. So that you have this rag soaked with this material, and then you breathe through your hand, how long does it take before this really has an effect on you?

Mr. DOE. Not too long. You could get high off the first soak, and it does not have to be soaked very much at all, or you could use it in bags, you know, just a bag.

Senator RIEGLE. You put the rag in a bag, and thus breathe through the top of the bag?

Mr. DOE. Yes.

Senator RIEGLE. How long after you have done that, how long does that feeling last?

Mr. DOE. Well, it is not really too long. That is why they make quantities of it.

Senator RIEGLE. So as a result of this, if you did this in the morning before you went to school, as you got to school, as you said earlier, you were doing, you were in your own world? I take it that you probably did not do very well in school at that time?

Mr. DOE. No, I was not.

Senator RIEGLE. Do you want to describe some of the other kinds of products of this sort that are being used by young people like this? What are some of the other common substances that are used?

Mr. SKALITZKY. Mr. Chairman, any of the aerosol cans would have some sort of a propellant in it that would cause intoxication. In a deliberate manner. I do not want to scare people away from using these. This is deliberate inhalation of these substances, hair sprays, and deodorants, paints and varnishes, as I mentioned, and many of the stronger industrial cleaning fluids that you can buy for commercial stains, or special problems, if you put a tile floor down, and you have the glue on the tile. Many of the oven cleaners would have some substance similar to that.

Senator RIEGLE. Is the pattern then that young people like this, young teenagers, will start with these kinds of readily accessible substances, and then graduate up into more complicated kinds of drugs? Is that the general pattern? What tends to be the next steps that occur with a young person like this?

Mr. SKALITZKY. As Mr. Doe mentioned, Mr. Chairman, the pop bottle is extremely cheap, whereas a can of aerosol would be very expensive, or a can of deodorant. So the cost factor would have them move onto a stronger and more dangerous substance.

As I mentioned, these are the lower socioeconomic backgrounds. If they choose to use a drug, the cost alone is the reason that they have decided to use the toil. The symptoms of toil intoxication are similar to alcohol intoxication. The individual stammers, he talks with a slur, he may stagger, fall down, and they also very often have blackout situations, where they will not remember a certain incident at all.

Senator RIEGLE. I gather that most of the friends that you had, that were using drugs of this sort you were using, were basically having to find ways, one way or another, to steal the money to pay for it, is that right? You mentioned the breaking and entering and so forth.

Mr. DOE. Yes.

Senator RIEGLE. Was that true of the other people? Did this force them to do things like that, and commit crimes, in order to get the money to continue to support that kind of a habit that they developed?

Mr. DOE. Yes. It was like some of the older ones, like a couple of years older, and around my age, around that, 2 years older.

Senator RIEGLE. What were some of the worst things that you know about that anybody did in order to get money to get hold of these drugs?

Mr. DOE. Knocking somebody out, and taking their wallet.

Senator RIEGLE. Do you know of cases where that happened?

Mr. DOE. Yes.

Senator RIEGLE. Were they armed when they did this, or did they just come up behind somebody?

Mr. DOE. Yes, it would be more like coming up behind, or scaring them, to give it to them. I never heard of whacking them.

Senator RIEGLE. Were you afraid that this might happen to you, that your addiction would come to the point where you would start doing these things? Or did you, in your own mind, think you would stop short of that?

Mr. DOE. Well, most everybody thinks yeah, I can do it, because I will not get hooked on it. It is like taking cigarettes, and then you get hooked on it.

Senator RIEGLE. And you got hooked on it?

Mr. DOE. Well, I never hit anybody for any money.

Senator RIEGLE. But you got hooked on the use of the drugs?

Mr. DOE. Yes.

Senator RIEGLE. It would seem to me, though, that if it got worse and worse, that the time might come that even though you did not want to go out and hurt somebody, that you might do it anyway?

Mr. DOE. It could happen

Senator RIEGLE. I gather it happened to some of your friends, or at least some people that you know.

Mr. DOE. Yes, because you do not know what you are doing sometimes, and it is just like you said, you do get blackouts, and you cannot remember what you did. Because I can remember sometimes, but somebody would tell me that I jumped off a very high building, a couple of stories high, and I do not remember doing it. I do not know.

Senator RIEGLE. What was the state that you found him in, when he was directed to you for help?

Mr. SKALITZKY. The first thing, Mr. Chairman, I was not the direct counselor of Mr. Doe. I was asked to come because of the time factor. I did work with the clients with backgrounds extremely similar, and initially what would happen, we would visit the individual at the detention facility in Grand Rapids. We would explain our program at that time, and try to make recommendation to the judge at his hearing, on a recommendation, for Sunrise involvement.

Sunrise is the adolescent program. What we try to provide at the Sunrise program is some basic counseling for the individual and his family about the situation that is going on at that time. We also try to identify for them exactly what the problems are that motivate them to use this type of a substance, to cope with their problems.

Senator RIEGLE. What would happen if a program like yours were not available? What happens to a young fellow like this, who

has developed this pattern, if there is not a community based organization like yours to intervene at some point?

Mr. SKALITZKY. Mr Chairman, I think it would be extremely unfortunate if we were not able to have a program like this for these individuals. Unfortunately, most of the individuals are identified because of their behavior, and not because of the problem. The behavior, for example, that Mr. Doe was finally identified for was the breaking and entering, and we all know how we treat criminals when they do breaking and entering, when the actual motivating factor was a drug, which we can provide treatment for.

Senator RIEGLE. If your kind of organization was not available, he would go through the criminal justice system, and depending on his age, would end up in some kind of institution?

Mr. SKALITZKY. Yes, Mr. Chairman.

Senator RIEGLE. Is that basically what is happening to the ones you are not reaching? I am sure you are not getting everyone in the community. That is the general pattern, that someone gets started, and the addiction develops, and they just go off down that road, and if they are caught, they end up in jail, is that basically the way it works?

Mr. SKALITZKY. That is true, Mr. Chairman, and one of the other feelings that I hold is the problem with police officers, is that the drug problem is one that is easily taken care of on the street. The officer will pick up a person who is unruly, and tell mom and dad, "Keep them off my streets." I do not care what he does to his body, but keep him off my streets, and then it develops into a problem, where the individual has to do criminal activity in order to get the money to support that habit, and that is when the individual becomes involved in the criminal justice system, and then they are placed in an institution of some sort.

Senator RIEGLE. How does your program help a young fellow like this?

Mr. SKALITZHY . We try to use some of the basic concepts of the prevention program, and that is teaching individuals basic communications. I think the biggest part of our program is the alternatives to the drug use, trying to teach individuals things to do with their free time, but also different ways of coping with problems, for example jogging or tennis, or skiing, et cetera. But teach them how to cope with different problems.

Senator RIEGLE. Let me ask you now, when you got into the program, what took place? What worked for you? How come it was able to be successful enough that you were able to break away from this? What part of the program seemed to really have a good effect for you?

Mr. DOE. Well, they talked to me, and getting me to understand what happens, if I would not—where I would go, and the——

Senator RIEGLE. What do you think would have happened if there had not been a program like this?

Mr. DOE. I probably would be in a boys training home.

Senator RIEGLE. A boys training home?

Mr. DOE. Yes.

Senator RIEGLE. What happens—do you know any case histories of other young people like yourself who ended up in a boys training home? Where did they go next? What happens to them?

Mr. DOE. Well, I have a couple of friends that are in those types of homes now, and I hung around with them, and they had done the things that—they did not get in Rehab, to go into like a foster home, get a chance there. One of them, he got into a foster home, and then he went back home, and then he turned around and did the same things over again, and then he went to a boys training home, and he was released from there, and now he is home, and he is still on drugs.

Senator RIEGLE. He is—pardon?

Mr. DOE. He is still on drugs.

Senator RIEGLE. So probably he is going to go right through this same pattern?

Mr. DOE. Yes, he will eventually get caught, because he will end up needing more money to get them.

Senator RIEGLE. How much does it cost you, on a per person basis, to help a young person like this?

Mr. SKALITZKY. The contract we have for our program is approximately $17 an hour for each of the hours that we spend with our clients, and that is based on four staff members.

Senator RIEGLE. The average case, how many hours of counseling and discussion, and help and so forth, would it take to help a young person like this break away from this pattern of drug use, and get stabilized?

Mr. SKALITZKY. Mr. Chairman, Mr. Doe has been on our program now over 2 years, and one of the neatest things about our program is we do not have a time frame. So the cost, for example, in his treatment, which has been extremely successful, is not something that I would readily have available to me. It is not uncommon for our counselors to see an individual who is having difficult problems at the initial phase in the crisis stage, two or three times a week, and six or eight times during a month, in counseling, or activity, or group therapy, and also all the time spent with his case workers through the court system, to all the other agencies, to become involved.

Senator RIEGLE. I take it then that it stretches out over a longer period of contact. You get through this contact, but you still maintain a link. You continue to support him, but he knows he has a place where he can go and talk, so he is not really alone with this, whatever the residual effect of his problem is?

Mr. SKALITZKY. Yes, Mr. Chairman. Especially when we are dealing with adolescents, we think it is much more important to have a support system based on that. Parents, a lot of times are not able to provide that support, because they do not understand drug problems.

Senator RIEGLE. I gather that not very many parents today understand drug problems. I do not understand how someone would come to know it, because it is not something that we teach in schools, there is not a lot of public information that is generally disseminated about it, and I would think parents in many cases would have a very hard time understanding, first of all, what was going on, and if it was going on, how to understand to deal with it Is that the pattern that you find with parents?

Mr. SKALITZKY. Yes, Mr. Chairman.

Senator RIEGLE. Now, what I am wondering is, how often now do you deal with the counseling center here? Do you see them at this stage of the game, once a week, how often?

Mr. DOE. Now, I think it is about once a month.

Senator RIEGLE. And then after how long a period of time, an hour or two?

Mr. DOE. A couple of hours, two or three.

Senator RIEGLE. Two or three hours. How many young people like him do you have in your program at the present time? Did I hear you say something like 300—no, that was a different figure.

Mr. SKALITZKY. An active caseload at the Sunrise is 60.

Senator RIEGLE. I assume you have people from all stages, since you just identified people like our witness, who sort of come through this thing, and are more or less at the other end of the process, who maybe need only one counseling session a month.

Mr. SKALITZKY. Also, Mr. Chairman, we must mention that Mr. Doe is in a foster home at this time. He has been completely removed from the family and at this time the foster parents, who have gone through extensive training, are able to provide some of the support that our sunrise program would provide anyway.

Hopefully, at the next court hearing, when Mr. Doe is returned to his natural parents, the support would also increase. However, it is true that we have individuals on the different levels where the frequency would be greater or less, depending on the problem.

Senator RIEGLE. Just taking sort of a rough calculation here, your cost of providing the service is about $17 an hour. You have frequency of contact in the first few weeks, but perhaps only one session a month 2 years down the road until his life is put in place. I would think that the cost over that period of time, on that kind of per hour basis is probably something less than $1,000, or at least something in that range. It is certainly not in the range of several thousand dollars.

Mr. SKALITZKY. That is probably true, Mr. Chairman.

Senator RIEGLE. You see what I am thinking of, and the reason that it is important for us to establish that, your program appears effective. It obviously has helped him, and has him now on a different track than his friend is on. His friend is going to a boys training home and is still hooked on drugs and presumably still doing the things that you have to do before you get the money to pay for them: Breaking and entering and other things of that kind. The cost that we are going to have to pay that way, if you were to say end up in the boy's training home, is going to be a lot more money than we are going to spend if we spend it for this kind of service. This is the kind of thing that we have to emphasize, the fact that as a society we have a choice, we can either spend the money in one form and we can spend less of it and help you get better, or we can end up spending the money in a different form, in which case we spend more of it, and you do not get better. Those are really the only two choices we have in terms of the practical realities of the case. That is why, when I look at the dollar amounts that we have appropriated or recommended in the budget, I see that we are missing many more young people like this one than we are helping. And so, in effect, what we are doing here is we are choosing this one path for ourselves—which is the more

expensive path, which does not help people—rather than the other alternative that we have where we can actually end up spending less and doing more and helping people like you.

Let me ask you, what do you see in your own future right now?

I gather things are getting better with your family. You are looking forward to leaving a foster home and getting reunited with your family. But, in terms of your own personal plans, with school and work, what do you see ahead of you at this point?

Have you been thinking of what you want to do with your life?

Mr. DOE. Not really. I thought about it once, but I do not really know what I would like to do. Now, I am in the 11th grade. I work after school every other night.

Senator RIEGLE. Where are you working?

Mr. DOE. At a Sunoco gas station.

Senator RIEGLE. And you are in the 11th grade now?

Mr. DOE. Yes.

Senator RIEGLE. Have your grades gotten better?

Mr. DOE. They are passable.

Senator RIEGLE. They are passable? I gather they were not before?

Mr. DOE. Well, not really.

Senator RIEGLE. So you have improved your grades, but I guess what you are saying is that you could do better?

Mr. DOE. Yes. But work is sitting there, too.

Senator RIEGLE. I know it is. That makes it tough. I think you are at an important time. You have got a lot of people who care about you and want you to do well. The fact that you are working on the side is a real plus. I really congratulate you for doing that and going to school at the same time, but I think you have got to make sure the 11th grade counts because after the 12th grade comes full-time work, and so this is really kind of a key time for you. And I hope you really make the most of it.

Mr. DOE. Thank you.

Senator RIEGLE. I am sure you will.

Mr. DOE. Thank you.

Senator RIEGLE. Are there any other points that you would like to make? I know you have some prepared observations there. Are there any other summary comments that you want to make about these programs that would be helpful for the committee to consider?

Mr. SKALITZKY. Mr. Chaiman, the one point in particular that I want to make is that you had mentioned that the cost in dollars and savings for a treatment program similar to the one like the sunrise program, the actual per diem rate for an individual who is in some kind of institution is $85 a day. I would like to see support for a program like ours but I would also like to support your program on prevention so that we do not need to have individuals like this in my program or individuals who I cannot reach who are in the programs, costing $85 a day.

Senator RIEGLE. Let me ask you, Mr. Bertler, what observations you think are relevant for us to consider that relate to this discussion?

Mr. BERTLER. There are a number of people together that met together at the beginning of the week representing most of the

professional groups in Michigan. The director of the State Office of Substance Abuse was one of those folks, and I have already given you the prepared testimony, that that group assisted in developing.

I think your estimate is correct about the cost. Previously I worked in Substance Abuse and worked with the Lieutenant Governor's Prevention Committee, and now I am working in Delinquency Prevention, and the similarities are astounding when you relate the cost of incarceration, which is what a youth home or boys training school in Michigan is, versus the cost of prevention. In Substance Abuse particularly, there has been some less than successful experiences that have been labeled prevention when they in fact have been education, and short-term campaigns which do not necessarily address all of the issues.

Senator RIEGLE. What are the prevention programs that work the best from your field experience?

Mr. BERTLER. I think Ken's touched on one of them, and that is the use of out of home placement for awhile. Foster care in this instance to just kind of change the environment. A lot of times the family is not as supportive or understanding as it could be, but still wants to see something happen and uses methods such as punishment for the behavior rather than some understanding, and some time away usually causes a family to say, well, our kid is really trying to do something, and maybe if we were trying to be a little bit more understanding and not saying, well, we caught you sniffing glue so you are grounded, more positive things would happen.

Senator RIEGLE. May I ask John Doe when you were back in the days when you were using these drugs did you have a lot of hassles with your family at that time?

Mr. DOE. We go ahead and do it again, but he cared and did try to punish us. But we wouldn't listen to him or our mom.

Senator RIEGLE. But he was probably pretty frustrated, I guess?

Mr. DOE. Yes; you could see it. I guess we did not care.

Senator RIEGLE. Do you think it helped when you got out of the house and got into a foster home? Do you think it helped change maybe the lay of the land here so that maybe your family could start to understand it a little better?

Mr. DOE. I do not understand.

Senator RIEGLE. Well, I guess what I am saying to you is that you were living at home for awhile?

Mr. DOE. Yes.

Senator RIEGLE. And you had to leave home, and you went into a foster home, is that not right? You are there now?

Mr DOE. YES.

Senator RIEGLE. I guess what I am wondering is if you went into the foster home, maybe it helped everybody within your family think about this problem in a little better way.

Mr. DOE. Yes.

Senator RIEGLE. You did find that that happened?

Mr. DOE. Yes.

Senator RIEGLE. What is your relationship with your father now? Has it improved?

Mr. DOE. Well, it is improving.

Senator RIEGLE. It is improving?

Mr. DOE. Yes.

Senator RIEGLE. That is a plus.

Mr. DOE. Yes.

Senator RIEGLE. Any other observations that are helpful for us to have, do you think?

Mr. BERTLER. I think there is a double standard operating in a number of families, too, relating to substance abuse. There are a lot of parents who are involved in use of alcohol, particularly, and young people find it very difficult to differentiate the activities and effects of one drug from another. For instance, if someone is using a solvent, like the witness, how much different is that than a parent becoming intoxicated with alcohol and how can that parent suggest to that young person that that young person's participating in some aberrant or nonhelpful behavior when they are doing it, and they may, in fact, be intoxicated in the process of telling their child that they shouldn't be using drugs. One of the things that is not looked at as part of the problem as much as I think it should be, is the massive use of well-financed advertising campaigns to sell substances in this country. A person turns on the TV, you or I watching television in the evening, and you see about six to eight beer commericals in an hour. They do not just ask you to buy beer, they show you a cold stream and people having fun and things like that. There is a lot of social pressure to be involved, not only the kind of adolescent peer pressure that the witness is talking about, but just general everyday advertising campaigns that you and I are exposed to, and everyone in the country is exposed to.

Senator RIEGLE. Is it your judgment of the work in the field that that has affected people like this?

Mr. BERTLER. Absolutely.

Senator RIEGLE. Do you feel it has, too?

Do you recognize that? Do you think it is so subtle that you would not recognize it? The things like that, ads on television?

Mr. DOE. You mean like seeing it and liking it?

Senator RIEGLE. Yes.

Mr. DOE. Yes.

Senator RIEGLE. You think maybe that did have some influence on you?

Mr. DOE. Yes.

Senator RIEGLE. What do you think we ought to do about it? Do you think those ads ought to come off television?

Mr. BERTLER. You may bettor answer that question. I would support some advertising controls. Of course, it is beyond my purview to do that.

This committee has some impact on that though. I would suggest, that that is a heavy duty issue; that is, an economic reality, I think, economically at this point in a time when money is tight, suggesting that people cut back on advertising which might cut into their profits, would not be well received.

Senator RIEGLE. Let me share with you a statistic I learned the other day. That is, that it is estimated that it costs the economy of the United States about $43 billion a year from alcoholism and alcohol abuse, and that is all of the medical costs, the deaths on highways, everything associated with it.

The best estimates are in the range of about $43 billion, an awful lot of money. And some of the stakes are very high. It comes back

to this question. Sometimes we end up paying one set of costs in one form and maybe our choice is to spend less in a different form and actually come out ahead.

Mr. BERTLER. Mr. Chairman, I support anything that you can do about responsible advertising because that is a real problem in society in general. I would like to make two more points.

One of them is that we in Michigan feel that a prevention initiative probably could be generated through mandated and supported Federal policies. There are things in the Michigan experience, such as the decrease in the use and need for Methadone treatment slots that are now being funded by both the funding sources—NIDA-NIAAA. Perhaps, those dollars could be moved into a prevention, based on some percentage.

I guess the point that I want to close with is that in most cases the kinds of substance use and abuse behavior that we see individuals present are not their attempt to be antisocial. They are, in fact, attempts to be social, to be part of society because the use and abuse of substances seems to be the norm.

Senator RIEGLE. Let me for a minute come back to this witness.

Of the kids and the young people that you have known that got using drugs the way you did—you started when you were 13—what is the youngest of anybody in your own personal acquaintance that started using drugs? What would be the youngest aged person that you know of?

Mr. DOE. I think it would be 8 or 9.

Senator RIEGLE. 8 or 9.

Mr. DOE. Yes.

Senator RIEGLE. This is in and around Grand Rapids, Mich., this is where you have grown up?

Mr. DOE. Yes.

Senator RIEGLE. Just a couple people or——

Mr. DOE. This is my little brother.

Senator RIEGLE. Your little brother was 8 or 9 when he first had his experience?

Mr. DOE. Yes. And he is with project Rehab, too.

Senator RIEGLE. So you think he is getting better now, too, because he is in the same program that you are in?

Mr. DOE. Yes. He is kind of hardheaded.

Senator RIEGLE. He is hardheaded?

Mr. DOE. Yes.

Senator RIEGLE. I see. That means more people are going to have to work with him. You are going to have to work with him, and the counselors?

Mr. DOE. Yes.

Senator RIEGLE. Did you ever get any drug education in school? Did anybody in the school setting try to alert you to some of these things that you might run into?

Mr. DOE. Yes. Some schools showed movies on what happens, if you do this on drugs and stuff.

Senator RIEGLE. Why did that not work? You saw the movies but——

Mr. DOE. I would always go to sleep.

Senator RIEGLE. Was it too late? Had you already started using the drugs, or the movies were not interesting to you?

Mr. DOE. Some of the movies I seen before on drugs. They did not have an effect on me.

Senator RIEGLE. They just did not have an effect on you?

Mr. DOE. No.

Senator RIEGLE. You think they have an effect on other kids?

Mr. DOE. Not really, because they showed movies in the biology class, what happens to you if you smoke, your lungs. Everybody laughs at it, and I think it is the same way for drugs. They show something like that, what happened to you. It does not do really any good.

Senator RIEGLE. Let me ask you one more thing. You mentioned some friends that you know that are still using drugs. Do they try to pull you back into using drugs, too? Is there still some social pressure to break away from the counseling and use drugs with your friends?

Mr. DOE. I am not living in Grand Rapids now so not really.

Senator RIEGLE. So you are away from that kind of pressure?

Mr. DOE. Yes.

Senator RIEGLE. Were you able to help anybody else break away from drugs yourself or were you so tied up in getting yourself away from it that you were not able to help anybody else?

Mr. DOE. It would be just myself.

Senator RIEGLE. It was that big a task alone just to try to get yourself squared away?

Mr DOE. Well, where I am now, there was not really anybody to help except my brother.

Senator RIEGLE. I see.

I want to thank the three of you for coming today. I know it is kind of hard to come into a situation that is as strange appearing as this one and talk about these kinds of things, but you have done a very good job today. It helps us because these are exactly the kinds of stories that we have to understand if we are going to understand these problems and what we can do to deal with them. Because you were willing to come and share these insights with us, it gives us a better chance to get some Federal money allocated to try to help other young people just like yourself. So that maybe instead of sleeping in class and daydreaming, they can be like you are, and that is in the 11th grade, getting passing grades and working every other night in a gas station. That seems to me like a pretty good improvement.

Mr. DOE. Thank you.

Senator RIEGLE. Thank you very much.

[The following statement was received for the record.]

TESTIMONY ON PREVENTION IN MICHIGAN; SOME HISTORY AND THOUGHTS FOR THE FUTURE.

PRESENTED BY: MARK J. BERTLER -- TECHNICAL ASSISTANCE SPECIALIST
MICHIGAN COALITION OF RUNAWAY SERVICES

PRESENTED TO: ALCOHOL AND DRUG ABUSE SUBCOMMITTEE, UNITED STATES SENATE

MARCH 2, 1979

INTRODUCTION

MR. CHAIRMAN, I WISH TO THANK YOU AND THE SUBCOMMITTEE MEMBERS FOR THIS OPPORTUNITY TO TESTIFY WITH REGARD TO PREVENTION ACTIVITIES IN MICHIGAN AND IDEAS FOR THE FUTURE OF A PREVENTION INITIATIVE.

MY TESTIMONY IS INTENDED TO REPRESENT THE FIRST CRACK OF AN OPENING DOOR OF ADDITIONAL TESTIMONY FROM PEOPLE AND ORGANIZATIONS IN MICHIGAN WHOSE BACKGROUND AND EXPERTISE FAR OUTSHINE MY OWN.

MR. CHAIRMAN, DURING THE COURSE OF PREVIOUS TESTIMONY, YOU HAVE BEEN EXPOSED TO, AND MADE AWARE OF, THE HOPELESSNESS, TRAUMA, PAIN AND SUFFERING BROUGHT ON BY THE INVOLVEMENT OF OUR NATION'S CITIZENS WITH DRUG AND/OR ALCOHOL ABUSE.

WITH THE SELECTED INSTANCES THIS COMMITTEE HAS BEEN EXPOSED TO, YOUR OUTLOOK MAY BE MOVING TOWARD GRIM. IT DOESN'T HELP, MR. CHAIRMAN, TO REALIZE THAT THOSE FOLKS WERE NOT TALKING ABOUT ISOLATED OCCURANCES. IT IS STAGGERING TO ACKNOWLEDGE THE AMOUNT OF HUMAN ENERGY AND LIFE LOST DUE TO THE MISUSE OF ALCOHOL AND OTHER DRUGS. THERE IS SOME HOPE IN KNOWING THAT DEDICATED INDIVIDUALS LIKE THOSE WHO HAVE TESTIFIED THUS FAR, AND THOSE WHO WILL TESTIFY DURING TODAY AND IN FUTURE HEARINGS ARE COMMITTED TO DOING SOMETHING ABOUT THIS LOSS OF VITAL HUMAN ENERGY AND POTENTIAL.

THIS COMMITMENT EXISTS NOT ONLY AMONG PROFESSIONALS AND INDIVIDUALS INVOLVED DIRECTLY IN ALCOHOLISM AND DRUG ABUSE PREVENTION AND TREATMENT. IT ALSO IS SHARED BY FAMILY, FRIENDS, AND CONCERNED CITIZENS.

AFTER HEARING TESTIMONY OF THE NATURE THAT YOU HAVE HEARD,

MR. CHAIRMAN, THE QUESTION OF "WHAT CAN BE DONE?" MUST BE ANSWERED AS ' PARTIAL ANSWER TO THIS QUESTION.

THERE HAVE BEEN MANY ADVANCES IN TECHNOLOGY AND TREATMENT TECHNIQUES CREATING A RELATIVE STABILITY IN THE FIELD OF TREATMENT FOR ALCOHOLISM AND DRUG ABUSE.

THAT, HOWEVER, IS LITTLE COMFORT FOR THE VICTIMS AND THEIR FAMILIES AND LOVED ONES. PEOPLE TAKE SMALL COMFORT IN KNOWING THAT ONCE EVERYTHING IN THEIR LIFE HAS BEEN DESTROYED, THERE IS A GOOD CHANCE THAT IT CAN BE REBUILT. THE OVERWHELMING PREFERENCE IS NOT TO HAVE THE DESTRUCTION OCCUR AND THAT'S WHAT PREVENTION IS ALL ABOUT; PREVENTING THAT DESTRUCTION BY BUILDING ON THE STRENGTHS THEY POSSESS RATHER THAN DIGGING THROUGH THE RUBBLE TO FIND, RECLAIM AND REBUILD SHATTERED LIVES.

THE MICHIGAN EXPERIENCE

IN THE STATE OF MICHIGAN, ALCOHOLISM AND DRUG ABUSE PREVENTION HAS BECOME MORE THAN AN ELUSIVE CONCEPT.

SERIOUS WORK HAS TAKEN PLACE OVER THE PAST FOUR YEARS TO IDENTIFY STRATEGIES, POPULATIONS AT RISK, AND METHODS OF PROGRAM IMPLEMENTATION AND EVALUATION.

IN 1975, THE GROUNDWORK WAS LAID FOR PREVENTION TASK FORCES WITH REPRESENTATIVES FROM ACROSS THE STATE REPRESENTING VARIOUS DISCIPLINES AND BACKGROUNDS.

A COMPREHENSIVE REPORT WAS COMPLETED IN LATE 1976.

FURTHER EFFORTS HAVE TAKEN PLACE IN THE INTERVENING YEARS AND AN INTERDISCIPLINARY PREVENTION COUNCIL IS CONVENING REGULARLY WITH A STATE-WIDE CONFERENCE ON PREVENTION PLANNED FOR MAY.

PROFESSIONALS IN ALL AREAS OF TREATMENT SERVICES HAVE LONG LOOKED TO POLICY-MAKERS TO FOCUS MORE RESOURCES ON PREVENTION.

TREATMENT PROGRAMS FOR THE MOST PART ARE AS EFFECTIVE AS THEY 'RE GOING TO GET.

THE ISSUE BECOMES SHEER NUMBERS.

WITHOUT THE DEVELOPMENT OF EFFECTIVE PREVENTION PROGRAMS, WAITING LISTS WILL BEGIN TO GROW ONCE AGAIN, AND TREATMENT PROGRAMS WILL AGAIN BE OVERWHELMED. AT THIS POINT IN TIME, PREVENTION PROGRAMS ARE A LOGICAL NEXT STEP IN MICHIGAN.

THERE IS A STABILITY IN THE FIELD AND A WILLINGNESS TO BEGIN A SERIOUS EFFORT TO IDENTIFY, IMPLEMENT, AND EVALUATE SUCCESSFUL PREVENTION DEMONSTRATION PROGRAMMING.

SPORADIC EFFORTS IN THE PREVENTION AREA HAVE DEVELOPED ENCOURAGING RESULTS. SINCE 1975 IN MICHIGAN THE SINGLE STATE AGENCY FOR SUBSTANCE ABUSE SERVICES HAS MAINTAINED A PREVENTION FOCUS MANAGED BY A SECTION OF THAT AGENCY COMMITTED TO ONLY PREVENTION PROGRAMMING.

WE IN MICHIGAN FEEL THAT NOW IS THE TIME FOR A STRONG AND SERIOUS POLICY INITIATIVE FROM THE GOVERNMENT TO BEGIN LONG-TERM CONVICTION AND SUPPORT IN THE DEVELOPMENT OF A COORDINATED PREVENTION EFFORT AIMED AT ALCOHOLISM AND DRUG ABUSE PREVENTION.

SOME THOUGHTS ON A MODEL

THERE SEEM TO BE FOUR AREAS OF IMPACT CRUCIAL TO ANY PREVENTION STRATEGY:

1. INFORMATION -- PEOPLE SHOULD KNOW RISKS AND DANGERS AND HAVE ACCESS TO TIMELY, ACCURATE, AND USABLE INFORMATION.
2. ATTITUDES AND VALUES -- PEOPLE'S ATTITUDES AND VALUES NEED TO BE ALIGNED WITH RESPONSIBLE, POSITIVE OUTCOMES.
3. BEHAVIORAL AND LIFE SKILLS -- PEOPLE NEED TO HAVE BEHAVIOR AND LIFE MODELS THAT DISCOURAGE ALCOHOLISM AND DRUG ABUSE, AND ARE REASONABLE.

4. ENVIRONMENTAL AND SOCIAL SUPPORT -- PEOPLENEED TO FEEL SUPPORTED IN ASSISTANCE AND RESPONSIBLE USE OF SUBSTANCES.

ALL OF THESE FOUR AREAS NEED TO BE ADDRESSED IN PREVENTION PROGRAMMING. UNTIL THESE AND OTHER FACTORS RELATED TO PREVENTION PROGRAMMING ARE RESEARCHED FURTHER, PREVENTION PROGRAMMING NATION-WIDE WOULD BE PREMATURE. A MODEL NEEDS TO BE DEVELOPED BEFORE INTENSIVE NATION-WIDE PROGRAMMING OCCURS.

PROGRAMS MUST SPECIFICALLY DETERMINE WHAT THEY ARE TRYING TO DO, AND THEY MUST SPECIFY WHAT THEY ARE DOING AND THEY MUST OFFER RESULTS TO SUPPORT THEIR PREVENTIVE CLAIMS.

SUCCESS OUGHT TO BE DEFINED AS PROVIDING USABLE INFORMATION. WE NEED TO KNOW WHAT DOESN'T WORK TO HELP NARROW US DOWN TO WHAT DOES WORK.

THE APPROACH THAT SEEMS FEASIBLE IS THE INITIATION OF A DEMONSTRATION PROJECT APPROACH.

THIS APPROACH REQUIRES THE RESHAPING OF FEDERAL PRIORITIES TO EMPHASIZE PREVENTION, AND A LONG-TERM COMMITMENT TO THAT EMPHASIS. THE COMBINED EFFORT OF ALL INVOLVED FEDERAL AGENCIES WOULD ALMOST INSURE SUCCESS.

SUPPORT FOR THIS INITIATIVE SHOULD BE ABLE TO COME FROM THE RE-ALLOCATION OF EXISTING RESOURCES (FORMULA GRANTS, ETC.) WITH AN EMPHASIS ON PREVENTION. ONE AREA BEARING CLOSE SCRUTINY IS THE POTENTIAL OF RE-DIRECTING THE FUNDS CURRENTLY USED FOR UNUSED METHADONE TREATMENT SLOTS TO PREVENTION.

THIS, OF COURSE, REPRESENTS A MICHIGAN PERSPECTIVE.

BARRIERS

A GOOD QUESTION TO ASK AT THIS POINT IS "WHY HASN'T ALL THIS HAPPENED?"

IF THE FIELD IS READY, IF THERE ARE MODELS, IF EXISTING RESOURCES ARE ENOUGH, WHY HAVEN'T WE DONE EXTENSIVE PREVENTION?

THERE IS MORE THAN ONE ANSWER.

THE MOST CLEAR ANSWER IS THE NEED FOR A SOLID MANDATE AS WELL AS INCENTIVES FOR DOING PREVENTION. MANY PROGRAMS HAVE BEEN DISCOURAGED WHEN INFORMATION AND EDUCATION PROGRAMS DIDN'T YIELD ENCOURAGING RESULTS.

THE SHEER MAGNITUDE OF ALCOHOL AND DRUG-RELATED PROBLEMS HAVE FOCUSED THE MAJORITY OF ENERGY AND RESOURCES ON TREATMENT.

SOCIAL AND ECONOMIC ISSUES HAVE ENFORCED ALCOHOL AND DRUG PROBLEMS. FOR INSTANCE, BY USING THE FOUR IMPACT AREAS MENTIONED EARLIER, WE CAN SEE MORE CLEARLY THE SOCIAL AND ECONOMIC IMPACTS.

1. INFORMATION -- HOW DO YOU CONVINCE PEOPLE OF THE DANGERS OF OS SUBSTANCES WHEN THEY ARE ENCOURAGED THROUGH WELL-FINANCED MEDIA ASSAULTS TO PURCHASE SUBSTANCES REGULARLY.
2. ATTITUDES AND VALUES -- WITH MEASURES OF COMPETENCE AND MATURITY RELATING TO HOLDING ONE'S LIQUOR (NO MATTER HOW MUCH THEY DRINK), SMOKING TOBACCO (TO APPEAR SOPHISTICATED), AND DRUG TAKING (OH YEAH? WELL, I TOOK 8!!), PREVENTION HAS QUITE A LOT OF COMPETITION.
3. BEHAVIORAL AND LIFE SKILLS -- AS LONG AS HAVING TOO MUCH TO DRINK REMAINS AN EXCUSE FOR POOR BEHAVIOR, AND DRUG PROBLEMS ARE CONSIDERED ONLY BELONGING TO THE PEOPLE WHO PRESENT THE MOST OVERT SYMPTOMS, PREVENTION MUST BREAK THROUGH MANY SOCIAL BARRIERS.
4. ENVIRONMENTAL AND SOCIAL SUPPORT -- IT NEEDS TO BECOME COMMON PLACE FOR PEOPLE TO ENCOURAGE RESPONSIBLE BEHAVIOR RATHER THAN SEDUCE PEOPLE INTO SUBSTANCE USING BEHAVIORS BEFORE PREVENTION CAN BE TOTALLY SUCCESSFUL.

HOPEFULLY, THE PREVIOUS EXAMPLES HELP TO SUGGEST THAT ALCOHOLISM ID DRUG ABUSE IS NOT AN INDIVIDUAL'S ATTACK AT SOCIETY BUT OFTEN AN INDIVIDUAL'S METHOD OF BECOMING PART OF SOCIETY.

PREVENTION IS EVERYONE'S RESPONSIBILITY, NOT JUST THOSE FOLKS WITH "PROBLEMS".

I HAVE ATTEMPTED TO PROVIDE A VERY BRIEF DISCUSSION OF SOME OF THE ISSUES INVOLVED IN THE PREVENTION OF ALCOHOLISM AND DRUG ABUSE WITH A FURTHER CLARIFIER BEING THAT MY COMMENTS ARE ON MICHIGAN SPECIFICALLY AND MAY NOT BE NATIONALLY APPROPRIATE.

THIS TESTIMONY WILL BE AUGMENTED BY MANY MORE OF MY COLLEAGUES FROM MICHIGAN WHO ARE MUCH MORE KNOWLEDGEABLE AND ABLE TO PRESENT SPECIFIC AND CRUCIAL ISSUES SUPPORTING THE NEED FOR A CONCERTED, LONG-TERM PREVENTION EFFORT.

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE AND STAFF, THANK YOU OR THIS OPPORTUNITY TO SHARE SOME THOUGHTS WITH YOU TODAY.

Senator RIEGLE. Our next witness, who I am delighted to call to the table, is former Senator Harold Hughes. He is coming forward now. It was he, more than any other person, who got the Nation and our Federal system to focus on these problems.

Just to complete my comments, Senator Hughes, you are known to me and I think everybody else who has become acquainted with the field of alcoholism, as a person who really provided the essential leadership to get this issue elevated and focused and to get the Federal Government to recognize that it was a national problem that required a national response. Those of us who now are privileged to work in this area are really inheritors of that work that you began. So we are very honored to have you here today and we are interested in what your thoughts are that you have for us.

STATEMENT OF HON. HAROLD E. HUGHES, FORMER U.S. SENATOR FROM THE STATE OF IOWA

Mr. HUGHES. Thank you, Mr. Chairman. It is a pleasure to be back with you this morning. It is an honor to appear before you and to come back and to share with you.

When I was first approached about appearing here today I refused, because when I left the Senate 4 years ago it was to devote myself full time to the service of the Lord. Because of that commitment, I have refused any request which I felt would detract from that goal.

But I was reminded by someone close to me that perhaps the way I could best serve Him on this morning of March 2, 1979, would be to appear before you to plead for the poorest of His poor.

Two thousand years ago, Jesus was often in the company of the social outcasts of that day—the prostitutes, the tax collectors, the lepers. Were He to walk on Earth today, I believe that it would be with the social outcasts of this day we would find Him—the alco-

holics on the skid rows of our cities, the drug addicts in the empty tenements, the lonely and the lost of our day and our time.

So though I fully realize that alcoholism is no respecter of persons, and that alcoholism touches those from every walk of life—yes, even Members of Congress—it is for that 3 to 5 percent of our Nation's alcoholics on skid row—and the drug addicts in the ghettoes—for whom I make my plea this morning.

Let me say at this point, Mr. Chairman, that many of my prayers for these outcasts have already been answered with your assumption to the chairmanship of this subcommittee. I have been told of your performance here last Thursday and Monday. I know your record as a legislator. I know that your vote has always been where your heart is on social legislation. I have also read in Jay Lewis' "Alcoholism Report" of February 9 your comments as you became chairman. You said: "I intend to serve as an advocate for all the victims of alcoholism and alcohol abuse." And you noted that you were becoming chairman "At a particularly critical time—because of the budget cuts—for the field of alcoholism prevention and treatment."

With those words, Mr. Chairman, you showed us that—in this age of proposition 13 fever—courage, compassion, and the love of justice, and love of our fellow man, have not gone out of style.

The subcommittee is in good hands.

I am grateful to you for assuming the chairmanship.

Senator RIEGLE. Thank you for those kind words.

Mr. HUGHES. Mr. Chairman, another reason I hesitated to accept your invitation is that I am no longer knowledgeable about the current issues—specific authorization levels, the needs of the research community, nor the latest prevention techniques. There are many in this room far more able than I to advise you on that.

Perhaps I can be most helpful to you if I give you a brief review of some of what I learned during the 6 years I sat in your chair.

A century ago an English author, Samuel Butler, wrote a book about an imaginary Utopian society called Erewhon.

And in this mythical society, when people got sick, the authorities put them in jail.

In 1969, when the subcommittee was formed, we did not have to look far to find modern-day Erewhons. Only the District of Columbia and the State of Maryland had decriminalized public drunkenness and provided for treatment in the public health system.

In this Lenten season it is interesting to note that the court decision which led to that change in Washington was called the Easter decision. In *Easter* v. *District of Columbia,* the courts held that a homeless alcoholic could not be punished for his public intoxication. Mr. Easter was one such. He had been incarcerated several hundred times before Peter Hutt, of the law firm of Covington and Burling, used him as a test case.

In every other State in the Union, alcoholic citizens were being thrown into jail for the sole crime of being sick in public. And many of them died in those jails from lack of medical attention. But I myself, Mr. Chairman, and I want to inject this into the statement I have here, in my younger years and all, was in jail in six States, and in the Army, and I know the experience of being in the jails in our country as a result of alcoholism.

And I should add, Mr. Chairman, that it is not only men. Women, too, are among their numbers. Perhaps we are not aware of the women on skid row because we rarely see a woman sleeping in the gutter.

Senator, they do not need to. A woman can usually find a bed for the night—by one method or another.

Dr. Veronica Maz, executive director of SOME—So Others Might Eat—has written a book called The Stick-Carrier. She tells of one such woman:

June shouted, "I just got out," as she ran to greet me at the front gate of our soup kitchen. I glanced at her arm and saw the identifying hospital band she was wearing.

Like many skid row women, June had experienced intense pain throughout her life but seldom discussed this with others. She had been beaten repeatedly. Seeing her with two black eyes or a swollen, bloody lip was not uncommon. Once her arm was in a cast. On another occasion her leg had been broken in several places.

June shared a room with several other persons on the first floor of a three-story slum apartment dwelling. The "accident" which prefaced her hospital placement occurred there.

Without any preliminary description, June explained, "He took me by my feet and dragged me like a sack of potatoes up three flights of steps where he raped me." She stated that her head had bounced on every step, and her skin was consistently bruised and scraped on the concrete steps. "He dragged me. He dragged me," with rising inflection she repeated what seemed to her to be the greatest pain of all.

Mr. Chairman, I have been told this morning that Dr. Maz is now executive director of "The House of Ruth," a home in the District for battered women.

In early 1970 I talked with one of the stick carriers. His name was Prince Wright. His story is also told in Dr. Maz' book should you care to know more about him. He was a big handsome black man, and his muscles and hands showed that he was a man used to hard labor. He hid his shyness behind a gruff manner.

He told me he had been a stick carrier. "What the deuce is a stick carrier," I asked him. He explained a stick carrier is the name given to the homeless, destitute, needy persons who sleep in abandoned buildings, cars or trucks, and whose fears are those of being lonely, hungry, hurt, sick, burned alive, robbed, beaten, or frozen to death. They carry a stick to ward off the rats with whom they share their bed and food—often found in trash cans.

Prince was now working for Dr. Maz at her soup kitchen.

"We need a water fountain," he blurted out. He then explained:

Where does a homeless, destitute man get a drink of water? He doesn't have a home—no water from there. He doesn't eat in restaurants and many restaurants refuse requests for water from noncustomers. Public drinking fountains are practically nonexistent. Getting a drink of water can be a serious problem.

To my lasting shame, I refused to give him some money. I was afraid he would go off and get drunk with it. I later learned that the Sisters of the Good Shepherd donated a drinking fountain to SOME.

Because of men like Prince—and women like June—in 1974 we amended the Alcoholism Act to give incentive grants to States which decriminalize public drunkenness and provide for treatment. More than half the States have now done this, but in many States in this country, Senator, alcoholics are still dying in jails for lack of treatment.

Parenthetically, Senator, alcoholics are dying in every stratum of life. Denial is the name of the game. We say with our lips that alcoholism is a disease but in our hearts we deny that we may be alcoholic. We deny that anyone in our family may be alcoholic. We deny that anyone on our staff may be alcoholic. We deny that our friend may be alcoholic. We deny that our colleague may be alcoholic. The stigma is still with us.

Mr. Chairman, when we drafted the alcoholism bill in 1970, and amended it in 1974, we made no specific mention of women. I make no apology for that. We did not know then that women would not receive full rights as citizens. I now know that little of the funds authorized by this subcommittee have gone to help women.

A degree of stigma is still attached to the term "alcoholic"—and for women it is a double stigma. Women are so ashamed to admit that they have alcoholism that they die alone in their bedrooms. And the shocking truth is that their husbands and doctors help them to do it.

So I am pleased to learn that in 1976 my friend, Pete Williams, amended the law to provide specific help for these women.

And we paid too little attention to what our children were trying to tell us at that time also. When heroin addiction was considered only an inner-city problem, we ignored it.

The shameful truth is that only when reports began pouring in about children from white, middle-class suburbs, children of famous Hollywood personalities—yes, even children of politicians—getting busted on drug charges or dying of drug overdoses, did we begin to react.

When Larry Alan Bear, then commissioner of addiction services for the city of New York, testified before this subcommittee in 1970, he read a headline from a New York paper "Dope Kills Eight Youths in Week." He pointed out that it was not a new headline, but had appeared on November 19, 1962, 8 years before.

In 1971 I heard testimony from a Harlem mother. She was testifying about how she could not get the police to close down a hangout in her New York City neighborhood where addicts shot up drugs.

"Nobody cares about us up there," she snapped. "Nobody will come and see for themselves what goes on * * * and," she glared at me, "I'm sure you don't care either."

Mr. Chairman, I was right here in this same hearing room when I was chairing the hearing. That mother had gone through hell trying to save her children from addiction and the children in the neighborhood and was getting shunted around by the authorities.

"I'll come," I said. "Well," she sniffed, "I'll believe it when I see it."

So, a few months later, I turned up in Harlem with a few other nervous Senators. Pete Williams was with me, as were Jack Javits and Dick Schweiker.

She was surprised to see us.

She told me to give $10 to a boy—he was not more than 11—and see how fast he would be back with heroin. We watched out a window as he went to the hamburger stand on the corner and brought back five bags of heroin. I later had the heroin brought back to Washington and tested. It was good heroin.

Then she challenged us to follow her to a shooting gallery across the street. We followed her down crumbling cement steps and through a basement doorway. I was frankly scared but she assured me I would be OK as long as I was with her and some other blacks.

She pulled back a blanket hanging across a clothesline and—in the light of two candles—we saw six men getting ready to shoot up. They were hooking up, a band around the arm, the needles ready. I will never forget the scene as long as I live.

Suddenly a bright white light flooded the basement. We had forgotten all about the TV cameramen who had followed us during the day and had, without warning, turned on their floodlights to film the scene. One of my staff members scrambled in front of me, trying to protect me, and then there was a massive darkness because the light from the television light went out and we scrambled to safety.

All hell broke loose. I dimly remember my staff man getting in between me and a very angry black man with a knife. We fell over one another trying to get out.

When we finally scrambled to safety, I turned to our hostess and said, "I thought you said it would be safe." Breathing heavily, she replied, "Well, I didn't know you were going to make it into a TV special either."

Mr. Chairman, you and I cannot possibly know the frustration that woman feels when she detoxifies an addict and then has to send him back into the same conditions that fostered the addiction in the first place: poverty, unemployment, tenements infested with rats, drug pushers on every corner.

Mr. Chairman, things do not appear to be getting any better. I have heard recent reports that young kids are shifting from the use of drugs alone to mixing them with alcohol.

I hear reports of young people who have to have a drink before they leave for school; who keep bottles stashed in their school lockers or cars; who share their pills at school, dumping them together to form a "fruit salad"; who, in addition, take Valium as casually as we take aspirin for the common cold.

And, Senator, I am not talking about kids in the ghettoes only, I am talking about kids like mine or like yours.

And many parents are so concerned that their kids might get into trouble with the law by smoking a little pot that they actually encourage them to drink.

So I am also happy to learn that Senator Williams amended the law 3 years ago to include provisions to direct more attention to the young.

Mr. Chairman, I have been deeply involved with the problems of alcoholism—my own and others—for more than 30 years. If at times I sound like an angry and frustrated man, it is because I am. I have been angry and frustrated half of my life in dealing with these problems.

I see this great abundant land of ours with resources beyond compare. I see the wonderful achievements of our science and technology; the miracles of modern medicine; the explosive growth of knowledge in numberless areas; the marvelous exploits of American industry and our space programs. But I am sick to my soul by our response to alcoholism. And I am sick to my soul that

even when we pass laws to help the alcoholic or the drug addict, we have remained blind to the illness that the alcoholism brings to the spouse or the young children in the family.

Mr. Chairman, it is not for nothing that the children of alcoholics are high risk to develop alcoholism or other emotional disorders. I want to add that much of my time to this day, is spent dealing with the problems of sick families of alcoholics and of the alcoholic themselves, both male and female, and children. The emotional warping done to the children, the strangulation of the families and the destruction of the family structure is one of the saddest things we can come across in our society.

So what would I do now if I still sat in your chair? I would ask a lot of questions. I would ask:

Why do hospitals still discriminate against alcoholics and addicts despite laws we passed in 1974 to prevent that?

What is wrong with our society that millions of our citizens, including children as young as 6—yes, I said 6—turn to alcohol or drugs to deaden their pain?

Why are doctors so afraid of the word "alcoholism" that one of them told a member of your staff recently that he would never ask her if she drank too much because she was "well-dressed."

And why, when an affluent alcoholic shows up in the office of a high-priced psychiatrist, does she so often wind up also addicted to Valium?

Mr. Chairman, as I was leaving to come here, I had a call from a physician in my State, himself an alcoholic, who finally, after years of alcoholism, had sought assistance and had gone into a treatment program. He was coming out of the program and did not know how to continue his professional life because of the illness. He was afraid and called me for counseling 1,500 miles from where he lived. Doctors do not give this kind of help even to their fellow colleagues. This is almost unbelievable in our time. And I would ask:

Why is it that millions of women—at all social levels and of all races—suffer beatings, rapes, and worse from their drunken husbands and yet many times are too ashamed to call the police or tell their ministers?

And why, when one does call the police, will the police not respond to a "domestic problem"?

Why is it that children who are physically and sexually abused by their own fathers—often with the mother's cooperation—grow into men who do the same to their own children?

And why is it that a young child recently jumped to his death from his seventh floor window because ever since seeing the movie "Superman," he had been trying to fly?

Why is it that children of alcoholics often wind up in back wards of mental hospitals?

And why is it that a little old woman, carrying all her worldly goods in two shopping bags, was refused her supplemental security income payments until a courageous doctor in New York—herself an alcoholic—was able "to get her back into the system"?

And while we are at it, why has that doctor talked to members of this staff over and over again only to be told that "There is nothing we can do to help because it's not our jurisdiction?"

Why is it that we turn our backs on old people who are being over-medicated to make life easier for the staffs of nursing homes?

And why is it that no one has looked into helping bring alcoholism treatment to our elderly or our physically handicapped?

And why has a woman begged again and again for that to change and still remain unheard?

And why do our colleagues on the Appropriations Committee still provide three times the money for dental research as they do for alcoholism?

Why are we unwilling to put warning labels on alcohol to warn pregnant women of the danger to their unborn children?

And why did an advertising executive sarcastically accuse a member of your staff of being a "neo-prohibitionist" and a "reincarnation of Carey Nation," when she quietly suggested that perhaps women were entitled to that information?

Why, Senator—in God's name, why? Why do we have to continue these ways and why do we have to continue crying out and remain unheard?

Mr. Chairman, my family often reminds me that I sometimes talk like the drunken truck driver I once was. Old habits are hard to break. Today, forgive me if I sound like I am preaching.

But, Senator, I believe with all my heart and soul that one day I will meet my Maker face to face. And on that day I do not believe that He will ask how many important offices I was elected to—nor how many acts of Congress bear my name—nor even whether I went to church regularly. I believe that he will ask "What have you done unto the least of these?"

Mr. Chairman, I pray that I will have the right answer

Senator RIEGLE. Thank you so much for your statement and the clearness that you give us in terms of seeing the things that you speak about.

There are a couple of things that I would like to raise with you and one that I would like to get your advice on, and another that I would like you to comment on.

We had an anonymous witness in here last week who told a very touching and tragic story of what has happened in her life with alcoholism in her family, the abuse, death threats, literally an adult lifetime of misery in all forms. And one of the points that that witness made was that there really is no place for family members of an alcoholic to turn for assistance if the person with alcoholism refuses to do anything for themselves at that point.

So the issue really centers on the family members of a person who is an alcoholic, whether the alcoholic will not seek or refuses to accept an kind of help or treatment. I responded to her, after hearing that testimony, that it was clear to me that there is a need, there is a very compelling human need, for some kind of facility, some kind of place for family members in this situation to go.

You stated some very good examples of people who have been in this situation in your own testimony. The Detroit Free Press, which is the large morning newspaper in my home State of Michigan took that suggestion. They have a daily question they put to the public on the front page of the newspaper, and they ask people yes or no, do they like this idea, and solicit public response. I want

to read to you the question as they phrased it for their readership to consider, and then I want to give you the response that they got, and then I would like to hear your reaction to it.

They posed the question this way. They say that Senator Riegle, Chairman of this subcommittee, is trying to secure Federal funds for programs aimed at relatives of alcoholics, whether or not the alcoholics themselves are cooperating with the programs.

Would you be in favor of this?

Those people who voluntarily responded came back this way. The noes 69.3 percent, and here were some of the comments that they printed:

> It would just help the alcoholic continue drinking. Why don't people who have lived sensible drug free lives get that kind of break? Our taxes are high enough in this country from helping everyone who happens to have a problem. Riegle should spend more time balancing the budget instead of spending it. It is another waste of taxpayers' money.

The yesses were 30.7 percent, and these were some of their comments:

> It is the families of alcoholics who suffer most when one of them is a problem drinker. My dad is an alcoholic and none of us knows how to handle it. Help for the alcoholic has to start with understanding at home and families need to be informed as to how to do this.

I think probably this reaction is a reasonably accurate gage of what may be some of the base level opinions of citizens, especially in today's climate.

What is your reaction to that? What feeling, what thoughts do you have in terms of that?

Mr. HUGHES. Well, first, Mr. Chairman, let me say that I support what you are trying to do for the following reasons: No. 1, if those people could understand, and did receive an education into what it is costing the State and the Nation for those people not to receive help, they could well know, in a practical matter that in dollars and cents, they would be millions and millions of dollars ahead if they helped the families, the suffering of the alcoholic family. It is costing the State, the cities, the Nation, millions in additional revenues to care for the destruction of those families that takes place. It is not a matter of wasting money, it is a matter of investing money, if for no other reason, to save money. If they do not give a damn about the members of those families, the women, the children, the families, whoever they are, and they are only worried about the buck, we ought to get them to support what you are trying to do because it will save money in the long run.

On the other side of the coin is the compassionate human standards of what we are doing to those children. I had a mother testify in this room—I recall it vividly, to this day—who had eight children, four born before her husband recovered from alcoholism, and four born in the aftermath of alcoholism. It is in the record of this subcommittee, an example of what it meant in that family.

The four children born while that man was an alcoholic, every one with tremendous emotional and social problems in his life. The four born after his sobriety, and their reunion in marriage, examples of children growing up in well balanced life, because they had the attention and help.

In this one family you had eight different situations. Four children warped and emotionally harmed in different ways, and four children who are not. Within a radius of the small rural area that I live in today, Senator, I could give you case after case of what is happening.

One instance I can state—a very tragic case of a man who I consider to be an alcoholic, caught in adultery by his wife. She later that same night poured gasoline on him, as he was passed out on his bed, and burned him to death. She was convicted, or I would not make that statement. She is serving a life sentence in the State of Maryland. What a hell of a way to die, even though you are an alcoholic, and even though you might deserve punishment. Four children now are fatherless and motherless, because we pay no attention to the problems within the home.

I have right now living with me a man who is a professional man, practicing in one of the neighboring cities, an alcoholic who has stopped drinking. His family is broken. He has two sons who he is trying to cope with as teenagers, to rebuild and restrengthen their lives. There is not a day of my life yet, that people do not walk in—people from the streets of life—come to me with those problems of the families of alcoholics.

I receive calls from all over this Nation, from people asking for help in coping with an alcoholic member of the family. How do I live with it? I do not have the answers, Senator. I do not have the help, and what can I do by long distance telephone? I can tell you one telephone call from a wife whose husband had a loaded gun in his hand. She had begged him to talk to me to get help from me on the phone. And he said all right, I will speak to Senator Hughes, I respect him. He was going out to shoot a man and a woman. He had a loaded shotgun in his hand.

I told her to call the police, and have him apprehended, when he got on the phone, which she did. He got on the phone, and we talked for half an hour, and he went and cried in his agony. He had tried to get help, and had nothing, and she had tried to get help, and did not know what to do herself. He wound up in jail, and as a result of being in jail he did wind up getting help later.

But, God, what do we have to do? On the basis of dollars and cents, it pays 10 to 1 to do something about the problem. What does it cost to keep people in mental institutions, children who never achieve their full status as human beings in our society, what does it take?

Senator RIEGLE. We have, in the budget before us, from the administration, a request that will actually, in the judgment of the committee, reduce the amount of money that is available for this kind of treatment and this kind of help. Let me tell you how it works.

The President has asked for $99 million for the coming fiscal year for State grants, for alcoholism, and the alcoholism programs, the drug abuse programs, but they are adding in a new area, very large, very strong, strong constituent based, mental health.

The current year, the last budget year, the budgeted amounts were roughly the same, $96.8 million versus the $99 million for just the two functions of alcoholism and drug abuse.

Do you know immediately, from your own experiences here, that by adding that third very substantial new area to come in and compete with the same number of dollars of funds, and forgetting the inflation, it is going to mean substantially less money for the kinds of alcoholism programs that you are talking about today?

Now, I look at the Federal budget, it is well over $500 billion, as you know. We are looking at a request for a 10-percent increase in the defense budget for 1 year. But we are looking at a request when we analyze it, to cut back in these programs, as small as they are, in the area of alcoholism and drug abuse.

I do not understand it. I do not understand the lack of perception. I do not understand the economics.

The last data that we could put our hands on indicates that the cost of alcoholism and alcohol abuse in this country in a year's time, was about $43 billion—$43 billion. Not to mention all the broken lives and the human tragedies of the sort that you were describing, and that we heard described here.

How we can be so foolish in terms of our strategic investment decisions, to not spend money to save such enormous sums of money and to do so much good at the same time I mean it just absolutely is beyond my ability to understand the reasoning that goes into that kind of budget priority.

So we made some recommendations to increase those sums, and to try to keep these programs standing in their own right. We do not want to find a situation where we are forcing a collision between the mental health advocates, with their proper concerns and needs, and the alcoholism and drug abuse programs with equally valid and necessary and urgent needs, as well.

May I ask you one more thing? You have been so kind to come today and share these thoughts with us. I think it is so important that we hear from you now, in today's environment, and today's climate.

You made a reference to proposition 13, and there are a lot of people who think that the most important thing right now is to mandate a balanced budget. Without any regard necessarily to these more substantial and difficult questions, do you know what is the investment value of some of these expenditures that we might make? You have been down this road yourself. I know you have written a book about it, an autobiography, to try to help people understand what it is like to be caught in this trap of alcoholism.

If you would be willing to do it, I think it would be very helpful if you could share some of those thoughts and insights with us. I think it would have great meaning, especially now, in today's climate.

Mr. HUGHES. You mean my own alcoholism, Senator?

Senator RIEGLE. Yes.

Mr. HUGHES. There was a very simple rule for me, Mr. Chairman. I can tell you without being too lengthy about it. I was an alcoholic, from the first drink I ever took in my life. I was an alcoholic as a teenager, in high school. I do not know what it is to drink normally ever. If there is such a thing as normal drinking, which I doubt, seriously.

But alcohol is nothing but trouble for me, and it is a progressive illness for me, and in those days I had no idea that I was sick. It

was the tough and manly thing to do, to drink with everyone. The fact that everyone else did not have lapses of memory and blackouts, to me I did not know. I thought perhaps I was the normal.

Hell, I was a healthy and powerful man in my younger years. I was able to withstand the brutal treatment that I gave my body in the process of that. But my drinking progressed through that, after high school, through the Army, my post-war years, and I finally began to realize that my drinking patterns were destructive. The people that I was hurting the most were those that I loved the most, my wife, my children, those immediately around me.

I promised time and time again that I would quit, and every time I failed, and each time that I failed, my own self esteem went down, and I thought I was worthless in the world. I was working daily, and had as good a job as there was for a working man in the country, and to most on the outside, not really realizing the destruction within me, they were not aware of what was taking place. Even my own aunt said a month ago, Harold, I did not know you were an alcoholic.

Well, I did not know, either. People knew that I was a drunk, that I was wild, and I would fight, and that I was disruptive. The abuse that I brought on my own wife and family, though I did not beat them, the mental, the verbal abuse, the questions, the wondering whether I was alive or not, they went through for years. It was a rocky road, until one time my wife left me, she took the children and left.

One day I woke up after a long time not drinking, and having drunk again, and I did not know how long I had been drunk. And I was sick, and I was hopeless, and I crawled to the window, to look out to see if the car was there, and did not see it. I did not know whether I killed someone, where my wife or children were, and the only thing that came to me was, what is the use in going on. I do not want to live like this. If I cannot control what I am doing, then I did not want to live. I did not have any faith in God then, Mr. Chairman. I was not at all sure that there was a God in this creation. If there was a loving God, I had seen little example of him in what I had seen in life.

The savagery in war, man's inhumanity to man, the statements that, who gave a damn to any of us, not anyone. That night I desperately decided that the only way that I could break the cycle of hurting my wife and family was to kill myself. It seemed the logical thing to do.

My wife was still relatively young, my children were still relatively young, they would be hurt, but they were young. My wife had filed charges of inebriety, to put me in a mental institution. I hired an attorney and beat that. I know the pain, the lonesomeness, the God-awfulness of waking up and saying what the hell is the use, no one cares. I cannot hack it any more.

So I loaded a gun, lay on the bed, and put the barrel in my mouth, and found that I could reach the trigger with the thumb, and then I thought well, what a mess I will make in the bedroom where we have lived, and had some happy hours, screwed up alcoholic thinking. I do not want to make that mess here, I will go in the bathroom.

So I got up and went in the bathroom, and suddenly something out of my youth came back, and I thought well, maybe if there is a God. I should pray. I know I should not commit suicide. I knew it was wrong. I had been raised in the church but I did not care if I had to pay the price of hell, and eternity. I would have paid to quit hurting my family.

So I knelt on the floor to pray, and I cried out in my agony, because I knew no words of prayer—God help me because I cannot help myself. If there is any reason to live, or take over my life, let me die, because I do not want to see the Sun rise again.

Something happened in me. I do not know what it was. But tears started streaming down my face, I got a great sense of peace entering into my body, and seemingly into every cell, and I was on that floor weeping, I do not know how long, an hour or more, I guess. But I realized suddenly that God was somewhere, that he had heard my prayer, and cared about me. I got up from that floor. I did not know much about God, I unloaded the gun, and put it away, and went back to bed and slept peacefully for the first time in weeks, perhaps months.

When I arose in the morning, I called my wife, and asked her if she would come home. She had no reason to. She should have stayed away, by my old drinking record, but she sensed something apparently in my voice, and she returned and brought the children back, and started over again.

Mr. Chairman, that was 25 years ago last month. There was not sudden relief from the pain, the suffering and the affliction. There was a long period of growth and loneliness, and desperation. But in the years that intervened, I found the peace that I had never known. I found it because I returned to that which I had strayed away from. The Scripture, the word, my church, my family, and recommitted my life to Jesus Christ in the hope and the belief that wherever he called I would follow.

I believe that he called me into the political arena, I believe that he called me out. I placed my life in his hands, because in my own it was death, it was hell, and it was destruction.

Senator RIEGLE. That scene that you described in your bedroom, and in your bathroom, those many years ago, I am sure is a scene that is being duplicated last night, tonight, tomorrow, with other people who are struggling, and are not finding the answers. For whatever the reasons, we are not saving them. We are not reaching them.

I think that your story is the story really of everyone who is caught in this trap, and caught in this circumstance. I think this is what we have to start to pay attention to. I worry so much about the fact that in our society, we tend, it seems to me, to becoming disconnected rather than connected. We are caring maybe less about other people's problems than we did before, which make it harder for those of us with difficulty to find help, to find a way to get through these most difficult times, and on to something better.

Mr. HUGHES. Mr. Chairman, I want to correct something that I said in my emotion. I made a mistake. That was 27 years ago, and I drinks again after that incident, 2 years later, and got drunk again. But I never drank after that last time.

Now, many times we consider people who are sick with this illness, who have a failure—what we call a slip—failures; they are not failures.

If you break the cycle of drinking that a man or woman has had for years, and he is sober for 30 days, or 60 days, or 6 months, and he drank again and then he sobers up again for a year, and then drinks again and then he sobers up and does not drink for the rest of his life he's not a failure. I personally had a friend who was in jail 360-some times, who was considered hopeless by every friend and every professional; he has now been sober for over 15 years, and a fine engineer. But there is no failure and there is no hopelessness that I know, except the failure of us to forgive, and to try again to have faith that they can make it.

Senator RIEGLE. Well, this subcommittee is determined to see to it that we reach people with this kind of insight and create linkages that can enable people to find a better answer. I hope the people who are in this room, who also care about these things, and not just those who have an interest in alcoholism programs, who have devoted their lives to work in this area, but others as well, can help in this debate, this national debate that is underway about what is important to devote ourselves to, and our resources to.

I serve on the Senate Budget Committee, and we are struggling right now with this question of the hard choices as to where we ought to put our dollars, and what we get for the dollars we spend. We had testimony from a young man who is 17, who became a drug addict at the age of 13, and who introduced his younger brother to drugs at the age of 8. In a sense, it is your story in a different form, as so many other stories.

We have one of our own colleagues, Senator Talmadge, who has been struggling to overcome alcoholism himself, very much in the news, because he has gone for treatment. I think all of us hope very strongly that those treatments are going to help him. But I think this problem is all around us, and we can either face up to it, and do something about it, and do what we know is right in human terms, and what is also right in the dollar terms, in terms of spending less money and getting more done with it, than to turn aside and to walk away, and to pretend that the problem is not there, and sentence our society and all the people in it with this problem, to these terrible circumstances that you have described, and that others are describing.

Mr. HUGHES. Mr. Chairman, may I make one last statement briefly, and I know you are busy with these hearings, and I do not want to detain you, but in my lifetime, and in my service, in the capacity that you are now in, I never at any time desired to take $1 from the field of mental retardation or the afflicted in any way.

I do not want to deny our society of the help they so desperately need, whether it be in the dental research, or in any other way, but I believe a society as wealthy and rich as we are in this Nation, cannot afford to leave other segments of illness untreated.

I am asking for additional money. We dress so well, and eat so well, there is no society in history that has ever lived that has had such abundance. How can we ignore the sick in our midst and let

them die in the hell that they live in, without giving them health care.

We must be concerned and care for the least of these in our midsts. Not simply because it is cost effective, obvious, but because it is right. Because it is just, and because it is morally sound in the spiritual realm of our existence.

I do believe that God cares about nations and people, and I believe he has his people in creation, and I believe he does care how we treat one another. To lay down our lives for one another does not mean that we live in abundance while others have little or nothing because of an illness.

My God, we spend so much in the destructive elements of our world. We coerce so much of our resources into destruction and killing, and the machinery of destruction. I am not privy to the intelligence or the needs in our society, and our international affairs today in these areas, but I know that man has never failed to use those instruments of destruction. But once he builds them, he uses them. But I know that if there is a counterspiritual balance in all of this, that it has to be in the compassionate hearts of men. There is no compassionate bending in the law. It has to be men like yourself, and your colleagues, who care and feel the hurt of others.

Senator, I hope you feel the pain of those that you are serving so that you can serve them well.

Senator RIEGLE. Thank you so much for coming today and sharing with us these thoughts and these personal insights. You can be sure that this subcommittee is in this fight to stay. We made some progress yesterday in the full committee in terms of seeking budget approval for sums that we think are more in line with what we ought to be doing.

We are going to resist the approach to be put into block grant form where programs have to try to devour each other. We think that we ought to be able to treat separate problems in their own right, and that that is a far better way to do it. So we will call again on your counsel and your support, and your prayers, as well, because this is work that we do together.

Mr. HUGHES. Thank you, Mr. Chairman. You will have them all. Thank you. [Applause.]

Senator RIEGLE. Our next witness is Mr. George Vaughn. Has he arrived?

I am told that he is running behind.

So at this time we are going to call the General Accounting Office, Mr. Gregory J. Ahart, who is here, who is the Director of the Human Resources Division. We are pleased to have you, and whoever is accompanying you, and we would like you to come forward at this time.

As everyone in the room gets situated, let me voice the appreciation of the subcommittee to the General Accounting Office, and particularly the staff members who are here, and others who have been assisting the subcommittee, to take a look at the NIDA programs. We have had great cooperation and great interest shown by you, and that is most helpful, and we are very appreciative. I want to particularly acknowledge Catherine Fitzgerald, Mr. Schechterly,

Mr. Diebel, and Mr. Smith, among others, for the assistance that they have given.

Now, if you would, I know you are prepared to make some observations to us on what your efforts have indicated to you, and we would like to hear those at this time. Maybe you could introduce all the folks that are with you at the table.

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY KARL DIEBEL, SUPERVISORY AUDITOR; WILLIAM SCHECHTERLY, SUPERVISORY AUDITOR; AND TODD CROW, SUPERVISORY AUDITOR

Mr. AHART. Thank you, Mr. Chairman. I will introduce my associates at the table. On my right is Mr. Bill Schechterly, who you mentioned. On my left is Mr. Karl Diebel from our Los Angeles Region Office, along with Doctor Crow.

I do have a rather lengthy statement, Mr. Chairman, and with your permission, I would like to summarize it very briefly, and go to questions. I know you are pressed for time.

Senator RIEGLE. Fine, I would appreciate it. Let me just say, this subcommittee feels very strongly about its oversight responsibilities. We see ourselves with two principal operational requirements here: One, is to write the law and develop good programs that address real needs, and that make sense and that are cost-effective, and then second, to see to it that those laws have that effect, are carried out intelligently. If programs are missing the mark, if they are not cost effective, if they are in some other way deficient, we need to know that, and we need help in finding that out, because then we will make corrections. So this subcommittee will have a strong commitment, a continuing commitment to that kind of aggressive oversight, because to me that is the other half of the legislative process, that is seeing that what we intend to do is in fact done.

So it is in that spirit that we are especially interested in what your observations are about our actual field experience at this time.

Mr. AHART. Thank you very much.

If I might, I would like to make a few preliminary remarks about the testimony that we heard this morning. I think all of us here feel privileged to have heard the testimony that you have heard. I personally have had the privilege of being Deputy Director of the Civil Division of the General Accounting Office at the time that Senator Hughes asked us to take a look at the Federal work sector.—what was being done to reach alcoholics in Federal employment, what would be the dividends of such a program. We issued a report which we think he found quite helpful. It demonstrated the thing that you are talking about this morning, about investments, what you get in return from investments.

I think our cost-benefit ratio, computed—based on the data that we could get—was about 15 to 1.

Senator RIEGLE. Fifty to one?

Mr. AHART. Fifteen to one. Do not hold me to those figures, but I think it was about that.

Senator RIEGLE. So just to underscore that, you are saying that for every dollar invested we would be saving $15?

Mr. AHART. I think that was the number, but it was in that order of magnitude. We felt privileged to give assistance to Senator Hughes, in what he was doing at that time, and we continue to work in this very important area.

I would like to spend about 5 minutes, if I might, and summarize the main points that have come out of our ongoing study.

I caution you that our work is not completed. The review is a follow-on to the earlier work which we undertook, in which we had identified several problems in the operations of NIDA and its grantees and contractors. NIDA was aware of many of these problems, and had issued corrective actions. Our current review is directed to assessing NIDA's progress in solving these problems. Our work to date shows a number of problems remain, specifically we found that NIDA's method of funding treatment programs contributes to problems such as unused capacity in treatment programs, inflation of recorded utilization rates, low levels of treatment provided to some abusers, and funding levels that do not reflect actual cost of treatment.

Second, standards for controlling the design for programs should be clarified and upgraded, and finally, NIDA's plans for States to establish plans that are equivalent to or more stringent than the Federal funding criteria have moved very slowly.

On the funding mechanism, Mr. Chairman, I will try to explain briefly how the funding is carried out. NIDA uses what is called a slot. The slot-funding concept. Basically this means that when a budget is put together for a treatment program, or a budget is put together for a Statewide program, the funds are based on the number of slots that are planned to be filled. A slot is defined as a capability to provide maintenance to one abuser for a 1-year period. It is not geared to how much counseling an individual needs, so on and so forth.

The program will receive up to $1,940 for an outpatient slot, $40,000 for an inpatient slot, and so long as the budget does not exceed that, NIDA would fund at least 60 percent of that amount, depending on what program they were in.

The problem that we see with this concept and funding mechanism is that it does not give consideration directly to cost of providing the service. How much counseling is actually provided?

The managers of the program have little incentive to provide more service, to provide the necessary service, because they are going to get that part of the budget paid for under the program in any event, regardless of how many people they actually have in the program—they may go under the budgeted slot number—and regardless of how much actual service is delivered, they will get up to 60 percent of the $1,940, or the $40,000 as the case may be.

We feel at this point that NIDA needs to take a hard look at the funding mechanism, to try to develop one which is more attuned to what is actually needed by the program. For example, the present mechanism does not give consideration to regional differences, the $1,940 is the same number, whether you are in my hometown, or in the middle of New York City.

Obviously, costs are different in those two settings. One which would provide more incentive for the people that are running these programs to deliver up to capacity, have outreach, and to bring the service up to that capacity. I think the $1,940 figure, or the $40,000 figure is important to some of the things that you are talking about this morning.

The original concept of funding slots was put together in 1973, based not on actual costs, providing service in any particular setting, or treatment in any particular setting—they were put together on the judgment of a panel of experts, and they have been updated, annually by about 5 percent a year.

Unfortunately, because of a kind of static funding in the program, every time those are upgraded, and you keep the same number of slots funded, you have to borrow money from someplace else in the program to do it, such as preventive services, and things such as that.

So we think NIDA has to take a hard look at their formula, their funding mechanism, and try to develop one that is more attuned to the needs of the program, and perhaps get a better fix on just what the real need is for money in this program as a whole.

The treatment standards, the standards which are now made a part of each contract or grant, are what are called minimal standards. They were put together in 1975; they are still being used. They are ones that we do not feel, or program people do not feel are a great deal of guidance, as to just how do you put together an organized and effective drug abuse program.

NIDA did contract with the Joint Commission for Accreditation of Hospitals, and they put together a much more stringent set of standards. NIDA is encouraging States to put together systems for certification or licensing of programs, which they hope will be more stringent than the Federal funding standards, the minimal criteria.

We feel that there is a lot of room for NIDA to give more help to the treatment programs in terms of guidance, organization, what kind of staffing you need, what kinds of qualifications the staff should have, and just how do you put together and operate a good program.

We believe that these standards need to be upgraded, and clarified to a considerable extent. This is a brief summary of the 27 pages, Mr. Chairman, and we would be happy to go to questions at this point.

Senator RIEGLE. First of all, I want to thank you for the work that has been done. The summary and total will be made a part of the record.

I think the verbal summaries you have given us have been helpful to us.

You have found some areas where we can do better, and I think your points are very well taken.

Now, at the present time we do not have a Director, and I think we have not had for some time, and this is a problem. It seems to me, in terms of just sufficient efficient management, if we are going to have some changes and improvements taking place, there has to be an operating executive in charge, who could take these very valuable findings and observations that you have developed and assimilate that information, and then apply it, actually get

more mileage out of these very limited dollars that we have to spend in this area.

So I am hopeful that we will hear shortly from the people in that area, particularly the Administrator, who I think is here with us now. I know a commitment has been made that we will have a head of this particular operation, a Director, selected, and perhaps we will have news on that today. But I think this illustrates why we need somebody.

In other words, we need follow through. We need somebody in operational charge that can take these recommendations and implement them.

Let me run through a series of questions here. Can you clarify how a State can have a slot utilization rate higher than 100 percent?

Mr. AHART. Well, basically, as I explained the slot funding concept, it is geared to providing the capability of service to one patient for 1-year's time. It is not geared to have a particular number of patients in a program at a particular point in time. The utilization rates that are reported in are points of time rates, the number of patients, say, as of October 31, September 30, something like that. So, at any one point in time you could have more people in the program than you have slots.

Now, overall, as you look at some of that States, you will see a consistent pattern of underutilization. Others you see more or less consistent pattern of full utilization.

Senator RIEGLE. If a provider gets the same amount of money from NIAAA with the utilization rate of 85 percent as for 95 or 105 percent, what incentive is there for a provider to do a better job?

Mr. AHART. Well, it does not give him much incentive, obviously, in a monetary sense.

As you know, the people that do work in this field are dedicated and they try to reach as many people as they can. But they really have no financial incentive to get as many people into the program as they can and to give them the treatment. At the same time, because of the funding ceiling, it may be that they feel they have to underutilize their slots in order to provide the adequate service to the ones that they do have in the program—they have a disincentive from that standpoint, too, of really trying to provide the best kinds of service to the clients that they can.

Senator RIEGLE. You think that if we are going to have any kind of financial disincentive, it ought to be in the direction or full use of resources' would that not make sense?

Mr. AHART. I think so. Some States are using what they call a unit-of-service concept now where the programs are reimbursed for services delivered—for example as mentioned this morning, the cost might be $17 an hour for some particular kind of service. California is one that is using the unit-of-service concept for reimbursing programs, and we feel that that neutralizes financial incentives. And if they want to provide more service they get more funding, and if they provide less service, then they get less funding. But the quantities of service they provide as opposed to x number of dollars per slot, determines their funding.

Senator RIEGLE. I must say I appreciate your reference back to the young fellow that we had today as a witness. I tried to do a

calculation in my head when he was here before as to what it may have cost us in terms of that dollar per hour rate to assist him, and I suspect, without doing careful math, that it is probably something between $1,000 and $1,500 over the course of the time that it has taken to get him to pull away from the pattern of drug use into a situation where he has some much brighter future ahead for himself.

When you stop and think about it, when you can make these programs work right, to think that we are actually salvaging a human being and getting him into a position to live a productive life for that kind of investment, even forgetting what it would cost us if we ignore the problem and it goes the other way where we get these enormous costs, it seems to me that it is such a bargain. It seems to me that that is a very high return right on the face of it.

Let me ask you this. I am quite interested in the long-term potential of paying drug abuse coverage through insurance and third-party payments. I am wondering what steps you think NIAAA could take in the areas of certification accreditation to to try to encourage this sort of trend?

Mr. AHART. As I mentioned before, NIDA has asked the Joint Commission on Accreditation of Hospitals to come up with accreditation standards for these, and I think to the extent that these programs are accredited—and by the way, NIAAA does accept accreditation as meeting the minimum funding criteria—it will be more attractive for third-party payers to pay under the program. Also to the extent that I think we move away from the slot funding ceiling concept, to more of a unit-of-service concept, it makes it much more administratively possible to work in a third-party program. It would make the paperwork a little more complicated but quite possibly could attract more insurance, third-party payment type funding.

Senator RIEGLE. I am going to have additional questions that I am going to offer for the record.

Let me ask you if any of your associates have any sort of summary that you would like to make to what has been said or anything said earlier today?

Mr. AHART. Mr. Diebel would like to make a few remarks.

Mr. DIEBEL. You were commenting on the hope for appointment of the NIDA Director, and I would like to say for the last 4 or 5 months that we have been working with NIDA, we have been pleased to work with Mr. Besteman, who has been the Acting Director. He has given us quite a bit of cooperation. I think picking up on the last comment, certification and accreditation, NIDA, within the past months, has issued additional direction to the States and providers that if they become accredited and go through the JCAH process, that that will be acceptable. So I think they are making some steps forward in that.

Senator RIEGLE. You feel good about that?

Mr. DIEBEL. I feel very good about that. We think that the current criteria have a long way to go and we think some of the aspects of the JCAH accreditation are very useful in providing a framework for quality treatment to be provided.

Senator RIEGLE. Let me thank you very much for your work. And again I want to emphasize how much we appreciate the kind of

close working relationship that the committee has been able to have with you. Your cocperation with our staff has been extremely valuable. I really want to commend you on the work and the positive kind of attitude that we found. And we appreciate it and we want to be close working partners with you on this.

[The prepared statement of Mr. Ahart follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION
BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM & DRUG ABUSE
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE
ON
DRUG ABUSE TREATMENT EFFORTS
OF THE NATIONAL INSTITUTE ON DRUG ABUSE

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss our ongoing review of drug abuse treatment efforts of the National Institute on Drug Abuse (NIDA). We started this review as a follow-on to earlier work in which we had identified several weaknesses in the operations of NIDA and its grantees and contractors. NIDA was aware of many of these problems and had initiated corrective actions. Our current review, directed at assessing NIDA's progress in solving its problems, was begun about 1 year after NIDA started its corrective actions.

In June 1978, shortly after we started our review, the Subcommittee asked us to provide it with the results of our work in time for these hearings.

Because our review is not yet complete the observations we are presenting must be considered as tentative. We have not fully developed the causes of the deficiencies noted nor have we developed recommendations for correcting them.

Our work to date shows that a number of the problems that we and others had identified continue to exist. Specifically, we found that

--NIDA's method of funding drug abuse treatment programs contributes to problems such as (1) unused capacity in treatment programs, (2) inflation of reported treatment utilization rates, (3) low levels of treatment provided to some abusers, and (4) funding levels that do not reflect actual costs of treatment.

--NIDA's standards for controlling the design and operation of treatment programs should be clarified and upgraded.

--NIDA's plans for States to establish standards that are equivalent to or more stringent than the Federal funding criteria have moved very slowly.

INTRODUCTION

Drug abuse in the United States costs an estimated $17 billion a year. Estimates of the number of drug abusers are difficult to obtain. However, a recent Office of Drug Abuse Policy publication shows that in 1977 an estimated 1.8 million persons used amphetamines for nonmedical purposes, 1.7 million used cocaine, 550,000 used heroin, 4.6 million used depressants and sedatives other than alcohol, 1.1 million used psychedelic drugs, and 175,000 used inhalants.

Each year almost 1 million people are treated for drug abuse problems in the United States. In fiscal year 1978, an estimated $518 million was spent for these drug abuse treatment services of which NIDA provided $132 million, the States provided $164 million and the remainder was provided by such sources as the Veterans Administration, local governments, and the private sector.

NIDA, under the authority of Section 410 of Public Law 92-255, administers a comprehensive program of drug abuse treatment services throughout the United States primarily through two mechanisms

--a statewide services contract which is a cost reimbursement/cost sharing arrangement with a designated State agency. Under this mechanism, State agencies

subcontract with local drug treatment programs to provide the treatment services.

--a direct grant to or contract with a local drug treatment program. Under this mechanism, NIDA deals directly with the program with little or no State involvement.

In addition to the above, the States may use formula funds provided under Section 409 of Public Law 92-255 to fund treatment services.

The NIDA funded treatment services are provided in four environments--outpatient, residential, day care, and inpatient. Over 83 percent of the services are provided in an outpatient environment. The drug abusers are treated in either a drug free, methadone maintenance, or detoxification modality. Of these, over 61 percent of the abusers are in drug free programs and over 35 percent are in methadone maintenance.

CONCERNS WITH NIDA'S METHOD OF PROVIDING FUNDS

We have several observations concerning NIDA's method of funding the treatment of drug abuse:

--based on reported utilization of treatment capacity, the nationwide treatment program could serve more drug abusers,

--because reported utilization rates are inflated, there is even more potential for treating additional drug abusers,

--the low level of success in rehabilitating drug abusers may in part be due to the low level of treatment provided, and

--NIDA cost ceilings may discourage programs from providing necessary treatment to their drug abusing clients.

As we mentioned, NIDA contracts with States and with individual programs to provide treatment services to drug abusers. Over 70 percent of the treatment funds is allocated to States, with the remainder going directly to individual programs. NIDA's management expects to fund virtually all of its assistance through statewide services contracts by fiscal year 1980.

NIDA funds are provided through a slot funding concept.

Under this slot funding mechanism NIDA funds treatment services based on the number of abusers in a program who could be in treatment at any particular time under conditions of full operation. Full operation, or capacity, is expressed in terms of slots; one slot can be defined as the capability to treat the equivalent of one abuser for a 12-month period. At any point in time, a program may be treating more or less abusers than its number of slots.

NIDA uses the concept of guideline slot cost ceilings as the basis for funding drug abuse treatment programs. Guideline ceilings represent the maximum amount against which NIDA will fund part of treatment costs. Based on criteria in the legislation, NIDA's share can range from 90 percent to 60 percent. Established ceilings for fiscal year 1979 range from $40,000 for an inpatient slot down to $1,940 for an outpatient slot.

Thus a State or a provider with, for example, a contract to provide 100 slots of outpatient drug-free treatment will have a ceiling of $194,000 for a year. The State or provider prepares a budget showing the estimated costs of personnel, facilities, utilities, and other items. If the budget does not exceed $194,000, NIDA will fund at least 60 percent of the budget. NIDA will not participate in any of the costs exceeding $194,000.

NIDA believes that the treatment slot concept is a simple, flexible, easy-to-monitor approach to funding a

nationwide treatment system. However, there are several problems which result from the use of slot funding. These problems lead us to tentatively conclude that NIDA needs to develop and implement a funding mechanism that will provide greater assurance that Federal funds are expended in the most effective and efficient manner. Until another funding mechanism is adopted by NIDA, we believe the following factors need immediate attention.

Unused capacity in treatment programs

The NIDA assisted drug abuse program could serve more drug abusers without any significant increase in costs because treatment capacity is underutilized.

The nationwide utilization rate, as reported by NIDA, declined from 95 percent in October 1975 to 89 percent in October 1978. NIDA does not want the States and treatment providers to fall below an 85 percent slot utilization rate. We noted three States with a pattern of reported utilization rates of about 80 percent.

By comparison, seven States reported utilization rates of more than 100 percent in October 1978. For example, providers in one State reported that they gave outpatient drug-free treatment to 272 drug abusers, although it is funded for only 226 slots--a utilization rate of 120 percent.

It has been noted by authorities that the slot funding mechanism does not provide an incentive for a provider or a State to raise their slot utilization rate. There is no incentive for a program to increase its utilization rate because NIDA customarily pays its full share of slot costs regardless of a program's utilization rate.

The reported utilization rates indicate that more drug abusers could be treated. For example, increasing the utilization rate from its 1978 national average of 89 percent to its 1975 rate of 95 percent, would involve treatment of approximately 12,000 more drug abusers annually. The estimate of 12,000 is computed on the basis that NIDA funds about 100,000 slots annually and that the average treatment period is 6 months.

Since (1) some providers and States have apparently developed techniques to raise their rates above 100 percent, and (2) other providers in States had inflated their reported utilization rates, as discussed later, we believe there is potential for NIDA to increase the national rate.

Reported utilization rates are inflated

Numerous attempts have been made to validate the reported rates of utilization of the slots. The results of these reviews indicate that the utilization rates are inflated. Thousands of abusers are being reported as served who are not being served.

NIDA requires that each treatment provider have face-to-face contact every thirty days with the abuser. If such contact is not made, the provider may not count that abuser as an "active client." While the issue of frequency of contacts with abusers will be discussed later, we want to point out that the unused capacity problem discussed above is made worse by the problem of an inflation of reported utilization rates.

A management consultant firm, under contract with NIDA continually reports that utilization rates are overstated. For example, in one of the States with a large share of NIDA's assistance, the reported rate was 84 percent but the actual rate was 74 percent. Within the past month, the report on tests in another State showed that the actual rate was 79 percent, but the reported rate was 96 percent.

We believe these examples are a fair presentation of the results of the tests made by the management consultant. While the firm does not go to every provider in a State, it verifies the reported utilization for a given provider using a scientific sample.

An ongoing audit by HEW's Inspector General, showed that one clinic reported a utilization rate of 109 percent and another clinic reported a rate of 87 percent; the actual rates were 76 percent and 56 percent, respectively.

Because of the attention given to this issue by the management consultant and the HEW Inspector General, our work was very limited. Yet we also found instances of inflated utilization rates.

We are cognizant of several steps taken by NIDA to upgrade the quality of the reported data. Some of these corrective actions were outlined to us in April 1978. Yet, the problem remains.

Though we have not completed our review, we have tentatively concluded that the providers could be treating many more drug abusers since the actual utilization rate is so much lower, in many States, than the reported rate. While none of the reviews allow projections of the results on a nationwide basis, the differences found are substantial. To illustrate, if the actual nationwide rate was 5 percent less than the reported rate, providers have the capacity to treat about 10,000 more drug abusers annually, since each percentage point represents the treatment of about 2,000 abusers.

Low level of treatment provided to abusers

Concern has been expressed by NIDA and others at the lack of treatment given to abusers by providers; yet the problem is not resolved. Since the reported rate of completing treatment is about 20 percent, the low level of treatment provided to the abusers may well be one of the

causal factors of the low success rate. The slot funding mechanism does not provide incentives to a program to increase the level of services provided to abusers because a program will receive the same level of NIDA funding for an abuser seen once per month as for an abuser seen 10 times per month.

According to NIDA's policy it is the responsibility of the State and the provider to make the clinical judgment of how often a drug abuser will be counseled and the kind of services to be provided. However, for purposes of continuing to receive funding, a provider is required by NIDA to have a face-to-face contact with the abuser at least once a month.

In December 1977, NIDA informed program directors that its work showed that the number of monthly contacts were low. NIDA explained that its findings were compatible with similar findings of its management consultant. The consultant had reported that the concept of funding programs on the basis of treatment slots does not appear to provide incentives that encourage a high level of client contact.

The HEW Inspector General's review has shown that clients in the five programs tested received, on the average, less than 30 minutes a week of counseling. The average weekly counseling of the drug abuser ranged from 10 minutes to 45 minutes. In this regard, NIDA's funding criteria, with which all programs must abide, states that a minimum of 3 hours of

formalized counseling per week shall be made available for each patient in outpatient methadone and drug-free programs. As discussed later, this requirement is vague and unenforceable.

The low level of contact continues to be brought to the attention of the States and NIDA by the management consulting firm. For example, in reports recently issued, the firm found that in one State about 75 percent of the abusers in treatment had two or less contacts per month; in a second State, 49 percent of the clients were seen on two or less occasions per month.

We recognize that the frequency and duration of client contacts will vary. For example, some authorities say that there are circumstances when an outpatient drug abuse client in the final stages of treatment may need only one contact per month. Further, a heroin abuser coming in for only methadone may not require any counseling.

A member of HEW's National Advisory Council on Drug Abuse, who is also a treatment provider, explained that counseling of heroin abusers in an outpatient drug-free program could range from hourly sessions three to five times a week for the abuser with major family and social problems, to once a week or less for an abuser about to complete treatment. He further stated that in practice, however, the tendency has been to regress to the most minimal contact so that the national average is only two to three times a month.

The management consulting firm has provided reasons for low levels of contact:

--There are problems in motivating drug abusers who are required by the courts to be treated.

--Programs receive the same level of funding regardless of the number of times an abuser is seen each month.

In our discussions with the director of a State drug abuse agency, who is also a past president of the National Association of State Alcohol and Drug Abuse Directors, we were advised that current clinical judgment is that once-a-month contact is inadequate for counseling purposes.

Based on the evidence we have gathered to date, it appears that NIDA needs to upgrade its funding criteria to increase the level of contact with the drug abuser.

Slot cost ceilings not consistent with actual costs

Since the slot concept provides for cost reimbursement based on a cost ceiling rather than on the actual cost of treatment, the ceilings may prevent programs from providing the necessary treatment services to drug abusers.

A technical assistance contractor reported in May 1978, that the actual cost of treating an individual may have little relationship to the budgeted slot cost. According to NIDA officials, the cost ceilings were established in 1973

based on the opinions of several experts, rather than on on historical cost data. They recognize that the slot ceilings are significantly lower than the actual cost incurred by the treatment programs. They further explained that as long as they have to operate the drug abuse treatment program under restrictions of a static budget and treatment capacity, they do not plan to change the funding mechanism, nor can they raise the cost ceiling to a realistic level.

Officials in the States we visited--California, New York, and Illinois--believe treatment costs are higher than the ceilings. A study completed by the California Division of Drug Abuse in March 1978, showed that the estimated cost for residential programs in California was about $12,000 annually per client; NIDA's slot cost ceiling was $5,400.

Further, the slot cost ceilings do not recognize other factors such as:

--differences in salaries of clinical personnel among different parts of the country; and

--differences in the cost of drug-free treatment versus treating a person with methadone.

For example, Federal regulations require that projects dispensing methadone be staffed with a minimum of one physician and two nurses. According to the chief of planning for the Los Angeles Drug Abuse Office, these staffing requirements lead to higher personnel costs in methadone maintenance programs than in drug-free programs. Yet both types of treatment are governed by the same guideline cost ceiling.

Some of NIDA's current work will provide information on the actual cost of treating drug abusers.

NIDA IS EXPLORING DIFFERENT TYPES OF FUNDING MECHANISMS

NIDA is exploring alternative ways to fund the Federal Government's share of the cost of drug abuse treatment.

The slot funding mechanism is considered by NIDA to be unique in the Federal Government. We recognize the utility of such a mechanism in the 1974-1975 period when NIDA needed to rapidly expand the national treatment system in response to public concerns over the increasing level of heroin abuse. However, as discussed earlier, there are several problems which result from the use of slot funding.

In a September 1978 publication, the National Association of State Alcohol and Drug Abuse Directors stated regarding slot funding that

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--only very imprecise cost information is available on which to base financial management decisions,

--it is difficult to clearly state what treatment services are being provided to whom at any given time, or over a period of time,

--there is no precise mechanism to ensure service delivery accountability, and

--slot funding may permit or encourage minimum contacts with a client and loose standards for client care.

Whether to continue using this funding mechanism has been a question before NIDA for some time. For example:

--we discussed the issue with NIDA officials in the summer of 1977.

--NIDA's management consulting firm addressed the concerns about slot funding in their January 1978 report.

--the White House's Office of Drug Abuse Policy in a March 1978 report, recommended the evaluation of a new funding mechanism and its adoption, if feasible.

--the panel on psychoactive drug use of the President's Commission on Mental Health concluded that a fundamental reappraisal of the quality of drug treatment services is necessary in part because of its concern

that the quality of treatment is being neglected under NIDA's slot funding concept.

NIDA has approached the growing concerns with a number of exploratory programs. One of NIDA's goals in fiscal year 1978, was to develop a methodology to reimburse costs in a manner which is closely related to the quality and quantity of patient care units of service actually being provided. NIDA plans in fiscal year 1979, to examine possible variations of the existing treatment slot system and other possible funding systems, including unit costing.

Several States use the unit of service concept. Under this mechanism, programs are reimbursed for the actual cost of service provided to the drug abuser. The advantages claimed are:

--overcoming clinical and financial management problems of accountability; and

--meeting third party reimbursement requirements to assist the treatment provider in obtaining such reimbursements.

However, some negative features of the unit of cost concept identified are

--increased paperwork;

--increased cost of monitoring; and

--possible funding instability for some programs.

We have tentatively concluded that the slot funding concept does not provide incentives for a program to

--increase its utilization rate because NIDA customarily pays its full share of slot costs regardless of a program's utilization rate, and

--increase the level of services provided to abusers because a program will receive the same level of NIDA funding regardless of the frequency or duration of treatment services provided to an abuser.

While we have not reached a judgment that unit of service funding is the best of the alternatives being explored, NIDA needs to develop and implement a mechanism that will provide greater assurance that Federal funds have been expended in the most effective and efficient manner.

CONCERNS WITH DRUG ABUSE TREATMENT STANDARDS

During 1973 the Special Action Office for Drug Abuse Prevention (SAODAP) took two major initiatives which signaled the beginning of Federal involvement in the development of drug abuse treatment standards. These initiatives were considered necessary because (1) SAODAP was concerned about the quality of service being provided to drug abusers, (2) traditional health care providers had not responded to drug abusers' needs and, therefore, drug abuse treatment

was being provided by ex-addicts and other non-professionals, and (3) the Federal Government needed a system which would control how its treatment funds were being spent.

The first of these initiatives was the development of a set of treatment standards known as the Federal funding criteria. The funding criteria were developed as minimal standards of acceptable treatment which must be met in order to receive Federal funds. The promulgation of "minimal" standards was necessary so that there would be the least possible disruption to the drug abuse treatment field. It was believed that, had more stringent standards been imposed, much of the then existing drug abuse treatment system would have been unable to continue operations. The funding criteria represent, according to NIDA, established levels of program performance achievable by all drug treatment programs with minimal assistance from the Federal Government. NIDA believed the criteria would provide the system needed to control how Federal funds were spent and would provide guidance to the nonprofessionals staffing many of the federally funded treatment programs. NIDA continues to incorporate the funding criteria into its drug abuse treatment grants and contracts and they remain as the minimal operating criteria for NIDA-funded treatment programs.

The second SAODAP initiative regarding standards was the awarding of a grant to the Joint Commission on Accreditation of Hospitals to develop standards for the voluntary accreditation of drug abuse treatment facilities. In contrast to the minimal requirements of the Federal funding criteria these standards were expected to represent maximally achievable standards for the drug abuse treatment field. SAODAP believed that Joint Commission accreditation would help assure quality treatment for drug abusers and would increase the probability of third party reimbursement for drug abuse treatment services. The SAODAP grant was replaced by a NIDA contract in June 1975 and the Joint Commission published its standards in the latter part of 1975. Since then the standards have been field-tested and revised where necessary, and a system of weights has been developed to prioritize the elements included in the accreditation process. The total Federal cost to develop these standards was about $659,000.

At the same time that the Federal funding criteria and the Joint Commission treatment standards were being developed, the States were acting to develop their own systems for licensing and/or certifying drug abuse treatment programs. This action was mandated by Public Law 92-255 which required the States to develop and implement licensing or accreditation procedures. However, in 1974 Public Law 94-63 repealed this

requirement and State certification systems were no longer mandatory. NIDA continues to encourage and assist the States to develop treatment standards. It is NIDA's hope that, despite the repeal of the State licensing requirement, States will continue to move toward the adoption of licensing or certification requirements. To this end, NIDA has told State authorities that if State promulgated standards are substantially consistent with the Federal funding criteria, NIDA will accept them in lieu of the criteria. NIDA hopes that the standards developed by the States will be more stringent than the criteria, thus upgrading the quality of treatment provided in the States.

COMPARISON OF FEDERAL FUNDING CRITERIA AND JOINT COMMISSION TREATMENT STANDARDS

In reviewing the treatment standards contained in NIDA's funding criteria, we noted that:

--some standards are vague and, therefore, cause problems of enforcement and interpretation, and

--important aspects of the quality of treatment are not addressed by the standards.

Therefore, we believe that the treatment standards of the funding criteria should be clarified and upgraded.

Our audit work at NIDA includes an examination of selected elements of the funding criteria and Joint Commission standards. Although our efforts are not intended to directly

address the issue of quality of care, we have been guided by an awareness of the importance of this issue. We recognize that the funding criteria were never intended to ensure that quality services would be delivered. However, these standards of performance were expected to ensure that a program's design and operation have been established within a framework such that quality treatment services can be delivered.

It is within this context that we examined portions of the funding criteria. We identified elements of these standards which are so vaguely written that they are unenforceable and/or do not provide sufficient detail to ensure uniform interpretation. This vagueness is illustrated by the funding criteria requirement for counseling services. NIDA-funded outpatient treatment programs are required to "make available" a minimum of 3 hours of formalized counseling per week for each client. Similarly, residential and day care programs are required to "make available" 10 hours of formalized counseling per week for each client. NIDA personnel responsible for monitoring program compliance were unable to define what the phrase "make available" means and agreed that the requirement is unenforceable.

Another example of a vague funding criteria requirement is that which deals with client records. The funding criteria require only that a client record system be established which

documents and monitors client care, is kept confidential and complies with all Federal and State reporting requirements. Inadequate client record systems have been continually identified as serious problems by NIDA's management consultants. Improvement in the quality of client record systems could be achieved if the funding criteria were more specific.

We are also concerned whether the funding criteria are still appropriate as minimal standards of performance for current drug abuse treatment programs and as a mechanism to control their design and operation. In order to make some assessment of the adequacy of the funding criteria, we compared selected Joint Commission requirements with the funding criteria. The Joint Commission elements selected for comparison are those we judged to be related to quality of care. Our judgment was influenced by discussions with NIDA personnel and other experts in drug abuse treatment. Our purpose was to determine the extent to which these "quality of care" elements of the Joint Commission standards were addressed by the funding criteria. Our comparison included four main topics: program administration, personnel, intake and assessment procedures, and community linkages. In the interest of time we will just discuss program administration.

We included program administration elements in our comparison because we were told by experts that such elements contributed to a stable and well-run program and that such a program was more likely to provide quality care.

In general, the funding criteria do not address program administration elements. In contrast, the Joint Commission standards include a variety of requirements regarding program structure and operation.

More specifically, the Joint Commission standards require that programs have a governing body that has ultimate authority for the program working through an appointed executive director responsible for the overall operation of the program. The funding criteria do not have requirements for program structure.

The Joint Commission requires written policies and procedures for many program areas including fiscal management, staffing, facilities management, and client records. The funding criteria do not.

The Joint Commission requires programs to do continuous and comprehensive evaluation, using explicit and measurable criteria. The funding criteria do not require internal program evaluation.

The Joint Commission requires that there be written policies and procedures that establish a staff development program and that designate an individual to supervise staff development activities. Staff development must include orientation for entry-level staff, on-the-job training, in-service education, and opportunities for continuing job-related education. Similarily, the Joint Commission standards require written policies for recruitment, selection, promotion and termination of program staff members. They also require written job descriptions for all positions. The funding criteria do not address the need for staff development or for personnel policies.

The Joint Commission standards we reviewed are considerably more specific and detailed than the funding criteria, and in many cases address issues that are not addressed in the criteria. The Joint Commission standards appear to offer considerably more guidance to drug abuse treatment programs. Although we recognize that the funding criteria and the Joint Commission standards were developed for different purposes, we are concerned about the significant differences in content and specificity between the two sets of standards, especially in those areas identified as important to the delivery of quality drug abuse treatment services. Therefore, we believe that the funding criteria should be clarified and upgraded.

NIDA's current efforts

Several actions undertaken by NIDA during the period that we have been reviewing NIDA's programs have impacted on the treatment standards issue.

The first of these actions is the revision of the contractual requirements contained in NIDA's statewide service contracts. The revised contractual language includes more stringent and/or explicit requirements for program staff training, community linkages, program evaluation and client records. These changes should, in our opinion, assist in upgrading the treatment services provided to drug abusers.

Secondly, in a February 1979 letter to program directors, NIDA strongly encouraged providers to seek Joint Commission accreditation. Although NIDA has, in the past, cooperated with the Joint Commission in developing standards and encouraged programs to seek accreditation, this latest action provides stronger endorsement of the accreditation process. Additionally, NIDA has made it clear to program administrators that the cost of the accreditation process is a reimbursable cost under NIDA grants and contracts. Finally, NIDA has agreed to accept Joint Commission accreditation in lieu of the Federal funding criteria in determining eligibility for continued Federal funding. Currently, there are 23 clinics in 17 NIDA-funded drug abuse treatment programs which have received Joint Commission accreditation.

A third activity undertaken by NIDA is encouraging State development of licensure procedures for drug abuse treatment programs. As we have mentioned, NIDA efforts in this area have been ongoing for several years. NIDA has provided technical assistance and consultation to interested States and has reviewed those State standards submitted to it for conformity with the funding criteria. To date, 26 States have submitted licensure standards to NIDA for review. However, only five of these have been approved by NIDA and accepted in lieu of the funding criteria. In spite of NIDA's efforts to encourage States to develop their own standards, little progress has been realized in this area. Only one State has had its standards approved since 1976.

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Mr. Chairman, this concludes my statement. We shall be happy to answer any questions that you or other members of the Subcommittee might have.

Senator RIEGLE. Next is Mr. Lee Dogoloff from the White House. Identify yourself for the record and proceed.

STATEMENT OF LEE I. DOGOLOFF, ASSOCIATE DIRECTOR, DOMESTIC POLICY STAFF, EXECUTIVE OFFICE OF THE PRESIDENT

Mr. DOGOLOFF. My name is Lee Dogoloff. I am the Associate Director of Drug Abuse Policy, Domestic Policy Staff.

Mr. Chairman, it is a pleasure to be here today to discuss the Executive Office drug oversight functions and to support the reauthorization of the National Institute on Drug Abuse.

I have prepared a detailed statement which, with your permission, I will summarize for you.

Senator RIEGLE. Fine.

Mr. DOGOLOFF. The 95th Congress extended the authorization of NIDA for only 1 year, for the expressed purpose of having the opportunity to judge the Office of Drug Abuse functions under Reorganization Plan No. 1 of 1977. This plan abolished the Office of Drug Abuse Policy and placed the operations within the Domestic Policy Staff. I am pleased to tell you today this new arrangement has worked out exceedingly well. The program and our staff have received the strong support of both the Congress and the administration, and continue to have the cooperation of the many Federal agencies and departments involved in drug abuse. The President has a continuing interest in and actively supports our program to reduce drug abuse.

In his recent state of the Union message to the Congress, the President wrote:

> In continuing our efforts to combat drug abuse, my Administration will rely on those programs and initiatives which have proven to be successful in the past year and which serve as building blocks for future programs.
>
> Today in the United States there are 110,000 fewer addicts than there were in 1975. One thousand fewer Americans died of heroin overdoses in the 12-month period ending June 30, 1977, than in the previous 12 months. Seizures of illegal drugs are at their highest level ever. Improved coordination and cooperation among Federal agencies have resulted in a more effective drug program without major budget increases. Much remains to be done, and the situation remains serious. In 1979 we will look more to the behavior of the individual who turns to drugs. We will stress financial investigation and a means of prosecuting those individuals responsible for the drug traffic, and will rely heavily on enlisting foreign cooperation in the overall drug program. These efforts should further our success in controlling drug abuse both in the United States and abroad.

The Drug Policy Staff within the Domestic Policy Staff has continued its function of providing overall policy direction, coordination and oversight of all aspects of the drug program. Meetings of the principal program directors of the drug programs continue to be held on a biweekly basis under the auspices of the Domestic Policy Staff. This group consists of the Assistant Secretary of State for International Narcotics Matters, the Administrator of the Drug Enforcement Administration, the Commissioner of Customs, the Commandant of the Coast Guard, the Director of NIDA, and the Special Assistant to the Secretary of HEW.

The projects undertaken by the Drug Policy Staff within the past year include, first, the Southeast Initiative, which is a major interdepartmental effort to halt the enormous quantities of marijuana

and cocaine entering the country through the Southeastern United States.

Secondly, the Federal Response to the PCP Problem, a comprehensive interdepartmental effort to focus the attention on the significant health hazards of PCP use and to take the necessary enforcement action to reduce the availability of PCP.

Thirdly, following up the President's message on drug abuse to the Congress in August of 1977, to insure that appropriate agencies and departments are complying with the President's directives. However, I do not want to leave the impression that the drug abuse problem is solved in this country, or that there is any reason to feel overly comfortable with our progress to date.

Although we have achieved considerable success with the heroin problem, we are concerned about increases in the consumption of marijuana and cocaine. One of our major concerns is the increased drug abuse among our youth. The latest survey results show that one in nine high school seniors smokes marijuana daily, and that this figure is probably quite a bit higher in urban areas.

We are concerned about the negative impact of this drug abuse on young people, because it occurs at a time when youngsters are less able to make good judgments about such behavior and are most vulnerable to physiological and psychological impairment as a result of drug abuse.

In the coming year we hope to undertake a number of initiatives to deal with this and other issues that confront us. The three most important areas that we will concentrate on are, first, an adolescent drug abuse campaign to provide accurate information about adolescent drug abuse to parents, teachers, and other key youth leaders so that they will be prepared to firmly discourage drug abuse by adolescents with whom they come in contact.

Secondly, increased financial investigation as a means of prosecuting individuals for drug trafficking, and thirdly, a plan to enlist foreign cooperation in the overall drug program, placing a particular emphasis on using developmental funds in narcotic areas, enhancing U.N. capabilities and seeking judicial assistance treaties.

In my more detailed statement, we indicate that we intend to pursue a very wide spectrum of activity in 1979. The administration and the Congress have proven that, working together, we can succeed in reducing the serious effects of drug abuse in our country.

Mr. Chairman, I look forward to working with you in achieving this objective, and will be happy to answer any questions you might have.

Senator RIEGLE. There are several things that I want to get into.

First of all, give me a little sketch of your own background, your professional background, as it relates to drug abuse.

Mr. DOGOLOFF. I would be happy to. I am a psychiatric social worker by training, and have worked as a therapist offering marital counseling and counseling to the parents of adolescents. I have worked in prison rehabilitation programs. My work in narcotics dates back to 1969 when I was employed by the Department of Corrections in the District of Columbia and was responsible for setting up community-based treatment services for offenders. That

program included what was probably the first halfway house offering: Drug treatment for offenders in the country. I went on to be the Deputy Director for the Narcotics Treatment Administration in Washington, D.C., the city agency which in 2 years grew from treating about 100 patients to 4,000 patients addicted to heroin.

I then was employed by the Special Action Office for Drug Abuse Prevention, where I served as Director of the Division of Community Assistance and was responsible for instituting and implementing the single State agency program in conjunction with what later became the National Institute on Drug Abuse.

At the National Institute on Drug Abuse, where I was employed for 2 years as the Director of Community Assistance, I had responsibility for all the federally funded treatment programs in the country, including all grants and contracts, and the formula grants program to the States.

After that position I worked at the Office of Management and Budget as the Deputy for Federal Drug Management, then was appointed by the President to be the Deputy Director of the Office of Drug Abuse Policy. Today I am the Associate Director for Drug Abuse Policy, Domestic Policy Staff.

Senator RIEGLE. Were you here in the room when we had the young 17-year-old fellow here, who started out sniffing glue and other substances when he was 13? Did you happen to hear that testimony?

Mr. DOGOLOFF. No, I am sorry; I did not.

Senator RIEGLE. My sense for the problem is that it is a stratified problem. You have hard drug users, and that pattern of activity, and it works its way down through other kinds of substance, and to different age groups, and the profile of the situation changes quite dramatically. We have tended to put a lot of necessary—emphasis on heroin, we have made progress, as you have stated. It seems to me there is a tremendous part of the drug abuse problem that is stretching down to teenagers, and we even had testimony today of a young fellow who was actually introducing a younger brother of his, who was 8, to the use of drugs.

So the problem does not lend itself to a single-focus treatment. It obviously has to be a very broadgaged sort of program strategy to get to these various kinds of problems.

Now, I am concerned and I would like to ask your professional opinion on this question, as somebody who has devoted a large part of your life to working in this area.

We have a budget request before us now where the administration is asking for $99 million in the upcoming fiscal year for drug abuse programs, alcoholism programs, but there is a new added program, and that is the mental health activities. As you know, that is a change from last year. Last year we had just the alcoholism and drug abuse programs funded at roughly the same dollar figure, slightly less—$96.8 million.

Now, you have been around this game a long time, and others of us have, and I think it is fair to say what that means in effect. What that is likely to mean is that by putting the three needs under the same umbrella—competing for the same pot of money—if we go down that road there is going to be less money available for drug abuse and for alcoholism programs, or we are not going to

be spending very much on mental health programs. My hunch is that with that as the very active area of interest for Mrs. Carter, that it is not likely to assume that the mental health thing is just being put in there for show purposes, but in fact it is going to get substantial attention.

So I see us facing a situation where the administration is actually proposing to spend, in practical effect, less money on drug abuse. How do you feel about that, as somebody who has worked in this area—and I would like a direct professional observation.

Mr. DOGOLOFF. What you are talking about, I believe, is the formula grant allocation, and the change to a comprehensive allocation on a statewide basis for all three programs. That is different from the research programs, which are at the same higher levels, and the services programs which are the direct services to provide treatment in community-based treatment, and those are a little bit increased for this year.

However, I understand your concern about combining those three formula grants, $40 million in the drug area, $55 million in alcohol, and what was, I think, $13 million in mental health, and at the same time reducing that by about 10 percent.

During the budget process, at one point there was a notion to completely eliminate the formula grant program. The compromise reached was not to eliminate the program but, rather, to combine in order to provide additional flexibility at the State level in allocating formula grant money between alcohol, drugs and mental health.

Senator RIEGLE. Let me just stop you there, because I understand that bureaucratic language—the great administrative flexibility. When you are trying to stretch the same amount of money across three functions that you previously spent for two, you could call it administrative flexibility, but you would have to be Houdini to figure out how to stretch that money for three needs with essentially the same dollar level.

You are someone who has lived and worked in the drug abuse area, and you know what this problem is like, and you know what it costs in terms of human life and damage there, and the patterns of crime and such.

Are you satisfied that that is enough money, even under the combined approach, to deal with this problem?

Mr. DOGOLOFF. Well, there are two issues. One is what is enough money. But aside from that——

Senator RIEGLE. Let us talk about that one first What is the amount of money that we ought to be thinking about? Let us start there. This is the authorizing committee, and we ought to take a look at what the size of the national need is, and address that, and then we will move on down the line to what we think we can afford to appropriate.

We will go to the Budget Committee, where I serve, and weigh this against other priorities. The thing that you can help us do, especially coming from the Office of the President, is to identify as accurately as we can the size of the need. So let us pin that down.

Mr. DOGOLOFF. I think, given the program that NIDA has, that the current budget as presented by the President is sufficient to meet those needs.

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Senator RIEGLE. Well, let me stop you there, because you have already defined again, by saying NIDA's current program. If that is our starting point, then it seems to me that you can make one set of observations from that. That is not the starting point I would like to begin from. I would like to begin from this substantial number of years of professional experience that you have of what the need is in the country, not just in terms of the hard drug user, but the drug abuse problem taken as a whole. And I would like an understanding from you as to what we ought to be thinking about spending, in terms of meeting that problem.

Mr. DOGOLOFF. I think there are underserved populations which were never, in effect, thought of in terms of the NIDA program, and by that I——

Senator RIEGLE. Should we change that?

Mr. DOGOLOFF. I do not think so. I think that we have, for example, the Community Mental Health Act that is coming up. I think that there is a whole group of people—women and others—who would not be "traditional clients" as I think of them for the NIDA system, which was in fact primarily created to meet the needs of a heroin population. When we talk about the multiple-drug-use population, we are talking about women, and some other special populations, that might not find the NIDA system particularly palatable or attractive to them

Senator RIEGLE. Should we not be changing that system? I am not sure that to open another door down the hall and hang mental health on it is necessarily the way to deal with the drug problem, is that what you are suggesting?

Mr. DOGOLOFF. Well, the mental health system, the centers as they exist, really do have the capability, at least in theory, to meet those needs.

Senator RIEGLE. But are you recommending that?

Mr. DOGOLOFF. It is my recommendation that the Community Mental Health Centers become more sensitive to the drug abuse population that they normally serve anyway, and to open their doors to them.

Senator RIEGLE. But I think that is still a different point.

I guess the question is if we are going to deal with somebody who has a basic problem with drug abuse, do we send them to the mental health window, or do we send them to the drug abuse window? That is the issue that I would like to try to establish. You did not do your work in mental health; you did it in drug abuse.

Now, I am just wondering, it seems to me there is a contradiction here.

Mr. DOGOLOFF. I think that the confusion and contradiction really comes in terms of the populations that are served. In my experience with mental health centers, there are mental health centers that really can provide treatment and do provide treatment for drug users, and in many instances that drug abuse is symptomatic of other things that are going on in their lives that can well be handled within the context of the mental health system.

The precise treatment, aside from some small amount of strictly physical medical treatment, the precise kinds of counseling that goes on, the psychotherapy that might go on, is not different from what would go on in the mental health system. What I am suggest-

ing is that we not think about setting up, in effect, a third system, in addition to the systems for traditional drug abusers and traditional mental health patients, but rather that we augment the existing systems to be more sensitive to those needs in the unserved populations so that they can serve better.

That would be, in my opinion, an unwise use of resources, when we can, instead, have some added staff capability, some added sensitivity, to the population within the mental health system.

We did an intensive policy review of the major areas in the drug program in our first year of operation, and the paper we published on this subject drew attention to this underserved population, and specifically recommended that ways be looked at to meet their needs.

I will be glad to share that report with you.

Senator RIEGLE. We would like to have that.

Were you part of the decision process to decide what budgeting amounts to seek for these functions?

Mr. DOGOLOFF. Not specifically. Our office reviewed each of the drug budgets, including the U.S. Customs Service, Drug Enforcement Administration, and so forth, to ascertain whether or not the levels in the budget were appropriate to continue major program functions.

At one point in the budget process, with the National Institute on Drug Abuse, we were very concerned that the level proposed did not in fact meet those requirements, and we brought that to the attention of the people within the budget process. Substantial changes were made, with major increases, as the final budget was submitted to the Congress.

Senator RIEGLE. Let me ask your professional judgment here, and it can only be an estimate, but right now that is the best that we can do, that you are in a strong position to make a guess as we can all call on.

If you were going to take $99 million for State grants, and divvy it up for three functions—we are going to add the third function, mental health—what is your estimate as to the portion of that $99 million that is likely to end up being spent on drug abuse?

Mr. DOGOLOFF. I honestly do not know, because in large part it will depend on the legislation that is proposed by the administration as to how to implement that consolidated grant process. I have talked with the people in HEW who are drafting that legislation, and expressed my concern that there be some fail-safe mechanism, or some thought given to protecting the existing single State agency functions for both drugs and alcohol, particularly drug abuse, so that that money is reserved, and the drug functions are not reduced.

Senator RIEGLE. When are we going to get that? We ought to have it now, quite frankly. In other words, it seems to me that two things essentially have to go forward at the same time. I do not know how you make a recommendation to combine, without at the same time making the recommendation on how to protect the alcoholism and drug abuse programs.

So when are we going to get that?

Mr. DOGOLOFF. I do not know the answer to that.

Senator RIEGLE. Who has the responsibility for that?

Mr. DOGOLOFF. Doctor Klerman——

Senator RIEGLE. Did he do that in his own right?

Mr. DOGOLOFF. No, it would have to come from HEW. HEW is drafting the legislation; it would then come over to our office and to OMB for consideration, and then be submitted to the Congress.

Senator RIEGLE. Can you veto it?

Mr. DOGOLOFF. No, we cannot veto it, but we could certainly impact it, and we will have approval authority on it.

Senator RIEGLE. Where is it now in this pipeline?

Mr. DOGOLOFF. It is somewhere in HEW.

Senator RIEGLE. It is somewhere in HEW?

Mr. DOGOLOFF. Somewhere in HEW, and maybe Dr. Klerman can tell us precisely.

Senator RIEGLE. Are you in a position to say, "Look, I am sort of the overseer in this area for the President, I want this thing on my desk by such and such a date?" Do you have that kind of authority?

Mr. DOGOLOFF. No, I do not.

Senator RIEGLE. Does anybody in the White House have that kind of authority?

Mr. DOGOLOFF. Normally we do not work in that way. When the Formula Grant decision was made, I contacted Dr. Klerman, and discussed my desire to be involved, and once it was drafted HEW promised to get a draft to me.

Senator RIEGLE. But you have no idea whether that will come in tomorrow, or 2 months, or 6 months?

Mr. DOGOLOFF. That is right, because it competes with other legislative drafting that is going on within HEW.

Senator RIEGLE. Let me tell you the fine wording here. We have to go ahead and report legislation. We have budget deadlines imposed by the Budget Act, and that is why we are having these hearings early in the session, because we are under those kinds of very tight operating deadlines. Those operating deadlines pass from here to you, because if we are going to pass on this judgment it has to be done in this timeframe.

Obviously you are one player in this thing, and if you are going to have to participate, it seems to me it is in your interest, as well as in our interest, to have you figure out, or persuade somebody to get this thing to you by a point in time so that it can move on from there and get here and can be relevant to our work.

I would like to consider it. I would rather have the benefit of that thinking than to go ahead and make these judgments as a committee, and subcommittee without them.

Mr. DOGOLOFF. I feel the exact same urgency, and have raised that issue with the Department. I know that they are moving as quickly as they can, to draft both that legislation and the reauthorizing legislation for NIDA. As recently as late last night, I got a commitment from the Office of the Secretary in HEW that reauthorizing legislation will be sent to the Congress sometime between the 15th and 22d of March. I do understand what you are saying.

Senator RIEGLE. That gets late, and we all know that. So I would hope that maybe that time schedule could be improved upon.

We spent $40 million on the drug part of these grants to the State last year. Is that what you think is going to be required in terms of providing some protections within the new budget figure?

Mr. DOGOLOFF. Yes, something within that range. That supports——

Senator RIEGLE. Well, plus or minus what, $3 million, $5 million?

Mr. DOGOLOFF. I think plus or minus 10 percent.

Senator RIEGLE. So it may well be something—maybe no less than $36 million, and probably no higher than $44 million—I guess that is what you are saying. Something in that range. That is what you anticipate, that is what your judgment would tell you you would like to see?

Mr. DOGOLOFF. Yes.

Senator RIEGLE. We have had a real problem, as you know, getting a permanent Director established over there. We also have the same problem with the alcohol area.

Now, do you participate in that decision?

Mr. DOGOLOFF. No, I do not.

Senator RIEGLE. So that is independent?

Mr. DOGOLOFF. I have had informal discussions with the Office of the Secretary, but I have not been included in any formal process. It is a decision of the Secretary of HEW. It is important to recognize that Mr. Besteman has been at the National Institute on Drug Abuse for a long time, and has done an excellent job as Acting Director, so there has not been that kind of interruption of leadership.

I agree with you on the importance of getting someone in there, permanently.

Senator RIEGLE. I think it is crucial. Dr. Klerman was here 8 days ago, and told us that that decision would be made within a week to 10 days. So we are coming down to the end of that timeframe, and we would be anxious to hear from him today, as to whether we are on track. He also said that we would have an NIAAA Director within 3 to 4 weeks, so we are now also 8 days into that time period.

Do you have the leverage to ask that this process move faster or not?

Mr. DOGOLOFF. Yes, I do have the leverage to ask that it be moved faster, and I have expressed that concern.

Senator RIEGLE. Does the President know about this? I guess he has a lot of other problems to deal with, but do you suppose he is aware of the fact that there are months and months that go by with vacancies there?

Mr. DOGOLOFF. I am not certain that he is aware of it.

Senator RIEGLE. I am not sure that he is, either, but I have a hunch, given his penchant for efficiency, and making decisions, and so forth, that he would probably tell somebody to settle this issue, especially it is known that there are candidates that have been around, they have been talked to, they have been evaluated.

Mr. DOGOLOFF. I will share your concern.

Senator RIEGLE. I would appreciate that, and it is a concern that is broader than just mine. All the folks that relate to the constituency groups that are involved here, are waiting as well. The GAO people who were up here a while ago also expressed that concern.

Let me make one other point to you, and that is this. The thing I am concerned about is that we still have not established, to my satisfaction, what the size of the need is in the area of drug abuse requirements in the country. I think it involves people who are addicted to prescription drugs. I think there is this hidden problem of women who are drug addicted in terms of either combination, either just outright on prescription drugs, or some combination of prescription drugs plus alcohol. You have got these teenagers that are being hooked on these readily available substances that we heard about this morning. I think you have a fairly big problem on your hands, and I am not sure that we have the problem defined very well.

I think it would be helpful if the office that you head, at the present time, and the area that you have responsibility in, could take a look at that. In other words, somebody has to take a broad view, and I think the country is prepared to make whatever decisions in terms of actions and resource decisions that are required if they have the facts.

Get the facts out, so that we are in a position to make a competent judgment.

I think what happens so often is that we do not get the facts, and therefore we do not make very informed judgments. We make a judgment based on reflexes, or which constituency is stronger than which, or which topic is more in the news, and so forth.

I think we have to develop some continuity in terms of these basic human difficulty areas of this kind, where you have predictions occurring, disabling characteristics, antisocial costs associated with it, and we have to be able to start from a clear definition, and then proceed logically to deal with that problem, measure our successes, see what works, we have programs that work, try new things, as long as it is cost-effective.

When I look at the dollars involved, I mean the tremendous ratio in terms of what we can save—the GAO is using a 15-to-1 figure in terms of dollars saved to dollars spent. This is the type of thing—you have the elevated platform to work from, and these are the kinds of things I think have to be done. I think we have to find a way to get that kind of information together, and out to the people, to let the country form some judgment, decide what it wants to do in these areas. We are not going to do it with fragments, and bits and pieces, of information that never make their way in any kind of coherent whole for people to consider.

I am going to have some other questions for you for the record. Let me submit those to you, because I want to go ahead and have Dr. Klerman come up.

I appreciate what you have said today, and you have offered to make some other information available to us, and we look forward to receiving that.

[The prepared statement and the report referred to by Mr. Dogoloff follow.]

TESTIMONY

OF

LEE I. DOGOLOFF

ASSOCIATE DIRECTOR

DOMESTIC POLICY STAFF

EXECUTIVE OFFICE OF THE PRESIDENT

before the

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

UNITED STATES SENATE

March 2, 1979

Mr. Chairman and Members of the Committee, it is a pleasure to be here today to discuss the Executive Office drug oversight functions, the role of the National Institute on Drug Abuse within the overall three part Federal drug program; and to share with you some of the major initiatives we hope to undertake during the coming year to ease the drug abuse problem in our country.

Since April 1, 1978, when the Office of Drug Abuse Policy was abolished under Reorganization Plan #1, my staff and I have been working within the structure of the White House Domestic Policy Staff headed by Mr. Stuart Eizenstat. With strong Congressional support we have pursued a significant number of activities which I believe have had a positive impact on the overall Federal drug abuse programs and have contributed to reducing the drug abuse problem in our country.

MEETING OF THE PRINCIPALS

Every two weeks, I have held meetings with the heads of the agencies that are responsible for the operational aspects of our drug abuse prevention and control programs. This effective on-going policy coordination mechanism, which has come to be known as the "Meeting of the Principals," involves the Assistant Secretary of State for International Narcotics Affairs, the Director of the National Institute on Drug Abuse,

the Administrator of the Drug Enforcement Administration, the Commissioner of the U.S. Customs Service, the Commandant of the U.S. Coast Guard, and myself, the Associate Director for Drug Policy on the White House Domestic Policy Staff. These meetings provide an opportunity to discuss policy, to exchange information and advice and to share operational problems and matters of mutual interest.

The problems of drug abuse in America and around the world are both fluid and complex. A broad spectrum of issues and priorities including domestic and international health, social, medical, criminal justice and economic considerations, must be weighed. In addition, drug policies must be considered in perspective with other national policies and goals. Active Executive Office oversight has proven the most efficient way to maintain this perspective, and to assure consistent policy formulation and interdepartmental coordination.

STRATEGY COUNCIL

In addition to the Domestic Policy staff coordination, the Strategy Council on Drug Abuse provides another coordinating forum for the Executive Branch. The Council, supported by my staff, consists of seven Cabinet Officers and six private members. The first annual meeting of the entire Strategy Council was held on November 7, 1977, and the second on

November 16, 1978. An additional meeting was held with the public members of the Strategy Council and representatives from the Federal agencies and departments to increase the participation of the public members in the formulation of Federal policy. Briefings were given at this meeting by the Department of State, the Department of Health, Education and Welfare and the Drug Enforcement Administration. In addition to these formal Strategy Council Meetings, working groups of the Strategy Council have been formed on an ad hoc basis. Examples of such working groups are:

(1) the International Affairs Working Group, which addresses such topics as economic development and multi-national financing of narcotics-related assistance projects; legal issues and the licit supply of and demand for narcotic drugs; and

(2) the Financial Working Group which is addressing the issue of attacking major drug traffickers through in-depth investigations of their financial holdings and operations.

Several other working groups are planned. They will address a government-wide research plan in the field of drug abuse; will review substance abuse indicator systems, and will address rehabilitation issues.

FEDERAL STRATEGY 1979

In accordance with the Drug Abuse Office and Treatment Act of 1972, the Strategy Council on Drug Abuse has also, with the support of the Domestic Policy Staff, developed a comprehensive strategy for Federal activities relating to drug abuse prevention and control. The 1979 Strategy has been completed and will be distributed after it is presented to the President.

MAJOR POLICY REVIEWS

During its year of operation, the White House Office of Drug Abuse Policy completed six major drug abuse prevention and control policy reviews. After March 30, 1978, the Domestic Policy Staff assumed the primary role in following up on the agencies' implementation of numerous recommendations presented in the reports. Very extensive follow-up reports on "International Narcotics Control Policy Review," "The Role of Intelligence in Narcotics Control Policy," and "Drug Use Patterns, Consequences and the Federal Response" have been submitted by the agencies and departments.

SOUTHEAST INITIATIVE

In an effort to halt the enormous quantities of marihuana and cocaine entering the country through the Southeastern United States, the Executive Office initiated, during the

summer of 1978, a major interdepartmental effort against drug trafficking in that area.

In July 1978, representatives from the Drug Enforcement Administration, the U.S. Customs Service, the U.S. Coast Guard, and the State Department met to review the situation and develop a comprehensive response. Since that time, representatives of the agencies have met periodically to review progress and discuss the activities.

Since the beginning of the Southeast Initiative, over 987 tons (1,974,680 pounds) of marihuana have been seized by the U.S. Coast Guard. This represents a three-fold increase over 1977 seizures during the same period (325 tons or 650,000 pounds). In addition the total number of smuggling vessels seized by the Coast Guard during 1978 (140) exceeded the total number seized during the previous five years (1973-1977).

The U.S. Customs Service has seized over 780 pounds of cocaine in Florida, Georgia and the Carolinas during this July through December period. These 780 pounds of cocaine represent a 45% increase over the amount of cocaine seized during the first six months of 1978.

In addition to significant gains in the effectiveness of actual law enforcement efforts, the initiative is directed at long range improvement, as well. The Drug Enforcement

Administration has increased it presence in the Southeastern United States, has conducted training programs for both State and Federal officers and has increased the level of drug investigation activities. Currently, there are interagency investigative task forces working on drug traffickers and the financial aspects of drug trafficking, particularly in the Miami area.

In terms of dollars, (based on the average price of $313 per pound for marihuana) marihuana traffickers and distributors have been denied an estimated $619 million, as a direct result of the Southeast initiative. Cocaine traffickers and distributors have been denied a minimum of $19 million based on the current cocaine price of $25,000 at the U.S. border. A copy of the January 1979 status report of the Southeast Initiative is attached, for the convenience of the Committee. The success of the Southeast initiative is a direct result of excellent cooperation and hard work by the Federal and State law enforcement agencies involved.

COLOMBIAN INITIATIVE

Complementing our intensified interdiction effort in the Southeastern United States, the U.S. Government has signed an agreement with the Government of Colombia aimed at drug traffic originating in Colombia. This agreement commits

Colombia to a military narcotic control interdiction effort, and calls for military surveillance in the Guajira Peninsula (the principal marihuana staging area of Colombia), destruction of clandestine air strips used by smugglers, strict control of all air and sea ports, and interdiction of illicit vessels and air traffic. The President of Colombia has issued a decree establishing air and sea restrictions which will enable the military to implement its narcotic control plan, and has committed Navy, Air Force, Customs and Army personnel and equipment to the effort. In addition, the Colombian Attorney General will provide the United States Government with statistics and intelligence resulting from enforcement of the restrictions.

To support this effort, the United States has agreed to supply limited amounts of equipment, intelligence and personnel resources to the Colombian Government.

THE FEDERAL RESPONSE TO THE PCP PROBLEM

A second major interdepartmental initiative coordinated by the Executive Office has addressed the increasing abuse of PCP (Phencyclidine) in the United States.

The PCP initiative began during the summer of 1978 when representatives from the National Institute on Drug Abuse

(NIDA), the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), and the National Institute on Mental Health (NIMH) met under the auspices of the White House Office of Drug Abuse Policy to review the situation and develop a comprehensive and coordinated response to the problem. The following represents only a select number of activities undertaken by the agencies and departments to combat the problem. The complete PCP update is attached for the convenience of the Committee.

Health Initiatives

(1) In August, 1978, NIDA published a comprehensive report entitled "Phencyclidine (PCP) Abuse: An Appraisal" (Research Monograph 21) which provides detailed information on the extent of PCP abuse, acute and chronic effects, diagnosis and treatment of adverse reactions.

(2) NIDA has also published "PCP: An Overview" (NIDA Capsule) and an assessment entitled "Phencyclidine Use Among Youths in Drug Abuse Treatment" for the general public.

(3) All NIDA publications about drugs in general now include a special section on PCP. Similar information is included in material developed for the 1979 National Drug Abuse Prevention Campaign aimed at preventing and reducing the misuse and abuse of all drugs, particularly among women and youth.

(4) As a result of the NIDA sponsored conference on PCP in February 1978, the agency's Division of Research has funded the following PCP research projects:

(a) an epidemiological study involving PCP, as well as four other drugs;

(b) a study on the effects of certain drugs on the brain function using electrode implants;

(c) an investigation into the pharmacological and behavioral effects of PCP;

(d) a study to develop methodologies and clinical approaches to determine the quantity of PCP and other drugs in certain body fluids; and

(e) an evaluation of the effects of specific antagonists on the acute effects of PCP.

(5) Treatment systems in five cities (Seattle, Chicago, Philadelphia, Miami and Houston) have been surveyed to determine the extent to which PCP users have

sought drug abuse treatment. The results, once compiled, will provide information on the outcome of current PCP treatment in these communities and will also be of assistance in designing more effective programs to deal with the problem. Beginning in 1979, PCP will be specifically coded on Client-Oriented Data Acquisition Program (CODAP) forms to allow the ongoing and continuous monitoring of clients admitted to treatment thro ·hout the nation for PCP use.

Supply Reduction Initiatives

Law Enforcement

(1) DEA's Special Action Office/PCP was established on June 1, 1978 within the agency's Office of Enforcement. During the four-month initial impact phase (Phase I) which ended on September 30, 1978, all projected program goals were met or surpassed. One hundred and forty-nine (149) PCP-related arrests were made during this period, 23 PCP laboratories were seized and the equivalent of approximately 6,609,760 dosage units were removed (based on 50% purity per dosage units.)

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(2) From October 1, 1978 through December 31, 1978, seizures and arrests continued (5 laboratories immobilized, 48 defendants arrested, and 2,297,800 dosage units removed) while investigators and analysts began to evaluate the results of the program. There appears to be a direct correlation between increased laboratory seizure activities and a downward trend in PCP inquiry mentions, as reported by the Drug Abuse Warning Network (DAWN). Phoenix, for example, went from 12 mentions in August to no mentions in September. During this period, a PCP laboratory was seized in that area. DAWN mentions have risen to five for October, still below the August high. Los Angeles has dropped to 27 mentions from a summer high of 45. There has been a corresponding increase in enforcement activity in the Los Angeles area. The Los Angeles area, although experiencing a decline in DAWN mentions, is still by far the area reporting the highest incidence of abuse. Buffalo and San Diego experienced a sharp rise in PCP mentions with marked drop off following the seizure of laboratories and arrests of violators. While other

major cities such as Miami, Detroit, Chicago and New York continue at comparatively high levels for DAWN mentions, it appears that the surge in PCP abuse is stabilizing.

(3) DEA, through its Precursors Liaison Program, is working closely with the chemical industry to identify the amounts of piperidine (a necessary element in the manufacture of PCP) that are needed for legitimate purposes and their destination. Relying heavily on voluntary cooperation by the chemical industry, those involved in the program will monitor unusual or suspicious orders for precursors used to manufacture controlled substances.

Regulatory

(1) During the past year, NIDA, DEA and FDA have been coordinating an effort to identify, prepare and test PCP analogs for scheduling. Under the Scheduling provisions of the Controlled Substances Act, some evidence of abuse potential must be available in order to schedule a substance, and high abuse liability must be demonstrated to move it into Schedule I. In an attempt to anticipate traffickers' illicit activities

the Federal Government has already synthesized twelve PCP analogs for which pharmacological testing is currently underway in several laboratories. The NIDA Addiction Research Center (ARC) in Lexington, Kentucky, is currently assessing the abuse potential of PCP analogs in dogs and has initiated behavioral studies in rats and monkeys. Researchers at the University of California at Davis are also studying these compounds. Once it has been demonstrated that several of the closely-related chemicals all possess PCP-like activity, a sufficiently strong case may be made to generically schedule all chemically related substances. Effective October 26, 1978, the ethylamine and pyrroladine analogs were placed in Schedule I.

(2) During the past year, DEA has provided information to six States (New York, Oklahoma, Pennsylvania, South Dakota, Virginia and West Virginia) which are considering rescheduling PCP, its precursors and/or analogs under their State laws. Much of the information provided to the States has been extracted from NIDA data sources and research studies. Additionally, rulemaking notices were published in the Federal

Register in at attempt to provide information which would enable the States to take the necessary regulatory action.

RESPONSE TO PRESIDENT'S MESSAGE ON DRUG ABUSE

In response to directives contained in President Carter's Message on Drug Abuse, presented to Congress on August 2, 1977, the following actions have been taken by appropriate agencies or departments. The Domestic Policy Staff continues to monitor these responses and has prepared two follow-up reports on their implementation.

International Efforts

- The Department of State is continuing to raise the international narcotics control issue in meetings with foreign officials from narcotics producing or trafficking countries and has encouraged the U.S. Ambassadors in these countries to do the same at the highest levels of the host governments.
- To enhance and strengthen the international narcotics control program, the Department of State has consolidated into what was formerly the Office of the Senior Adviser for Narcotics Matters the policy and program management responsibilities previously shared by the Senior Adviser and AID. The Executive Branch and the Congress have further recognized the importance of this program by elevating the Office of the Senior Adviser to the Assistant Secretary level.

- Department of State guidelines of December 23, 1977 specifically direct AID Missions to concentrate, to the extent possible, on economic development projects in narcotics producing areas of the countries. AID has ongoing development activities in the following primary source and transshipment countries: Afghanistan, Bolivia, Peru, Thailand and Pakistan.
- In Pakistan, the overall AID development effort includes health and population planning, education, food and nutrition, and is aimed at the rural parts of the country where the illicit drug producers reside.
- In the coca producing regions of Peru, two AID projects are now underway involving:
    (1) the establishment of research training centers on soy and corn production to develop farming techniques applicable to small farmers, and
    (2) the financing of small agri-business loans.
- In Bolivia, AID has provided a loan to assist in the establishment of a coffee production cooperative in a primary coca producing region. In FY 79, AID is planning a loan of $5 million for the development of the Yugas and Chapari areas which produce most of Bolivia' coca leaf crop.

- In Thailand, the Highland Integrated Rural Development (Mae Chaem Watershed) project will be implemented in FY 79 and will introduce a stabilized agricultural system to disadvantaged hill tribes who have been engaged in illicit opium cultivation.
- Over time, most, if not all, of these projects should have some reducing impact on illicit drug producing areas by providing farmers with economic alternatives to cultivating drug producing crops.
- The Central Intelligence Agency has augmented the coverage of the golden triangle area of Southeast Asia to include information on heroin refineries, trafficking routes and amounts of drugs being shipped to other parts of the world. The Agency is formulating estimates on the amount of opium being cultivated in Pakistan and Afghanistan and has made a similar effort with regard to the coca-producing countries of Latin America.
- In conjunction with these estimates, CIA is also developing the capacity and methodology for monitoring world opium poppy cultivation.
- The CIA has also increased efforts to collect and analyze narcotics-related information, particularly related to the economic impact of illicit trafficking in Central America and the Caribbean.

•The Central Intelligence Agency is continuing to produce finished analytical intelligence on the political and economic aspects of international drug trafficking and has maintained the same level of commitment and resources in the international narcotics intelligence program despite budgetary and personnel reductions.

•U.S. representatives to the multi-lateral development banks in conjunction with the Department of the Treasury are now seeking to incorporate specific provisions in loan agreements to ensure that proposed projects do not contribute to narcotics projection and will consider such provisions when voting and deciding upon the U.S. position. The U.S. Executive Director to the Asian Development Bank, in conjunction with the Department of the Treasury, was successful in the inclusion of an anti-opium clause in a loan agreement for an irrigation project in Afghanistan.

Domestic Efforts

•The National Institute on Drug Abuse is continuing to ensure that compulsive users of any type of drug receive high priority in NIDA funded treatment programs, with priority on those individuals who present the greatest clinical need for treatment. The Institute is currently trying to improve:

(1) training for health professionals in treating non-opiate drug abusers; and

(2) the capability of general health care facilities under HEW jurisdiction in identifying and treating problems of non-opiate drug abuse.

•The Department of Health, Education and Welfare has prepared a draft prevention work plan with an emphasis on mass communication of drug abuse information, prevention program evaluation, and research on the correlates and causes of drug abuse.

•The Department of Health, Education and Welfare has also completed the study on sedative/hypnotic drugs and found that:

(1) these drugs are unnecessary in many cases; often actually hinder sleep; and contribute to nearly 5,000 overdose deaths a year;

(2) Benzodiazepene, with some qualification, is at least as effective as other sedative/hypnotic drugs, has a greater margin of safety and presents less risk of drug interactions;

(3) the efficacy of short-acting barbiturates is questionable when administered on a chronic basis;

(4) the existing evidence, however, does not warrant the removal of barbiturates from the market;

(5) some non-barbiturate, non-benzodiazepene sedative/hypnotics have relatively little clinical utility and carry serious risks.

- Based on this study and the Institute of Medicine Study on the prescribing practices of physicians, a timetable and plans for future research will be developed by March. 1979.
- The Department of HEW is discouraging the unnecessary use of barbiturates and sedative/hypnotics in HEW facilities through surveys, internal reviews, dispensing restrictions, and physician education programs. Barbiturate purchase and non-barbiturate sedative/hypnotics (except flurazepam) purchases by the U.S. Public Health Service have significantly declined. An additional follow-up survey on the decreasing use of barbiturates and sedative/hypnotics is scheduled for January and should be completed by March 1979.
- The prescribing and use of barbiturates in military hospitals continues to decrease. The Department of Defense is currently in the process of evaluating what might be done through the CHAMPUS program to control the licit use of barbiturates.
- The Department of Defense will also, by April 1979, determine what additional actions must be taken in the area of barbiturate use, based on the current evaluation of last year's efforts and the Institute of Medical Study on Barbiturate Use.

•The Veterans Administration has experienced a 22% decrease in the amount of sedative/hypnotic drugs ordered thru VA pharmacies (approximately 70% of the total VA prescribing) from FY 1976 to FY 1978.

•The VA has undertaken a study of the prescribing practices in psychiatric treatment by physicians and hospitals to determine appropriate practices, identifyi problem cases and serve as the basis of trainin

ıe VA has sent a Professional Services Letter on
ɜdative/hypnotics to directors of all VA health care
ıcilities, directed each facility to provide training
ı prescribing practices and conduct workshops for
ıiefs of Staff and Chiefs of Veterans Administration
ɜdical, Surgical and Psychiatric Services of VA hospitals
ı improving prescribing practices of medical personnel
ı the VA health care systems.

ʻe Drug Enforcement Administration conducted 119
ıvestigations of barbiturate manufacturers resulting
. 49 adverse actions; 74 investigations of distributors
ɜsulting in 28 actions; and 72 investigations of
rtailers (pharmacies and practitioners) resulting in
5 actions. There was no evidence of diversion of
bɜrbiturates at either the manufacturing or wholesale
level; most of the violations involved recordkeeping

and security. The major diversion problem appears at the pharmacy and practitioner levels.

- The Department of Justice has worked with the States in establishing Diversion Investigation Units (DIU's) in 16 States and the District of Colombia to identify practitioners and other individuals (i.e. nurses, pharmacologists, etc.) who are involved in drug diversion. During the period July 1977 to July 1978, the DIU's were responsible for approximately 484 state and local arrests and seizures totalling an estimated 3/4 million dosage units of diverted drugs. Current plans include establishment of DIU's in three additional States each year for the next ten years, beginning with States which have the most serious diversion problems. In addition to the DIU's, Federal investigators have been able to obtain investigative leads involving diversion at the practitioner level based on an analysis of drug purchases as reported in ARCOS (the Automated Reprots and Consummated Order System).

- Though the complete study will not be available until December 1981, the Department of Transportation is working on the following interim projects to comply with the

President's directive:

--a study on the development of less intrusive methods to test for drug use, particularly marihuana use, to be completed by March, 1979. The preliminary results are not encouraging and indicate that breath tests for marihuana are unreliable and that saliva tests can detect the presence but not the amount of marihuana in the system.

--A laboratory study of the effects of marihuana on simulated driving tests to be completed by the summer of 1979.

--A review of the state of knowledge on drugs and driving to be completed by March, 1979.

- The Department of HEW will conduct extensive research ($1,000,000) on smoking behavior and tobacco dependence at the Addiction Research Center this year.
- The Department will also continue the joint NIDA and NIAAA Substance Abuse Program which reviews research grant applications concerned with both alcohol and drug abuse.

- The Department is preparing a timetable and plan by May, 1979 for project Big Sleep -- a project designed to assess existing knowledge, to determine what additional information is needed and to establish a physician-patient education program on sleep disorders and their treatment which would include the use and abuse of sedative/hypnotic drugs.
- The Department has completed a study on the impact of alcohol abuse on women and youth.

LEGISLATION

We have been fortunate in the past year to have worked with an actively involved and concerned Congress which passed a number of pieces of legislation which strengthen the Federal Government's capability to deal with the drug abuse problem. I would like to list several of these laws:

(1) On October 3, 1978, the President signed the Customs Procedural Reform and Simplification Act of 1978 (PL 95-410) which under Section III of Title I increases the dividing line between administrative and judicial forfeiture from $2,500 to $10,000. This legislation will

enable vehicles, vessels and aircraft used by drug violators to be processed for forfeiture under administrative regulations in a much more timely manner with attendant savings in storage costs and court proceedings.

(2) On November 10, 1978, the President signed PL 95-633 in which a specific title is devoted to PCP criminal penalties and piperidine reporting. Under the Act, the penalties for unlawfully manufacturing, distributing or dispensing PCP and the penalties for possessing PCP with the intent to unlawfully manufacture, distribute or dispense it have been increased from a maximum of five years imprisonment and/or a $15,000 fine to a maximum penalty of ten years imprisonment and/or $25,000 fine. It also increases the penalty for a PCP offense for any person who has previously been convicted of a felony offense under Federal drug laws from a maximum of ten years imprisonment and/or a $30,000 fine to a maximum of twenty years imprisonment and/or a $50,000 fine. Possession of piperidine used to unlawfully manufacture phencyclidine (PCP) carries a penalty of a maximum of five years imprisonment and/or a $15,000 fine. In addition to these criminal

penalties the Act also requires anyone who distributes, sells or imports piperidine (a chemical used in making PCP) to report such transactions to the Attorney General. The legislation further states that anyone who distributes, sells or imports piperidine in violation of this requirement is subject to a maximum civil penalty of $25,000.

(3) The enabling legislation for the Psychotropic Substances Treaty was enacted by the 95th Congress, and has been signed by the President. The Treaty will be submitted to the Senate for ratification in the 96th Congress.

(4) On October 4, 1978, the House passed the Magistrate Act of 1978 (S. 1613) amending a Senate passed bill to expand the role of magistrates in Federal civil and criminal court proceedings to relieve the caseload burden on judges. The bill has been a top priority of the Justice Department which has been supporting a series of bills to relieve Federal Court congestion. As passed by the House, the bill specifically calls for an expanded Magistrate Criminal jurisdiction to allow full and part-time magistrates to try, with the consent of the accused, misdemeanors either with or without a jury. The differences, however, between

this bill and the Senate Magistrate bill passed in July 1977 were not resolved in the 95th Congress. This legislation (S.237) is now pending in the Senate Judiciary Committee.

CONGRESSIONAL TESTIMONY

Our appreciation to the U.S. Congress does not limit itself to legislation alone. The Committees of the House and Senate have, on many occasions, provided the Administration with opportunities to convey and explain our policies and programs at public hearings. Since the reorganization of the Office of Drug Abuse Policy into the White House Domestic Policy Staff, I have testified before you and other members of Congress on the following occasions:

February 17, 1978	Subcommittee on Health and Environment (Psychotropic Convention)
April 18, 1978	House Select Committee on Narcotics (Prevention)
April 19, 1978	House Select Committee on Narcotics (Methadone Diversion)
April 19, 1978	Subcommittee on Health and Environment (NIDA authorizing legislation)
April 27, 1978	House Select Committee on Narcotics (Drug Abuse in the Military)
May 9, 1978	Senate Subcommittee on Drug Abuse and Alcoholism (Cocaine Trafficking - Colombia)

June 14, 1978	House Select Committee on Narcotics (Treatment and Rehabilitation)
June 21, 1978	Joint Senate Subcommittee on Drug Abuse and Alcoholism and the Subcommittee on Juvenile Delinquency (PCP)
July 21, 1978	House Select Committee on Narcotics (Southeast U.S.)
August 8, 1978	House Select Committee on Narcotics (PCP)
August 22, 1978	Subcommittee on Juvenile Delinquency (Southeast U.S.; Trafficking on the High Seas)

The results of all of our joint efforts during the past few years, Mr. Chairman, have been most encouraging. During the past two years, we have realized many successes in the Federal drug abuse prevention program: in 1977, 1,000 fewer people in the U.S. died from heroin overdose than in 1976; the heroin purity rate, which indicates availability, is at its lowest level, 4.2% down from 6.6% in 1976; and our cooperation with the Mexican Government has brought about a 20% decline in the amount of Mexican heroin available in the U.S.

In the last session of the 95th Congress, (on September 18) the House and Senate extended for one year the authorization of the Federal Drug Abuse Program. While a three-year re-authorization was initially expected, Congress allowed only

a one year extension at this time to give the Administration time to follow through on its commitment to maintain high level coordination of drug abuse activities following the elimination of the Office of Drug Abuse Policy. We have met this commitment and our accomplishments, some of which are listed above, attest to this.

Since your Committee is currently examining the effectiveness and implementation of the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and its amendments, I would like to comment at this time on the demand reduction aspects of the legislation and its role in our three-part federal drug abuse program. The National Institute on Drug Abuse within the Department of Health, Education and Welfare is the primary Federal agency we look to for drug abuse research, prevention and services. I would like to discuss just briefly some of NIDA's accomplishments in these three areas which would not have been possible were it not for the energetic, dedicated and professional staff of the Institute.

Research

During the past year the agency has funded a significant number of applied research grants and contracts and communicated the results of this research to the drug abuse field and the

public -- through a wide variety of publications. The following list is not all inclusive, but does represent the vast diverse areas which have been addressed during the past year.

(1) Drug Dependence in Pregnancy: Clinical Management of Mother and Child; Services Research Management Series.

(2) Self-Administration of Abuse Substances: Methods for Study: NIDA Research Monograph 20 - July 1978.

(3) Chemistry and Toxicology of Paraquat Contaminated Marihuana.

(4) Research Monograph on Smoking Behavior. In conjunction with this research, NIDA provided four chapters on smoking which were incorporated into the Surgeon General's Report on Smoking and Health Report released in January 1979.

(5) Cannabinoid Assays in Humans.

(6) Phencyclidine (PCP) Abuse: An Appraisal; Research Monograph No. 21.

In addition to the above, NIDA has also played a watchman role in identifying new drug abuse trends and special populations which have been victimized by drug abuse. Most scientists

will agree that trend data is far more indicative of the problem than are the numbers themselves. NIDA has been the forerunner in focusing attention on:

(1) The PCP problem. As early as December 1977 the Institute sent out letters to professionals, emergency room and medical facilities throughout the country alerting them to the dangers of PCP.

(2) The drug problems of women. The Institute has addressed this subject since 1974 and it was the subject of public hearings in July 1978. NIDA has launched five major research projects which address pregnancy in drug dependent women and has undertaken six demonstration research projects involving the female addict.

(3) The alarming number of deaths in this country attributed to Darvon (d-propoxypheneon).

In the case of PCP, the other departments and agencies of the Federal Government looked to NIDA for abuse liability information and the hard scientific data needed to determine whether a rescheduling of the drug under the Controlled Substance Act was in order and necessary.

PREVENTION

As many of you are aware, the 1979 Drug Abuse Prevention Campaign promises to be one of the most effective drug abuse media and community efforts ever undertaken by the Federal Government. The campaign is directed to two primary audiences -- young people, ages 12-14 and women, ages 18-24. The TV spots and materials prepared for the 12-14 year olds depict positive role models and drug abuse prevention models that respond to negative and positive peer pressure to promote drug free behavior. The materials prepared for the 18-24 year old women depict positive role models that deal with stress without resorting to drugs. We look forward to the release of these materials in April with great enthusiasm as they reflect the extremely professional and creative work of a number of the Institute's staff.

SERVICES

Drug abuse treatment is one of the cornerstones of NIDA's program. By focusing national attention on the problem and by providing Federal funding on a matching basis, the Federal investment has stimulated the development of a national treatment effort far beyond that which the Federal resources alone could have built. It is significant to note that in

Fy 78, NIDA was not the primary source of any treatment funding but provided the impetus behind the creating of innovative and effective programs within the States. During the fiscal year, NIDA provided $132 million for drug treatment while the States collectively contributed $164 million.

Not only is treatment available, but it is used. The overall utilization reported in the 1978 survey was 89%. In fulfilling the primary program mission of providing treatment, NIDA has learned that the diverse characteristics of the treatment population often demand unique responses. Compared to the general population, a higher percentage of racial and ethnic minorities are found in treatment programs. This situation presents specific treatment challenges and opportunities. Current demonstration projects are trying to determine whether certain treatment modalities are more effective than others in meeting the needs of minority groups. Special studies are looking at differing treatment outcomes among minority groups; ways to treat inhalant abuse among native Americans; the effectiveness of family counseling with Cuban and Puerto Rican drug abusers; and the role of cultural stress in drug abuse.

Now I would like to discuss the future -- some of the initiatives we in the Executive Branch plan to undertake during the coming year.

ADOLESCENT DRUG ABUSE CAMPAIGN

With one in nine American high school seniors smoking marihuana daily, drug use among our youth is an issue of great concern. Experimental drug use continues to rise significantly in high schools across the Country. The most recent youth Gallup Poll shows that teenagers themselves share our concern, in that they list drug use and abuse as the foremost problem facing their generation. Parents, teachers and students themselves need to have accurate information available to them. In addition, parents and teachers need some assistance in developing ways of conveying this information to their youngsters.

Our goal is to provide this accurate information about adolescent drug abuse to parents, teachers, and other key youth leaders so that they will be prepared to firmly discourage drug abuse by adolescents with whom they come in contact. Through this campaign, we hope to reach out to local communities and encourage them to bring about significant changes in the attitudes of our youth toward drugs. We will involve the NIDA, HEW, DEA and a number of key community groups, such as the National PTA, the National Education

Association, etc. in this effort.

DRUG ABUSE IN THE MILITARY

Drug abuse in the armed services is an especially sensitive subject because of the potential impact on Defense readiness. This concern is emphasized by widespread media coverage and continuing Congressional scrutiny. The DOD has undertaken a number of initiatives, many in response to an ODAP policy review, to address this problem.

Our goals are to identify and respond to those issues which directly involve the White House, to monitor the DOD implementation of its new drug abuse prevention programs, and to ensure that DOD drug activity is integrated into other U.S. drug prevention activities in Europe.

DIVERSION OF PSYCHOTROPICS FROM THE LICIT MARKET

Most abused psychotropic substances come from legitimate domestic manufacturers and most diversion occurs at the retail/practitioner level. Adequate means exist to identify physicians, pharmacists and other health professionals whose questionable practices result in large scale diversion. The problem is to use this information to bring appropriate professional peer pressure as a first resort or, failing that, to get criminal convictions against these people.

Our goal will be to work with the State licensing boards, professional associations (AMA, PMA, APhA, etc.,) peer groups and others to both identify the sources of diversion at the practitioner level and to halt this diversion. In addition, we will assure that Federal authorities work with State and local enforcement agencies to investigate and prosecute those individuals committing clearly criminal acts. To have maximum impact, this issue must not be seen as totally law enforcement oriented, but will include such things as physician education, etc.

DRUG INTERDICTION AT OUR BORDERS

Improvement of our capabilities to interdict drugs at our national borders is a high priority during 1979. We will continue to emphasize interagency coordination and responsiveness to changing trends in drug smuggling. The highly successful Southeast Initiative which I discussed earlier will be used as a model for other border interdiction efforts along the Eastern Seaborad and Gulf Coast of the United States.

ERADICTION AS A MECHANISM FOR REDUCING ILLICIT PRODUCTION

Eradication with herbicides is the most cost efficient and effective means of destroying narcotics at their source.

Problems exist regarding the possible ecological and health impact of spraying programs on both the citizens of host governments and on Americans. There is the additional question of eradicating crops where no other sources of income is available for farmers.

Our goal is to determine whether herbicides can be safely used for eradication, to review the effectiveness of other means of crop destruction and crop suppression and to gauge the political consequences of any steps taken. This effort involves the Departments of State, Justice, HEW and Agriculture. It will require an overall Administration assessment and policy decision in which both program and political issues are carefully considered.

USE OF DEVELOPMENTAL FUNDS IN NARCOTICS PRODUCING AREAS

The only successful means of reducing narcotics cultivation in "traditional" producing areas, such as Afghansitan, Bolivia, Burma, Pakistan, Peru, and Thailand, is to aim for overall development of the region. Alternative sources of livelihood must be made available to growers through programs of crop and income substitution, and health and educational improvement, concurrent with enforcement of

narcotics cultivation bans. Since narcotics funds are inadequate to do this, we must encourage AID, other bilateral donors, the IFI's and U.N. developmental organizations to target assistance to these areas.

Our goal is to implement the President's policy of aggressively pursuing development of narcotics producing areas by gaining the producing country's support, as well as by working with bilateral and multilateral donors to make the necessary funds available. We will coordinate the efforts of State, AID, Treasury, and DEA, all of whom have roles to play in this initiative.

ENHANCE U.N. CAPABILITIES

International organizations have been involved in both drug demand and supply reduction efforts for over fifty years. Because of lack of resources and bureaucratic and personnel problems, the success of these efforts has been varied. As part of our effort to "de-Americanize" the drug problem, international organizations should be encouraged to assume a more visible role in the entire drug field.

Our goal is to work with other governments and the appropriate personnel in international organizations to develop more aggressive and effective UN drug programs in such areas as international drug trafficking interdiction,

international demand reduction, economic development of narcotics producing areas and assuring a balance between supply of and demand for licit narcotics. To accomplish this, we will involve a number of bureaus in the Department of State, as well as AID, HEW, DEA, and the USDA.

JUDICIAL ASSISTANCE TREATIES

The prosecution of drug-related crimes committed outside the jurisdiction of the United States or committed by foreign nationals has been a major law enforcement problem. We must foster freer and quicker exchange of needed information and develop procedures within national judicial systems to help apprehend, prosecute and convict drug traffickers. Our goal is to assure that the U.S. enters into appropriate treaties to enhance enforcement of drug trafficking laws involving international transactions. This activity involves the Departments of State, Justice and Treasury.

THE SOUTH ASIAN PLAN

Heroin from South Asia poses an increasing threat to efforts to control drug abuse within the United States, for this heroin has already flooded Western Europe and is readily available to U.S. personnel and their dependents stationed in Germany. By establishing and implementing an active South Asian plan, we hope to limit the problem before it begins to have a major impact on the U.S. heroin market.

Our goal is to develop a plan which will propose viable courses of action to deal with the increased opium production in Afghanistan and Pakistan. The plan will identify ways in which we can further U.S. and U.N. development or assistance in diplomatic initiatives designed to reduce the acreage devoted to illicit drug cultivation. At the same time, it will identify ways in which we can encourage additional effective law enforcement action by host country enforcement authorities. Once identified, these courses of action will be pursued through the diplomatic and enforcement channels of the appropriate departments.

FEDERAL STRATEGY 1979 - FOLLOW-UP AND IMPLEMENTATION

The staff will use the new Federal Strategy as the blueprint for program initiatives in the coming year. We will follow each of the specific recommendations to assure implementation.

STRATEGY COUNCIL ON DRUG ABUSE - ACTIVITIES AND PUBLIC ROLE

In December we began a series of highly successful meetings with the public members of the Strategy Council. The continuing involvement of both public members and departmental representatives fulfills the President's commitment to a truly revitalized Strategy Council and will continue in 1979.

As you can see, we intend to pursue a wide spectrum of activities in 1979. The Executive Branch cannot accomplish these alone. We look, therefore, to the continued support of the U.S. Congress and, above all, to the American public in reducing the serious effects of drug abuse in our country.

January 15, 1979

FEDERAL RESPONSE TO DRUG TRAFFICKING
IN THE SOUTHEASTERN UNITED STATES
JANUARY 1979 UPDATE

The purpose of this report is to review the progress made during the first six months of the Federal initiative against drug trafficking into the Southeastern United States.

As background, the ongoing initiative against drug trafficking in marihuana and cocaine to and through Florida and other Southeastern States was initiated in the summer of 1978. The Federal enforcement agencies have been working together to develop and implement plans to control this illegal activity. In July 1978, representatives from the Drug Enforcement Administration, the U. S. Customs Service, the U. S. Coast Guard, and the State Department met to review the situation and develop a more comprehensive response. Since that time, representatives of the agencies have met periodically to review progress and discuss the activities.

During the past several months, the Federal law enforcement agencies have dramatically increased their activity in the Florida area. The United States Coast Guard seized nearly 2 million pounds of marihuana during the period July through December, compared to only one-third that amount during the comparable period last year. The number of smuggling vessels seized during the same period exceeded the total seizures during all of fiscal years 1973-1977.

A major success of this effort thus far involves the response of the Government of Colombia. In November, the President of Colombia initiated a major military effort to establish control over drug smuggling originating in the Guajira Penninsula. Initial reports indicate that the military initiative has been successful, particularly in curtailing the loading and departure of drug smuggling aircraft and sea going vessels. This military activity may result in reduced drug seizure statistics during the next few months.

The Southeast initiative is a tribute to the hard work and dedication of the DEA, Customs Service and Coast Guard. It has produced a major improvement in cooperation and support between Federal agencies and has provided a significant opportunity for improving the relationships between Federal, State and local enforcement activities. Agency representatives report that the cooperative efforts associated with this initiative may be used as models for similar efforts in other parts of the United States.

The interest and support of the U. S. Congress have contributed significantly to the successes experienced in this initiative. Of particular importance is legislation passed by the Congress

in the past six months which materially strengthens the capability of law enforcement activities in dealing with traffickers.

The current status of specific actions as reported by the agency representatives follows.

I. Source and Transit Countries

--DEA's Office of Intelligence published a report in November 1978 on Colombia as a source country for marihuana. Additionally, that Office will be preparing periodic assessments of the effectiveness of the Colombian military effort in the Guajira.

--The National Narcotics Intelligence Consumers Committee (NNICC) has been developing intelligence requirements for key foreign countries, including those involved in the traffic affecting the Southeast United States area. Additionally, much work has been done on estimating the quantity and value of various drugs reaching the U. S.

--DEA conducted a seminar in the Virgin Islands in October 1978 on conspiracy investigations. Approximately 30 persons participated in the seminar.

--A Department of Justice team traveled to Colombia to discuss prosecutions of Colombian nationals in Colombia based in part on evidence developed in the United States. The objective was to assess the potential of such prosecutions. It was determined that the use of this technique will be difficult because of restrictions under Colombian law. The principal problem is that any witness who testifies to involvement in a transaction is culpable and prosecutable under Colombian law. A witness's testimony would, therefore, automatically place the witness in jeopardy. The Colombian law currently is quite inflexible; however, every effort is being made to open this prosecutive avenue.

--The Government of Colombia has initiated an aggressive military campaign in the Guajira Peninsula in an effort to disrupt the massive flow of marihuana from that area to the United States. Presidential decrees have been published which significantly control the movement of vessels, aircraft and vehicles in this area. Current status reports of this military operation are encouraging. The Colombian Government states that, to date, it has seized 25 aircraft and 41 boats, as well as a variety of weapons and communications equipment. This effort will be monitored to assess the results and the effect on the availability of marihuana in the United States.

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--While it is too soon to make a definitive assessment, the Government of Colombia's anti-drug activity appears to have slowed the traffic. The number of vessel seizures in December in the Caribbean/Florida area dropped significantly as an apparent result of the Colombian military campaign.

--U. S. Customs presently has two advisors working in Colombia principally in the area of training in narcotics interdiction techniques. Also, assistance has been provided in the form of radar units to track the illegal entry of aircraft into Colombian airspace.

--In early January, Colombian Customs will initiate a training program on its southern border with Equador through which large amounts of cocaine and coca paste pass enroute from Bolivia and Peru to Colombia where it is refined and further distributed.

--The Commandant of the Colombian Coast Guard visited various U. S. Coast Guard and U. S. Customs Service units in Florida during November 1978. This was followed by briefings and meetings with Coast Guard/Customs personnel in Washington.

--In December, the Commandant of the U. S. Coast Guard visited the Bahamas, Venezuela, Panama, Ecuador, Colombia, and Honduras to discuss international anti-narcotics trafficking cooperation. Each country agreed that the U. S. efforts against drug trafficking were necessary and agreed to cooperate fully. A specific subject of discussion was the reporting of sightings of suspicious vessels to a central point.

--Colombia and Venezuela have signed an anti-narcotic agreement which provides for resources committed to control drug traffic, develop a joint strategy and to establish a commission to recommend specific action.

--State reports that the U. S. Ambassador to the Bahamas has asked that a DEA office be opened there to focus on drug trafficking through that area. The request is supportive of the Southeast Initiative. The State Department has approved the request and personnel selection is underway.

II. Southeastern United States

--In September 1978 a meeting was held in Miami, in conjunction with the IACP, for key state and local law enforcement officials. The U. S. Customs Service,

Coast Guard, and the Deputy Chief of Mission from Bogota participated actively in this session which was held for officials in leadership and policymaking roles. A significant aspect of this seminar was to elicit training needs from State and local officials.

--DEA, Customs and the Coast Guard will hold monthly seminars through December 1979. These seminars concentrate on air and sea interdiction and trafficking patterns and are designed to enhance State and local capabilities in support of the overall enforcement effort, principally in Florida. One thousand officers will be trained in 10 seminars and 4 two-week schools.

--In December, DEA, the Coast Guard, and Customs participated in a conference concerning the Chesapeake Bay as an interdiction area for vessels smuggling drugs into the United States. This resulted from indications that the Southeastern Initiative may cause drug traffickers to utilize the Chesapeake Bay area for their smuggling activities. Customs and Coast Guard are currently planning to initiate an intelligence effort in the Chesapeake Bay.

--An intelligence collection school for 20 members of the Georgia Bureau of Investigation was completed in December 1978. DEA sponsored an intelligence collection conspiracy school in mid-December in Miami for 55 State and local officers.

--Federal, State and local intelligence exchange was significantly enhanced with the signing of EPIC agreements in key states. These agreements facilitate the sharing of drug movement intelligence and are key initiatives in support of real time operational situations. In September, agreements were signed with Florida, Georgia, South Carolina, and Arkansas.

--DEA had detailed 15 Special Agents TDY to assist in handling the heavy case load in the South Florida area. These TDY details have been completed and increases in permanent staff are being made.

--DEA has opened offices in Panama City and Fort Myers, Florida.

Panama City
Two Special Agents have been assigned to Panama City and they are currently in temporary space. Negotiations are underway with GSA to acquire a permanent facility.

Fort Myers
One Special Agent has reported to the Fort Myers office which is currently functioning out of space in the U. S. Attorney's Office. A Resident Agent-in-Charge has been selected and will report in January 1979.

--Customs has undertaken special intelligence gathering on vessels operating from source countries to secure accurate information on potential smugglers.

--The Customs' Miami Air Interdiction Unit, stationed at Homestead Air Base, has received two additional aircraft, a sensor equipped S2D and turboprop aircraft. These aircraft will provide additional detection and interdiction capabilities.

--After an in-depth study of the radar at Guantanamo Bay, Cuba, Customs is preparing to contact the military to incorporate this capability into the current radar network. The radar would extend detection capability to smuggler routes previously not covered by radar.

--DEA held a meeting with the IRS counterparts from Washington, Atlanta and Florida to review the level of IRS investigative resources assigned to drug-related tax cases. Extensive discussion was also held to seek more effective use of resources. IRS has reported that they have increased the number of personnel working on drug-related tax cases, both criminal and civil.

--DEA's Regional Director at Miami has provided a briefing to the Federal judges in South Florida.

--Increased at-sea intelligence has resulted from an agreement between the U. S. Coast Guard and the U. S. Navy. Sightings of suspect vessels and vessels matching an easily recognizable smuggling vessel profile are being reported to Coast Guard Area Commanders and the Naval Ocean Surveillance Information Center (NOSIC) by U. S. Navy ships. Navy aircraft have also been utilized for maintaining surveillance of suspect vessels on occasion. This activity is part of the normal Navy maritime surveillance and is not to interfere with normal Navy operations.

--U. S. Coast Guard maritime drug interdiction efforts have increased throughout the national coastal area by additional offshore patrols by cutters and aircraft and increased coastal and inshore patrol by smaller utility boats.

--Customs reports that some vessels engaged in smuggling and usually operating along the Florida coast now have shifted to Texas ports. A special vessel search operation is to be undertaken in the Galveston-Houston area. The operation will improve interdiction along the entire Gulf Coast.

--Currency Task Force (Miami): Since July 1978, the Customs Currency Investigative Task Force has directed a major effort to develop better information on currency transfers and to intercept these movements. A recently completed comprehensive investigation has pinpointed particular ports, estimated the amounts of cash flow, and the modes of transfer. In conjunction with this program, Customs has assigned additional agents and increased its investigative efforts. As a result of these activities, several major currency transfers have been intercepted since July 1978.

--The joint DEA/FBI Investigative Task Force in Miami anticipates indictments in February or March. Several other investigations are ongoing. Substantial assets are likely to be seized at the time the first indictment is returned. The investigation continues to be conducted under the rules of grand jury secrecy.

III. Legislative Initiatives

--The Congress of the United States has amended Section 511 of the Controlled Substances Act. This new legislation expands existing law to provide for the forfeiture of the following additional types of property:

1. All monies, negotiable instruments, securities or other things of value furnished or intended to be furnished by any person in exchange for illicit controlled substances;

2. All proceeds traceable to such an exchange for illicit controlled substances; and

3. All monies, negotiable instruments and securities used or intended to be used to facilitate any controlled substance law violations.

--The Congress also amended the Tariff Act of 1930 with respect to administrative forfeiture. This legislation increases from $2,500 to $10,000 the value of property which may be handled by administrative forfeiture procedures and became effective October 4, 1978. This legislation, which has been requested for the last 15 years, will enable vehicles and vessels in particular to be

processed for forfeiture in an administrative fashion rather than through a lengthy court procedure for a value of up to $10,000.

IV. Other Initiatives

--DEA reports considerable study has been done on the question of destruction of bulk seizures of marihuana. This is a particularly acute problem in Florida because of the extremely large amount of marihuana seized. Study to date indicates that the most cost effective method for destruction would be utilization of an open pit burning technique. DEA, Customs, Coast Guard, and representatives of the Florida Department of Environmental Regulations, the Dade County Environmental Protection Agency, the Federal Environmental Protection Agency, and the U. S. Department of State have conferred on this difficult problem. Within a few weeks, a determination can be made as to the feasibility of open pit burning.

--DEA and Customs are implementing a joint project for analysis of drug smuggling. The plan envisions the combining of analytical resources between the two agencies to enhance interdiction results and places principal emphasis on the use of EPIC as the focal point for these activities. This program's first objective will concentrate on the cocaine traffic out of South America, particularly Colombia, and into the United States.

--Customs reports an operation will begin in the near future involving the installation of sensors at normally deserted landing strips. These sensors will permit Customs to track and interdict the numerous smugglers thought to be using these locations.

THE WHITE HOUSE

WASHINGTON

January 24, 1979

FEDERAL RESPONSE TO THE PCP PROBLEM
January 1979 Update

This report reviews the progress of the Federal Response to the PCP Problem, and updates the September 1978 report published by the PCP Action Coordinating Committee.

A. BACKGROUND

The PCP initiative began during the summer of 1978 when representatives from the National Institute on Drug Abuse (NIDA), the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), and the National Institute on Mental Health (NIMH) met under the auspices of the White House Office of Drug Abuse Policy to review the situation and develop a comprehensive and coordinated response to the problem. Since that time representatives of the agencies have provided progress reports on their activities.

PCP (phencyclidine), the legally manufactured tranquilizer and general anesthetic used in veterinary medicine, surfaced as a major drug abuse problem in 1977 and early 1978. An estimated 7 million Americans have tried PCP. In 1977 an estimated 150 people died in PCP-related accidents and 6,000 persons were admitted for emergency treatment. For the period January through October 1978, approximately 3,800 individuals were admitted for emergency PCP treatment.

While the figures still reflect an alarming number of individuals who are using the drug, data collected via the Drug Abuse Warning Network (DAWN) indicates that PCP abuse today is generally down in some cities or has leveled off from the peaks reported during the spring and summer of 1978. Los Angeles still remains a city of primary concern to the Federal agencies in that the number of emergency room mentions for PCP use in this area continue to remain high. The major enforcement effort and health initiatives undertaken by the Federal agencies

during the summer and fall months, together with an increased awareness on the part of the American public as to the danger of PCP abuse, are largely responsible for this apparent stabilization in some cities and in some areas decline of the number of PCP accidents and deaths.

The interest and support of the U.S. Congress in focusing on the PCP problem have contributed significantly to the results realized to date. The August 1978 hearings of the Select Committee on Narcotics Abuse and Control followed by the Committee report "PCP - A Killer Drug on the Rise" have helped to focus national attention on the problem and provide a forum to discuss what the Federal Government is doing to combat this problem. Of particular significance is the legislation passed in the final days of the 95th Congress which will, through increased penalties and PCP reporting procedures, sensitize the courts to the seriousness of the problem and also give a clear signal to PCP traffickers to show the Federal Government's commitment to resolving this problem. The current status of specific actions as reported by the agencies follows.

B. HEALTH INITIATIVES

1. In August, 1978, NIDA published a comprehensive report entitled "Phencyclidine (PCP) Abuse: An Appraisal" (Research Monograph 21) which provides detailed information on the extent of PCP abuse, acute and chronic effects, diagnosis and treatment of adverse reactions. The report surfaced several new findings which deserve particular attention:

a) Chronic users of PCP report persistent memory problems and speech difficulties as well as mood disorders. Paranoia and violent behavior may appear in later stages of chronic use. There is some clinical evidence that PCP may precipitate a persistent prolonged psychosis resembling schizophrenia even after the user has abstained from the drug. This reaction is not completely understood, but it may occur in susceptible individuals who may be latent or borderline psychotic.

b) One of the more puzzling questions about PCP use is just why users continue to use it in light of the widely noted and even user-acknowledged negative aspects of the experience. In a study (Siegel, p. 6) of some 319 adult PCP users ranging from 21 to 38 years of age, users reported positive reactions such as heightened sensitivity to outside stimuli, disassociation, mood elevation and intoxication. Negative effects by the majority of users included perceptual disturbances, restlessness, disorientation and anxiety. The reinforcement value of the PCP experience may also be a motive for use regardless of certain aversive consequences. The excitement of not knowing just how the PCP experience will turn out and the ability to later boast of the risks taken may also be a motive in that these accounts may confer status, especially among drug using peer groups.

2. Over 200 responses from the general public and health professionals were received by NIDA based on the December 1977 letters to treatment programs, emergency rooms, and other agencies alerting health professionals to the PCP problem, its effects and treatment.

3. NIDA has also published "PCP: an Overview" (NIDA Capsule) and an assessment entitled "Phencyclidine Use Among Youths in Drug Abuse Treatment" for the general public.

4. All NIDA publications about drugs in general now include a special section on PCP. Similar information is included in material developed for the 1979 National Drug Abuse Prevention Campaign aimed at preventing and reducing the misuse and abuse of all drugs, particularly among women and youth.

5. As a result of the NIDA sponsored conference on PCP in February 1978, the agency's Division of Research has been able to fund the following PCP research projects: a) an epidemiological study involving PCP, as well as four other drugs; b) a study on the effects of certain drugs on the

brain function using electrode implants; c) an investigation into the pharmacological and behavioral effects of PCP; d) a study to develop methodologies and clinical approaches to determine the quantity of PCP and other drugs in certain body fluids; and e) an evaluation of the effects of specific antagonists on the acute effects of PCP. Fourteen projects related to PCP have been reviewed and are pending final approval by the National Advisory Council scheduled to meet on January 24 and 25, 1979.

6. In February 1979, NIDA's Division of Research will sponsor a Scientific Technical Review to discuss the pharmacology and Toxicology of phencyclidine and its analogs, with an emphasis on the abuse liability of new and uncontrolled analogs.

7. Treatment systems in five cities (Seattle, Chicago, Philadelphia, Miami and Houston) have been surveyed to determine the extent to which PCP users have sought drug abuse treatment. The results, once compiled, will provide information on the outcome of current PCP treatment in these communities and will also be of assistance in designing more effective programs to deal with the problem. Beginning in 1979, PCP will be specifically coded on CODAP forms to allow for the ongoing and continuous monitoring of clients admitted to treatment throughout the nation for PCP use.

B. SUPPLY REDUCTION INITIATIVES

Law Enforcement

1. DEA's Special Action Office/PCP was established on June 1, 1978 within the agency's Office of Enforcement. During the four-month initial impact phase (Phase I) which ended on September 30, 1978, all projected program goals were met or surpassed. One hundred and forty-nine (149) PCP-related arrests were made during this period, 23 PCP laboratories were seized and the equivalent of approximately 6,609,760 dosage units were removed (based on 50% purity per dosage units).

2. From October 1, 1978 through December 31, 1978, seizures and arrests continued (5 laboratories immobilized, 48 defendants arrested, and 2,297,800 dosage units removed) while investigators and analysts began to evaluate the results of the program. There appears to be a direct correlation between increased laboratory seizure activities and a downward trend in PCP inquiry mentions, as reported by the Drug Abuse Warning Network (DAWN). Phoenix, for example, went from 12 mentions in August to no mentions in September. During this period, a PCP laboratory was seized in that area. DAWN mentions have risen to five for October, still below the August high. Los Angeles has dropped to 27 mentions from a summer high of 45. There has been a corresponding increase in enforcement activity in the Los Angeles area. The Los Angeles area, although experiencing a decline in DAWN mentions, is still by far the area reporting the highest incidence of abuse. Buffalo and San Diego experienced a sharp rise in PCP mentions with marked drop off following the seizures of laboratories and arrests of violators. While other major cities such as Miami, Detroit, Chicago and New York continue at comparatively high levels for DAWN mentions, it appears that the surge in PCP abuse is stabilizing.

3. DEA, through its Precursors Liaison Program, is working closely with the chemical industry to identify the amounts of piperdine (a necessary element in the manufacture of PCP) that are needed for legitimate purposes and their destination. Relying heavily on voluntary cooperation by the chemical industry, those involved in the program will monitor unusual or suspicious orders for precursors used to manufacture controlled substances.

4. On November 10, 1978, the President signed P.L. 95-633 in which a specific title is devoted to PCP criminal penalties and piperdine reporting. Under the Act, the penalties for unlawfully manufacturing, distributing or dispensing PCP and the penalties for possessing PCP with the intent to unlawfully manufacture, distribute, or dispense it have been increased from a maximum of five years imprisonment and/or a $15,000 fine to a maximum penalty of ten years imprisonment

and/or $25,000 fine. It also increases the penalty for a PCP offense for any person who has previously been convicted of a felony offense under Federal drug laws from a maximum of ten years imprisonment and/or a $30,000 fine to a maximum of twenty years imprisonment and/or a $50,000 fine. Possession of piperdine used to unlawfully manufacture phencyclidine (PCP) carries a penalty of a maximum of five years imprisonment and/or a $15,000 fine

5. In addition to these criminal penalities the Act also requires anyone who distributes, sells or imports piperdine (a chemical used in making PCP) to report such transactions to the Attorney General. The legislation further states that anyone who distributes, sells or imports piperdine in violation of this requirement is subject to a maximum civil penaly of $25,000. At the present time, the "interim regulations" outlining the proposed piperdine reporting procedures are being finalized by the Department of Justice for publication in the Federal Register which allows interested parties to comment on these proposed procedures. Barring any difficulties or strong opposition, the final regulations will probably be issued by the middle of February, 1979. DEA is currently developing an ADP system to store the piperdine reporting information, drafting manual directives and finalizing the piperdine reporting form.

6. DEA is continuing its educational program for the chemical industry to inform these companies of the PCP problem and of ways to deal with it.

7. DEA's Advanced and Basic Agent Schools and Training Programs for State and local enforcement agencies now include updated training in the detection and elimination of illicit PCP laboratories.

Regulatory

1. FDA, DEA and NIDA are working closely to ensure that PCP and similar drugs are quickly placed under appropriate Federal control.

2. The only two legitimate manufacturers of PCP, Parke-Davis and Philips-Roxanne, do not believe that they can comply with the new more stringent Schedule II requirements for PCP

and hence have voluntarily asked FDA to withdraw their new animal drug applications (NADA's). In view of the lack of an approved NDA and consequently "no current medicabuse in treatment in the U.S.", FDA, DEA, and NIDA are considering the appropriateness and feasibility of rescheduling PCP to Schedule I.

3. During the past year, NIDA, DEA and FDA have been coordinating an effort to identify, prepare and test PCP analogs for scheduling. Under the Scheduling provisions of the Controlled Substances Act, some evidence of abuse potential must be available in order to schedule a substance, and high abuse liability must be demonstrated to move it into Schedule I. In an attempt to anticipate traffickers' illicit activities, the Federal Government has already synthesized twelve PCP analogs for which pharmacological testing is currently underway in several laboratories. The NIDA Addiction Research Center (ARC) in Lexington, Kentucky, is currently assessing the abuse potential of PCP analogs in dogs and has initiated behavioral studies in rats and monkeys. Researchers at the University of California at Davis are also studying these compounds. Once it has been demonstrated that several of the closely-related chemicals all possess PCP-like activity, a sufficiently strong case may be made to generically schedule all chemically related substances. Effective October 26, 1978, the ethylamine and pyrroladine analogs were placed in Schedule I.

4. During the past year, DEA has provided information to six States (New York, Oklahoma, Pennsylvania, South Dakota, Virginia and West Virginia) who are considering rescheduling PCP, its precursors and/or analogs under their State laws. Much of the information provided to the States has been extracted from NIDA data sources and research studies. Additionally, rulemaking notices were published in the Federal Register in an attempt to provide information which would enable the States to take the necessary regulatory action.

C. FUTURE INITIATIVES

The responsible Federal agencies are monitoring the abuse of PCP and its effects. They have been working to reduce the health and social harm caused by PCP and the progress has been encouraging. The White House Domestic Policy Staff will continue to oversee the efforts of the agencies and we look forward to the continued support of the legislative, executive and judicial branches of the Government working together to meet this problem.

Senator RIEGLE. Doctor Klerman, I understand that Mr. Besteman is with you.

Fine, we are delighted to have you both. We are prepared to hear from both of you. So why do you not proceed as you will?

STATEMENT OF DR. GERALD L. KLERMAN, ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION, ACCOMPANIED BY KARST BESTEMAN, ACTING DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. KLERMAN. We both have formal statements to provide for the record, and for the committee's perusal. I would like to make an opening statement, and then be prepared to respond to questions.

I shall not repeat what you have already indicated, as to the evidence regarding the extent to which drug abuse is a serious problem, and its impact on the economy.

Senator RIEGLE. I want you to go ahead and make your summary remarks, but I think there is one thing we should deal with, a piece of unfinished business from our last conversation. I was hoping that you were going to have a surprise for me today, and that was the new Director here, because we are coming down to the end of that week to 10 day commitment that you gave us the last time you were here, and the clock is ticking.

How do we stand on that? Are you waiting for the end of the testimony to surprise me?

Dr. KLERMAN. The appointment of the Director of NIDA is a decision authorized by statute of the Secretary. I discussed with the Secretary, the day after my meeting with you last week, the concerns of this subcommittee and of the constituency in the field about the specific appointments to NIAAA and NIDA. I expect that the Secretary will make an announcement early next week in regard to the NIDA appointment.

Senator RIEGLE. Let me try to be a little more specific. I understand he has to make that decision, but presumably he makes it off the recommendation which is prepared for him, has that happened? Does he have a recommendation before him?

Dr. KLERMAN. A set of recommendations as to the leadership of NIDA have been given to him.

Senator RIEGLE. So this thing is done at this point. In other words, it is to the Secretary and awaiting his decision?

Dr. KLERMAN. The Secretary is on the west coast, as I understand. He is due back at the end of this week, and will hopefully act on our recommendation early next week.

Senator RIEGLE. I have great affection for the Secretary, and he is a versatile human being in every respect. I am confident that he

can make decisions on the west coast as well as he could on the east coast. So I trust if you put this before him in a sense of urgency, that——

Dr. KLERMAN. I can reassure you again, Senator, that after my meeting with you here, which was 8 days ago, I met the next day with the Secretary and conveyed to him the sense of this subcommittee's thinking regarding various legislative matters and appointments.

Senator RIEGLE. I do not know if there has been an occasion yet to try to perhaps keep the chairman of the full committee, Senator Williams, abreast of some of the latest thoughts, but I think we discussed that. I think that might be a healthy thing to do.

Dr. KLERMAN. One of the things was the willingness of the Secretary to discuss and meet with you and Senator Williams. We are prepared to do that.

Senator RIEGLE. I think it would be helpful, and I can speak for him, to say that we would be available, either or both, for that purpose, because we both feel very keenly about it.

How are we coming on NIAAA?

Dr. KLERMAN. The NIAAA situation is not that close. I hope that we can meet the deadline that we promised. The Secretary wants us to move with haste. He shares your concern that too much time has elapsed, although Mr. Archer, I might add, has done a fine job as the Acting Director.

Senator RIEGLE. You said 3 to 4 weeks before. Are we going to get that?

Dr. KLERMAN. I think so.

Senator RIEGLE. You think so?

Dr. KLERMAN. Yes.

Senator RIEGLE. I take it that you are going to bend every effort to do that, and it is your current hope that that can be done?

Dr. KLERMAN. It is as close to the top of my personal actions as almost anything that goes on.

Senator RIEGLE. I appreciate that. I appreciate the response to the concern expressed before. I know these things are not easy, and I do not mean to say they are. But a long time has elapsed, and I think it is a matter of bringing the issue to a judgment and conclusion. So I will take on good faith what you are saying, and that we will have some response rapidly, in both these matters. I think that will help us.

Having covered that, let me now step out of the beginning of your summary, and let you continue with your remarks.

Dr. KLERMAN. Well, I shall say a few things in summary, because I think the best way to deal with this difficult issue is through an exchange. You have raised a number of questions with the previous witnesses this morning. I wish to comment on some of the questions that are pertinent.

With regard to the issue about the consolidated formula grant, I think we discussed that last week when I appeared before you. A draft of the administration's proposal has been submitted to the Assistant Secretary for Legislation and the Office of the General Counsel, in the Department of HEW.

One of the proposals that we are making concerns a mechanism to insure that the gains of the drug abuse and alcohol abuse and

alcoholism programs in the recent years through formula grants, are not lost. At the same time, the administration wishes to provide the Governors with more flexibility in the meeting of local needs at the State level.

In addition, there has been a small formula grant program in mental health, authorized by section 314(d) of the PHS Act. The alcohol and drug abuse fields have made great use of State formula grants coming from the Federal Government. Part of the reason is historical. Mental health programs were initiated in the States, and the States funded the programs as a major part of State activity.

I am prepared to answer additional questions. We hope to get the administration bill up within the next few weeks.

Senator RIEGLE. Let me tell you, we are under terrific time pressures here. I do not want to see us writing this legislation, if we could help it, without that kind of participation by the executive branch.

You know as well as I do what the budget deadlines are that we are operating under here and we have to draft this, so that also has to be pushed up somebody's operational list of priorities.

I do not know how many steps that has to go through. Maybe there is a way to reduce the number of people that have to sign off on this thing. I am not trying to interfere in terms of your internal process, all I am saying is if the words are going to mean anything in terms of our deliberations, we have to have it, and we have to have it on a timely basis, and we have to have it now.

Dr. KLERMAN. I would like to comment. As Mr. Dogoloff indicated, the original proposal was to eliminate the formula grant approach. The current proposal for consolidated State formula grants was a compromise, an attempt to continue to make Federal funds available to the States, as stated.

The decision was not made until relatively late in the budget cycle. Therefore, we have not had as much time to work on it. I present this information to you as background, and again promise that we shall present the bill to you shortly.

Senator RIEGLE. Well, I can understand the problem you described, but that does not mean the world can stop. When the world keeps moving you have to get on with it here. So I hope we can find a way to accelerate that effort.

I want to go into some detailed questions, if I may, and you may both wish to respond.

Did you have any initial comments that you wanted to make?

Mr. BESTEMAN. No.

Senator RIEGLE. Your own evaluation conducted by Texas Christian University indicates that outpatient detoxification does not work. In light of that evaluation, I am wondering why are you continuing to use it.

Mr. BESTEMAN. We are continuing to use it.

Senator RIEGLE. You are or are not?

Mr. BESTEMAN. We are continuing to use it, although not with great emphasis within the Institute. There are still principals in communities and treatment programs who believe that outpatient detoxification, and detoxification itself, is a good step toward pa-

tient recruitment. That is the risk you take when you take someone into detoxification, if they are addicted.

Even when we point out some of the deficiencies we cannot arbitrarily say that a service may not be rendered in a community, when it is the clinical and professional judgment of competent treaters and policymakers in that community that they need such a service.

We do not promote it. We bring to them a series of difficulties that cluster around this type of service, which the Public Health Service has had experience with, which goes back to 1935. This is no great surprise. But it still represents, in some people's mind, a legitimate way of enticing, or getting an opportunity to present the treatment potential to a person who otherwise would never come to the health system.

Senator RIEGLE. When you have got a heroin addict, or drug abuser, who is judged not to need methadone, but yet you do not have a way to fit him into any other program, do you think it is effective to handle that person in a methadone maintenance facility, if that is all there is available?

Mr. BESTEMAN. If a person is not an appropriate candidate for methadone maintenance, I do not think it should be handled. Are you saying that they should be given treatment in the methadone clinic, without receiving the methadone?

Senator RIEGLE. No, I'm asking your opinion.

Mr. BESTEMAN. I think that can be done. In fact, there are outpatient clinics that do service both methadone and nonmethadone patients. However, in major cities, just because of management convenience, sometimes these clinics are separated. But there are situations where both treatments occur. It is not easy, it causes clinical problems, but it is not at all impossible.

Senator RIEGLE. I have a concern that I know some others share, that we not move people on the methadone, if that is not necessary, and if there is a way to deal with the problem short of that, that that alternative be used

Mr. BESTEMAN. I think that you have to realize that at least within the federally funded treatment component, and I can speak to that, there have been two very significant things happening.

One, the number of patients presenting themselves with heroin as their primary drug abuse has been decreasing sharply in the last year. Therefore, the pressure to put patients on methadone is less, just as a general class.

Another thing that has happened is that I do not believe that clinically, as many clinicians are convinced, that methadone is the only way to go with a heroin addict any more. The majority of heroin addicts in the centers are in drugfree outpatient therapy.

So I have no problem with your philosophical concern, and I think the behavior of the system that we monitor is going generally in the direction that you are indicating.

Senator RIEGLE. Is there any way for us to know whether when we reduce the population of heroin addicts, those folks might be showing up somewhere else, with other kinds of substance abuse? Do we have some increase somewhere else along the substance abuse scale that we should pay particular attention to?

Mr. BESTEMAN. We have evidence of local variations of other drug abuse occurring. There is not a national pattern occurring. But in certain cities, there was a trend because of the availability of other substances. In Washington, D.C., for a short time it was dilaudid. There was a lot of talwin and pentacozine—T's and blues—in Chicago, there are others.

Another combination of drugs will have a sudden spurt of popularity. When we check to see who is in that population, it is not unusual to find some who were able to get heroin, or made the decision that the heroin did not satisfy their mental state, and they went to a different substance. There is also evidence that as this reduction in heroin occurs, people do not come into the heroin scene, and marginally people fall out from it because of lack of availability.

Senator RIEGLE. You are saying that as the heroin addiction is going down we are actually pulling some people out of drug abuse altogether?

Mr. BESTEMAN. I think there is evidence to show that; yes.

Senator RIEGLE. But part of the movement is from heroin to other substances, is that correct?

Mr. BESTEMAN. Well, when a person has made a lifestyle commitment to being in a drug state, and the average heroin addict has already reached that state, taking away the drug is not going to take away their behavior or desire to be in a drug state. Depending upon their local situation, their own ingenuity, their own personality, pharmacology, they will seek out another substance. Some of them will spontaneously extinguish, that will be the end of their drug life, but that represents a minority population.

Senator RIEGLE. What kind of fraction would you say, in the range of what, 10 percent, 20 percent?

Mr. BESTEMAN. I would say it depends considerably in where they are in their heroin history. We have talked about this phenomenon since 1940, I think when you have heroin addicts who have gone through an extended heroin history, and then for some reason comes the nonusing state, the probabilty of their making some other decision is much higher than someone who is still in the early drug scene, enjoyment area.

Senator RIEGLE. How about alcoholism? Are people moving off illegal drugs and ending up alcoholics?

Mr. BESTEMAN. Yes; we find that our best evidence is that within the drug abusing population, alcoholism problems occur at a minimum, at the same rate as they occur in the general population. So you have, to a degree, dual addiction.

Additionally, certain patients at a time, when they are addressing their drug treatment, their drug taking behavior, and when they have not finally made up their mind on that, will episodically substitute both alcohol, and if they can obtain them, therapeutic drugs. These are attempts to continue with the drug state, but to get out of the other, the negative aspects of illicit life, and so on.

Our clinicians have to be aware that this is a possibility and learn not to ignore it as a possibility, and respond to it appropriately.

Senator RIEGLE. Now, I take it that a large part of your own professional background is in the drug abuse area, is that fair?

Mr. BESTEMAN. The last 21½ years, approximately.

Senator RIEGLE. That qualifies, in my mind.

Mr. BESTEMAN. For something.

Senator RIEGLE. How do you feel—and let me just ask for the frankest responsible response that you can give—how do you feel about the idea of perhaps combining the drug abuse problem and treatment approach with mental health generally? Sort of taking these two functions, which at least up to now have been treated as separate functions, and putting them together. How do you feel about that?

Mr. BESTEMAN. If I can make a couple of qualifying statements before I express myself. You have to understand that prior to the National Institute on Drug Abuse, drug abuse was handled within the National Institute on Mental Health. So there is a long association there.

Senator RIEGLE. It was split apart, taken apart for several reasons.

Mr. BESTEMAN. I would make another point, that the major leadership in establishing drug abuse as a separate area did come from the mental health background, and in that context, I still would say that I have some concerns for the relationship between drug abuse and mental health, their different priorities, and their different relationships, and if I can just use a couple examples.

Senator RIEGLE. Please.

Mr. BESTEMAN. Interestingly enough, drug abusers do not necessarily perceive themselves as being mentally ill, or having mental problems. That might be quite acceptable for me, it does not appear acceptable for them.

Additionally, our relationships, which was highlighted in the statement of Mr. Dogoloff, in terms of who get together regularly within the Federal system, there is a heavy interaction between the criminal justice system client and the drug abuse client. There is a heavy interaction with the social service system, and considerably less relationship with the psychiatric and medical community. That is both a fact and a handicap of the drug field, since the psychiatric and medical fields have services that we would like to obtain. Yet, we do not obtain these services at all times. But it puts the drug abuser, at best, as a special kind of patient within mental health concerns. Very often, when one looks at sheer numbers, priorities, and so on, it is very difficult to administer all of that and meet all objective needs. How do you determine who gets a dollar in this day, when dollars are very scarce?

It is easier to make that decision when you are being concerned with one area, which is why it is easier to be in the National Institute on Drug Abuse than it is to be the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration.

Senator RIEGLE. What I am concerned about here, is that mental health being stronger, a very important function in its own right, if it is now going to be combined with these other two areas, what will happen is that the essential traditional approaches and programs in mental health will tend to predominate.

Why am I worried about that? I am worried about that because we have got some very hard evidence that shows what alcoholism specifically costs us, and we have some sophisticated estimates that

show that in excess of $40 billion a year is the dollar cost, direct cost from alcoholism, and all wreckage that comes from excessive use of alcohol. Tremendous national expenditure.

Frankly, I want to stop some of that waste. This is an enormous area of waste, and this is the age in which everybody is concerned about eliminating waste, and so I think it is positive that here is an area where we can stop some of that waste, and heartache that goes with it.

The problem is, if we dilute the rather modest effort we are already making in the area of Federal attention to a national alcoholism problem, I suspect that the $43 billion cost may well go higher.

In other words, we will kid ourselves into thinking that we are saving a tiny bit of money over here, and in fact by taking that step, we are going to spend enormously larger sums over here by not dealing with the problem.

Now, I do not want to see that happen. In other words, I do not want to see the alcoholism treatment area, with that kind of scale pushed over in a back corner of a mental health clinic, intending no disrespect to the mental health functions.

Now, help me here. How do I reconcile this? How does the Congress reconcile, in light of the fact that this is a departure? We have made gains. We established ourselves. We split it out as a separate function, because we felt it needed prime attention. We have been giving it prime attention, and now suddenly in the name of consolidation we are going to go back to where we were when we started.

Where is the sense in that? It really escapes me.

Mr. BESTEMAN. I am sorry, I cannot help the chairman. I have not seen the proposal. I do not know the details. I know the general framework that you described, and I have some anxiety.

Senator RIEGLE. You have some of the same anxiety that I have; is that right?

Mr. BESTEMAN. Yes.

Senator RIEGLE. Let me just describe them in dollar terms, because that is really the bottom line here.

Last year we spent $96.8 million for the State grants for alcoholism and for drug abuse activity—that is, for the fiscal year that we are completing now.

The proposal, the budget proposal, which we do have from the administration, shows that that figure would go up very slightly less than the rate of inflation, would go up to $99 million but, of course, mental health gets added in.

Dr. KLERMAN. Senator, I think the record should show that in addition to the formula grants for alcohol and drug abuse, which do total about $96 million, also $13 million of the 314(d) formula grants for the States, and the administration proposal is to formulate those three formula grants at the level of $99 million.

Senator RIEGLE. Let me understand one thing, though. The $13 million that you reference, is that for services or is that planning?

Dr. KLERMAN. That money is used by the States to eliminate inappropriate placement of persons in institutions, to provide assistance in screening persons who are being considered for inpa-

tient mental health care, and to provide followup care in the community for patients discharged from institutions.

Senator RIEGLE. What is the split? Is not planning a predominant use of the money?

Dr. KLERMAN. According to the statute, 70 percent of the amount allotted to a State must be used to provide services in the communities.

Senator RIEGLE. I think we would have to have it, because my sense is that is predominantly a planning operation, and it may not be appropriate to add that in when we are talking about service dollars.

Dr. KLERMAN. My understanding is that the States use their full grant money in alcohol and drug use for services and administrative costs, and for planning, as well as a conduit for a large amount of that money going to local communities for drug programs, and for alcohol programs. The figure is probably higher in drugs and alcohol than it is in 314(d).

Senator RIEGLE. Well, let us get that. Let us take a look at that.

Dr. KLERMAN. The arithmetic is correct. The proposal would result, if adopted by the Congress, in a reduction in the sum total of the 1979 appropriations for the State formula grants for alcohol, for drug abuse, and the 314(d) State grant.

In that sense you are absolutely correct, Senator.

Senator RIEGLE. The question that the committee is getting at, is that penny wise and pound foolish? Is that costing us money by doing that? Because all the evidence suggests that the return that we get on every dollar spent for drugs and alcohol use programs is many times greater than the dollar spent. I think it is essential that professionals like yourselves, who have devoted the larger part of your professional lives to working in these areas, to try to help people—just as earlier witnesses, Senator Hughes, and others have done—should speak up.

If we are moving away from a sensible approach to that problem, I think we have to say so. The reason I stress that point, there is a big consolidation move on right now. It affected the Interior Department, and there was a debate within the administration to consolidate certain functions with respect to economic development—and apparently the internal fight went the other way—and there are proposals to consolidate this, and proposals to consolidate that, and the point is there is no magic in consolidation. Sometimes it makes sense and sometimes it does not make sense.

We have a clear record of history here. We split alcoholism out of mental health. We identified a separate and serious problems. Those functions were separated out so we could get at them. Now what I am hearing is that, in the name of economy or in the name of efficiency, that somehow we are better off if we sweep it all back together.

My own background happens to be in management and organization, so I have seen enough different situations that I know that that is not a magic formula that can solve problems. That is why the professionals in this area, I think, have a professional obligation, if they are concerned, to point out that some of these consolidations do not make sense.

Presidents are not always right, and top policy staff people in administrations are not always right, and that is why very often they are not the people charged with getting the administrative work done. That is why you have field professionals that are charged, most often, in administering these programs.

So I think it is important that if we are moving in a direction here that the history and our knowledge to date puts into question, that we address that, and we be forthright about it, because there are an awful lot of people whose fate hangs in the balance. I am not talking about those who run for elected office. I am talking about the whole client population.

So I would hope that we would be strong enough to really make sure that we are keeping this debate and this issue focused on the kind of professional knowledge level that is the basis upon which the decision ought to be made, and not on the basis of some current reflex, or other kind of desire within this administration, or any other, to want to take and apply some kind of a general practice to a number of different areas when they may not fit. So I hope I make my point.

If either of you want to respond, you are certainly welcome to.

Dr. KLERMAN. I want to respond.

Senator RIEGLE. You are responding by frowning, and you are responding by smiling.

Dr. KLERMAN. Pardon me?

Senator RIEGLE. Now, you are smiling and he is frowning.

Dr. KLERMAN. I want to reiterate the point that Mr. Besteman made. As I review the history of these fields, and as I said before in this committee and in many public statements, the fields of alcoholism and drug abuse were neglected, both at the Federal and State level, when they were assumed under the mental health umbrella.

Senator RIEGLE. You say they were neglected?

Dr. KLERMAN. They were neglected. There is no doubt about it. That is an historical fact. It is worthy of being reiterated, and the same thing could be said of mental retardation. The general pattern was established at the Federal and State levels. After World War II, mental health responsibilities extended to mental retardation and alcohol and drug abuse.

With respect to mental retardation, alcoholism, and drug abuse—at both the Federal and State level—the legislative bodies, particularly the Congress, responded to this neglect by mandating categorical programs. The administration wishes to continue the functions and activities of the two Institutes as independent, autonomous, and growing advocates in program development within the Federal Government. The Federal responsiblity should and will continue in the two respected areas.

Senator RIEGLE. Is it not a fair statement, though, that many people who slip into a pattern of addiction to alcohol are not mentally ill? They may behave as a mentally ill person might, under the influence of alcohol, but in fact when they get out of alcohol addiction are again normal.

In other words, I do not know that we want to sort of leave the inference here that the two things are necessarily combined.

Dr. KLERMAN. I did not want to imply that, and I do not believe that personally. I believe alcoholism is a separate disorder. However, there is a certain degree of overlap. People with alcohol problems also have mental, psychiatric, and social problems. One in particular is depression, where we have evidence recently of a higher degree of overlap between depression and alcohol. There may even be other conditions, but the only mental illness that I can state that I believe where good evidence supports is a higher degree of frequency among depressives and alcohol. It goes both ways. There is a certain overlap with heroin, particularly in viewing the VA with certain young males. But the majority of alcoholics do not wish to, and should not be considered as having a mental illness.

Alcohol is an addictive substance, and my statement would be that if any of us were, for any reason, forced to take enough alcohol over long periods of time, we would all at one point suffer effects. There are probably differences in the readiness in which alcohol produces tolerance and dependency.

Senator RIEGLE. I think what you just said is a profoundly important point, and I thank you for making it. I think you made it clearly and strongly, and if nothing else came out of this hearing today, that fact and that piece of insight for people to weigh and consider in their own lives and circumstances, and not only in terms of their own drinking patterns, but understanding what may be going on with other members of their families, and associates, and so forth, I think is just an absolutely profound fact.

I think it is a fact that most people do not understand. Somehow or another we have not managed to get that very basic fact across to most people. By saying it from your position of authority today, at least you make it possible for us to have something that we can try to disseminate.

Dr. KLERMAN. Let me give one further statement, Mr. Chairman. I would ask you to take a look at the total budget for alcohol and notice that we have included in a tight budget period, a special initiative in alcoholism focusing upon women, youth, and prevention. We have proposed approximately 35 million for earmarked programs in research, prevention, services for women and youth, and occupational programs. The Secretary has taken a direct, personal interest in the planning of this initiative, and will soon announce its details in a public forum in this city later this spring.

I know you are very concerned about the wisdom of the proposal for consolidating the State formula grants, but I would also, in addition to your concern for that part of the total package, hope that you will also look at the other parts of our program in alcoholism. I personally believe it reflects a great deal of progress and a good deal of thoughtful decision in the legislative and executive branches. It indicates the efforts of a number of key Congressmen and Senators, including yourself and Senator Williams. Senator Hughes has been quite helpful, whose personal interest and dramatic attention to this problem is having an impact on the executive branch slowly, belatedly, but definitely.

Senator RIEGLE. I want to say, with respect to the Secretary of HEW, that I really applaud the leadership that he has given in

this area. He has spoken out, it has not been easy in terms of the internal fight and pressures on the budget, I know.

I appreciate that. I know he has been tough in fighting to try to defend more adequate resource levels, for alcoholism particularly, and he has shown in other areas very special concern and willingness to try to do something about addictive drugs and addictive substances of all sorts that hurt people, and that create other problems, and so I acknowledge that, and we welcome that. But I think we have to go beyond that. Because the program increases that you talked about, if we end up paying for those with decreases in State programs, because we are folding in mental health, and mental health swallows up the dollars, we ought not to kid ourselves to say that we are in fact increasing. If we increase here and decrease here, the two things can cancel one another out. This is the concern that I have.

In a sort of reorganization fever, I do not want us to slip backward in an area where we have had to fight inch by inch to do something about these problems.

The pattern and the profile of the person who has alcoholism is different, as you both have acknowledged, than other problems that might be severe in their own right, but are just not the same problems.

I do not want us to see us lose the gains we have made.

Let me do this. I have a series of detailed questions that I would like to ask you to respond to for the record. I have about 14 specific ones here that go to specific points. I think rather than to take the time now of our last witness who has arrived, and everyone else, to go through these, I will ask you to respond to these for the record. I would like you both to have a chance to do that, and I know you have something else you want to say, and I want to hear it.

[The following was received for the record:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20857

OFFICE OF THE ADMINISTRATOR

APR 5 1979

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

I have enclosed responses to the additional questions for the record of the Subcommittee's hearings on the reauthorization of the programs of the National Institute on Drug Abuse. In addition, we have provided a statement for the record in response to the testimony of the General Accounting Office.

I enjoyed testifying before the Subcommittee and look forward to a future marked by productive working relationships.

Sincerely yours,

Gerald L. Klerman, M.D.
Administrator

Enclosures

1

SLOT FUNDING MECHANISM

Question: GAO testified that NIDA's plans include an assessment of alternative funding mechanisms to slot funding. Why does it take so long to reach a decision?

Answer: We have begun our examination and assessment of the current funding method, variations in this funding method, and new funding methods.

The study involves the development of rational alternatives which are indicated. The assessment process involves the development of alternatives, analysis, field testing, data gathering, decision making as to funding method which best meets the criteria established, and implementation of this method.

NIDA's Management by Objective (MBO) Number 11 for its Division of Community Assistance outlines this examination process, and establishes September 30, 1981, as the completion (including implementation) date. A copy of this MBO is attached. (TAB B)

SLOT FUNDING MECHANISM

Question: GAO testified that more abusers can be served while you continue slot funding. Are their estimates reasonable?

--Can you provide some insight into why some States consistently do better than 100 percent, or at least do better than the national average of 90 percent?

Answer: During the calendar year 1978, 30 States were identified that had utilization of 90 percent or better for at least two quarters during that year. These 30 States are made up of States which have the greatest level of NIDA support, i.e., New York, California, Florida, Texas, as well as States or territories which receive less than 100 slots from NIDA such as Guam, Wyoming, North Dakota, and Colorado. It is difficult to identify a single common element which separates this group of 30 from the rest.

Some States require their programs to maintain at least a 90 percent utilization. For those programs who do not maintain this level, the State will take the initiative to reallocate those slots to those areas where there continues to be an unmet need.

In other communities, treatment programs are quickly accepted by the drug abusing community and their utilization continues to be high.

It is difficult to maintain a 100 percent utilization in any health care delivery system due to the array of variables which cannot be controlled or anticipated by the service providers. These range from loss of staff, loss of local financial assistance, local zoning ordinances to the other extreme of availability of illegal drugs due to law enforcement activities. Most health care systems consider an 85 percent level of utilization as quite acceptable and desirable.

NIDA continues to expect a 100 percent level of utilization of all of its programs. Our policy is to reduce the level of funding to those programs which fall to a level of 85 percent or less and who are unable to initiate actions to improve their utilization within a reasonable period of time. This level or rate of utilization is monitored on a quarterly basis. Seldom is a grant or contract allowed to function at an 85 percent or less level for more than two quarters without NIDA initiating funding action.

SLOT FUNDING MECHANISM

Question: GAO was not exactly complimentary to the record keeping, or perhaps to the reporting of utilization, by the State of New York. Do you wish to comment on their concerns?

Answer: Until 18 months ago, the New York State Division of Substance Abuse Services (DSAS) did not submit client census information to NIDA. The State claimed that their Client Oriented Data Acquisition Program (CODAP) submissions were sufficient to meet the need for this information. In October 1977 they began to regularly submit client census data.

In November 1978, there was some confusion. The person who was supposed to provide the census information to NIDA was given incorrect directions by his supervisor. As a result, an incomplete data sheet was sent in. By the time the Quarterly Reviews were held for that period, the client census statistics were still missing. It was only after several telephone exchanges that NIDA was able to receive the right information from DSAS. For the current Quarterly Review, DSAS sent in the required information on time.

4

STATEWIDE SERVICES CONTRACT

Question: How effective have the States been in assuring NIDA that the appropriate quantity and quality of treatment have been delivered?

Answer: The quantity and quality of treatment services are assured by the States' program assessment activities--program monitoring and evaluation. There is considerable variability among States in the quality of the assessment process; however, most States are seriously assuming this responsibility. Several of the larger States have more program monitors than NIDA has for the country as a whole, and all States have many more monitors than NIDA has for them. An excellent program assessment tool, the Statewide Services Contract Program Review Manual, has been, or is being, implemented in more than half of the States.

Reporting to the Client Oriented Data Acquisition Program (CODAP) on utilization or the quantity of treatment, with the exception of the Out Patient Drug Free modality, has been very good. Additional guidance is being provided this year to improve the quality of Out Patient Drug Free CODAP reporting.

5

STATEWIDE SERVICES CONTRACT

Question: Are the States doing as good a job in monitoring and provider evaluation as your staff does for direct grants?

Answer: By the sheer number of monitors the States would almost have to be doing a better job than NIDA. NIDA has 20 project monitors, including Branch Chiefs, while New York State alone has over 100. In addition, more than half the States are using or planning to use the Statewide Services Contract Program Review Manual which we developed. This is an excellent assessment tool and the States have the manpower to use it fully.

6

STATEWIDE SERVICES CONTRACT

Question: GAO testified to a number of abuses in the slot funding mechanism.

--Do you leave it to outsiders such as the consulting firm, the HEW Inspector General and GAO to make these critiques?

Answer: NIDA project officers routinely monitor slot utilization and the accuracy of these reports. On occasion the accuracy of the reporting is systematically checked by all project officers and overall accuracy rates determined. NIDA's staff of 20 project officers must monitor the 50 Statewide Services Contracts and their subcontractors as well as those treatment programs funded by the Institute by direct grant. We can and do uncover problems; however, in view of the magnitude of the treatment system to be surveyed we welcome the findings of reviews of outside organizations.

7-8

STATEWIDE SERVICES CONTRACT

Question: What do your monitors find?

Answer: NIDA and other organizations which have monitored utilization rates and the number of client contacts have all obtained similar results. The major problems identified include the accuracy of Out Patient Drug Free Program Management Review utilization reporting and the level of service delivery.

The accuracy of reporting problem is being addressed by additional guidance in the current contract award process; the level of service problem is being addressed in the funding mechanism study. The study will seek to determine a funding mechanism which supports the delivery of adequate levels of service and funds in relation to the level of services provided.

When deficiencies are identified in the individual programs or States, a plan for corrective action must be provided. NIDA project officers follow up on the implementation of the plan. If technical assistance is required it is made available.

9

STATEWIDE SERVICES CONTRACT

Question: Have the States been held accountable for their problems?

Answer: Yes, Single State Agencies have been required to remedy deficiencies identified either by NIDA project officers or through the Program Management Reviews. If necessary, NIDA has provided technical assistance for resolving the problems.

10

STATEWIDE SERVICES CONTRACT

Question: The consulting firm recommended last fall that NIDA place its own monitoring of the States on a more systematic basis. What action has been taken?

Answer: NIDA has been working to maximize its administration of the Statewide Services Contracts. A Statement of Project Officer Responsibilities has been issued and further instructions for both on-site and off-site monitorings are being developed. Off-site instructions will cover topics such as the review of quarterly progress reports. On-site instructions will include a guide for monitoring the Single State Agencies for Drug Abuse and instructions on how to use the Statewide Services Contract Program Review Manual. Project officers do not have sufficient time on site to review all of the elements contained in the manual. The main purpose of their reviews is not an assessment of the programs themselves, but a review of the Single State Agency assessment process.

Nevertheless, there must be some probability that all items of the Statewide Services Contract Program Review Manual will be addressed by the project officer on a site visit, or neither the program nor the Single State Agencies will take the review seriously.

The instruction for the project officer will insure use of all parts of the Statewide Services Contract Program Review Manual, although not with equal frequency. The Statewide Services Contract Program Review Manual itself will be modified to become a general program review manual.

11

STATEWIDE SERVICES CONTRACT

Question: Are your statewide contract administering personnel located in the State?

--How many times a year must they visit a State?

--Must they visit a sample of the providers in a State?

Answer: Most of the people responsible for administering the Statewide Services Contract are based in Rockville. However, six project officers who are responsible for servicing the western States are based in Los Angeles, California. NIDA has found this organization effective for administering the treatment services grants and contracts and otherwise communicating NIDA policy to States.

Project officers must visit providers to insure that the States are adequately assessing the providers' services. This must be done at least three times a year for Statewide Services Contracts. Directly funded programs must be visited at least annually.

12

STATEWIDE SERVICES CONTRACTS

Question: You have just made a decision to move from contracts to grants to the States. Will you explain the basis for that decision?

--How will this affect the slot funding technique?

Answer: On February 3, 1978, P.L. 95-224, the "Federal Grant and Cooperative Agreement Act of 1977," was enacted. This Act distinguished Federal assistance relationships from Federal procurement relationships. It also standardized the usage and clarified the meaning of the legal instruments which reflect such relationships. Under this Act, the general rule is to require use of a procurement contract when the principal purpose is acquisition, by purchase, lease, or barter, or property or services for the direct benefit or use of the Federal Government. The use, as appropriate, of either a grant or a cooperative agreement is required when the principal purpose is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute.

The principal purpose of the National Institute on Drug Abuse's (NIDA's) Statewide Services Program is that of Federal financial assistance in order to accomplish a public purpose of support authorized by Federal statute. Therefore, in order to comply with the provisions of P.L. 95-224, NIDA immediately proceeded to implement the process of converting its Statewide Services Contracts (SWSCs) to Statewide Services Grants (SWSGs). This change will not affect the slot funding technique. We believe that the purpose, intent, and essence of the Statewide Services Program can be maintained using the grant mechanism.

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Question: Studies show that return to treatment runs about 60 percent. What efforts does NIDA have under way which will reduce recidivism?

Answer: Initial analysis of the Drug Abuse Reporting Program (DARP) data for first cohort examining returns to treatment over a 4-6 year period found 61.2 percent of clients returning to some treatment form during that period. Further analysis, using cohorts 1 and 2 and exploring returns to treatment over a 3-year period, indicated that approximately 50.9 percent of all clients returned to treatment during that time frame. Moreover, 26.4 percent of those clients returning to treatment do so within a month after leaving and approximately half do so within 6 months. Over the full 3 years of the study, the rate of return to treatment for different modalities is as follows:

Methadone maintenance	56 percent
Therapeutic community	46 percent
Drug-free	41 percent
Detoxification	62 percent
Intake only	53 percent

It is important to note that the strategies associated with some forms of treatment, e.g., methadone maintenance and methadone detoxification, assume a significant level of returns to treatment and involve efforts to make that service form available to the individual on need. Thus, in those modalities, the heroin addict is viewed as an individual suffering from a chronically recurring disorder for whom the treatment program should be constantly available.

Question nonetheless arises as to whether or not efforts can be made to allow the client to be retained in the community in a productive life style. Through its Demonstrations program, the Institute has taken the lead in exploring differing programs of continuing care that can help to guarantee that retention. Currently, the Institute is exploring the use of self-help groups in the form of alumni associations which would permit formerly addicted individuals to come together on a regular basis in an effort to provide each other mutual support, encouragement and assistance in negotiating the non-addict community and adopting new roles and lifestyles. This model, in the form of Alcoholics Anonymous, has enjoyed large success in the related field of alcoholism treatment. It is hoped that elements of the self-help process developed in the field of alcoholism, developed in the ex-offender area (Fortune Society) and in mental health (Recovery, Inc.) can be adapted to the drug abuse field.

Currently, NIDA is supporting, or has plans to support, three such projects. Additional projects have been solicited and, if approved, can be funded if dollars can be made available for these Demonstration projects. These represent experimental self-help efforts which the Institute is examining to determine the efficacy of this technique. In addition, the Institute has alerted all federally-funded treatment programs, and all State agency drug abuse directors regarding the availability of alumni associations as a continuing care model to aid their exiting clients in adapting to the larger community. This has been accomplished through use of a publication entitled "Nonresidential Self-Help Organizations and the Drug Abuse Problem: An Exploratory Conference."

The Institute, through its Demonstrations program, is also exploring the use of additional aftercare or continuing care models making use of both community agencies and community volunteers to aid the former client to remain productively in the community.

15

Question: There seems to be more emphasis on the subject of aftercare in the treatment of the alcoholic than in the treatment of the drug abuser. Does NIDA need to increase its efforts in this area?

--Will increased emphasis probably result in more abusers completing treatment?

Answer: In a real sense, the field of alcoholism has grown up with the organization Alcoholics Anonymous (AA). That organization was founded in 1935 and has exerted a considerable influence on the treatment process. AA is both an aftercare function and an alternative to existing formal treatment initiatives. Narcotics Anonymous (NA), organized approximately 25 years ago, has developed far more largely on the periphery of drug abuse treatment. It exists as an alternative treatment form only to a greater extent than AA, and has been most conspicuous on the West Coast.

There are clearly additional aftercare initiatives needed in the field of drug abuse and there has been considerable effort over the course of the last 2-3 years to stimulate the growth of such programs. In 1977, NIDA sponsored a Conference devoted to the self-help area to which were invited drug abuse program and planning personnel as well as representatives of self-help programs concerned with varying kinds of behavior disorders. The Conference, whose Proceedings have been widely disseminated, has led to several initiatives in the area of the organization of alumni (i.e., aftercare) groups. These projects, which are now in varying stages of completion, will allow NIDA to examine the impact of this aftercare form on client outcome.

In addition, NIDA has undertaken the development of other aftercare models to explore the impact of those initiatives on client functioning in the community. One such model makes use of community volunteers drawn from the same backgrounds and circumstances as the addict-client to work with individual ex-addicts as companions to help them develop the coping skills necessary to remain productively in the community. Another model makes use of program personnel to work with the exiting client in making use of community agencies and services appropriate to his/her needs, and in undertaking a prosocial role in the community. Additional work is ongoing to delineate the aftercare needs of male compared to female clients and of aftercare needs that may be associated with persons of differing ages and ethnicity.

As information is acquired with regard to needs and effective models, those findings will be communicated to the treatment and planning communities to allow them to make use of those initiatives. Currently, these projects are being conducted as a part of NIDA's Demonstration effort. It seems likely that an effective use of aftercare will allow individuals to remain in treatment to completion and to remain in the community thereafter.

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STATEWIDE SERVICES CONTRACT

Question: Why haven't things been cleaned up?

Answer: We respectively disagree with the presumption behind this question. Although a number of problems have been identified with the slot funding mechanism, it also has certain advantages. We are looking at alternative funding mechanisms and ways in which to improve the slot mechanism. When this study is complete, we will make a decision on how to modify or change the funding mechanism. Modifying the mechanism prior to the results of this study being available could not only fail to produce a funding mechanism which was optimally effective but could easily result in a funding mechanism less effective than that currently being used.

18

COMPLETING TREATMENT

Question: By stressing a body in a slot--as opposed to stressing units of service to the abuser--is NIDA's slot funding technique contributing to recidivism?

Answer: NIDA's slot funding technique is not contributing to recidivism. Under the current funding method an individual can continue to be counted as a client, with the program being reimbursed, if he/she has received legitimate person-to-person services, described in the Federal Funding Criteria, at least once per month on a regularly scheduled basis. A criticism of this method is that it may not provide adequate incentives for drug programs to use Federal funds most efficiently. An example of this would be that of a treatment program which maintains an individual as a client while only providing the minimal level of services allowable. Such a situation would not lead to recidivism, but rather to the continued maintenance of an individual as a client. The criticism maintains that this is not always the case, and that there are not adequate incentives to minimize this type of situation.

A properly developed "units of service" funding system could provide incentives for the provision of additional treatment services. However, a units of service funding system, in itself, does not necessarily reduce or eliminate recidivism. For example, some units of service (e.g., physicals, psychiatric, and psychological exams) could bring more financial reimbursement into a treatment program than other units of service (e.g., counseling). Unless the system is properly developed, with appropriate safeguards, clients could inappropriately receive more of certain units than others. Also, clients could be discharged and readmitted in order to receive such units, thereby exacerbating recidivism. This does not necessarily have to be the case, and appropriate safeguards can be developed to minimize such activities. NIDA is carefully examining alternative methods for funding drug treatment services.

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COMPLETING TREATMENT

Question: In the process of going from the clinician to the provider, to the State, to NIDA, what are the review or oversight processes in each to assure that quality care is provided?

Answer: Each treatment program is responsible for administering the clinics which it operates in a manner that will result in the delivery of quality care. This administration includes activities such as staff selection, obtaining appropriate equipment and facilities and the development of suitable protocols.

The State government drug abuse agency or the Statewide Services contractor is responsible for assessing the administration of the program. Such assessment includes not only monitoring compliance with requirements but also the evaluation of the efficiency, economy, and effectiveness of the operations. The assessment covers all aspects of the program administration including a review of client records to determine if the services delivered comply with the programs' treatment protocol.

NIDA monitors the State to determine if the State is adequately assessing the treatment programs. This monitoring of the State includes, but is not limited to, NIDA site visits to programs to independently assess the program administration including reviews of the client records. The State evaluations of the program are compared to the NIDA findings to determine the adequacy of the State assessment process.

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Question: Your evaluation by Texas Christian University shows that outpatient detoxification for heroin users is not working; other previous work reached similar conclusions. How much longer before that modality will either be blended into other modalities or discontinued?

Answer: The Institute is concerned with providing effective treatment to clients who volunteer for methadone detoxification. NIDA seeks to have individuals treated in outpatient detoxification transferred to drug-free outpatient treatment. It should be clear that some number of clients are not motivated to become invested in longer term, more demanding treatment programs; we feel as a public health agency that we should continue to offer these services for that type of client. There is ample data to suggest that those clients, eligible for methadone maintenance and/or therapeutic communities, who elect to enter methadone detoxification treatment differ significantly from those clients who opt for maintenance or therapeutic communities.

NIDA is currently in the process of gathering information to assess the response of methadone detoxification clients to differing detoxification strategies. Through the use of this study, NIDA will be enabled to present to the Food and Drug Administration recommendations with regard to optimal methadone detoxification strategies for allowing addict/clients to derive the largest possible benefits from treatment. It must be recognized that some significant number of clients will continue to select outpatient detoxification as their treatment of choice and it behooves the Institute to sponsor that study that will best determine the manner in which that treatment form should be administered.

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WHAT TREATMENT WORKS

Question: Give us your views on the acceptability of an outpatient methadone maintenance program admitting a drug abuser for treatment who is judged by the intake personnel to need the drug-free modality?

Answer: In order to qualify for admission to a methadone maintenance treatment program, a narcotic dependent individual must meet the minimum standards for admission, as stated in the current Methadone Regulations, which include current physiologic dependence upon a narcotic drug, a 2-year history of addiction, and voluntary participation with informed consent. The final decision whether to admit an individual to methadone maintenance treatment must be made by the program physician.

There are a number of substance abuse programs which may have a methadone component as well as a drug-free component. The decision to admit a client to any treatment modality is made together with the individual client and the treatment staff, following an appropriate evaluation of the client which includes a substance abuse history, psychosocial history, medical history.

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WHAT TREATMENT WORKS

Question: Studies show that more and more people in our society are using alcohol in combination with drugs. Has NIDA made any change in its policy of not accepting people whose primary substance of abuse is alcohol?

Answer: NIDA has not made a change in its policy as our primary mission remains that of the provision of treatment services for drug abusers whose primary substance of abuse is other than alcohol. However, alcohol is a secondary or tertiary drug of abuse of many of NIDA's clients. Provisional data on clients in federally-funded treatment show that 12 percent of all clients admitted in the July-September 1978 quarter had alcohol as a secondary drug of abuse. (National Institute on Drug Abuse Statistical Series Quarterly Report - Provisional Data - July-September 1978--Series D, Number 8--Table 8, page 16).

WHAT TREATMENT WORKS

Question: The President's Mental Health Commission's Task Panel expressed concern that the causal, recreational, and experimenting abuser was accepted into the NIDA assistance treatment program. Is there a NIDA monitoring system which assures that NIDA monies are restricted to the chronic and compulsive abusers and addicted people?

Answer: On July 25, 1975 Dr. Robert DuPont, then Director of the National Institute on Drug Abuse issued a notice to all program directors in which he set forth the policy that NIDA treatment slots should be occupied only by a client whose compulsive use of drugs has resulted in their physio-biological dependence on the drug and/or has assumed a central and negative role in their life style and coping mechanisms. This policy statement specifically addressed the issue of treating individuals whose drug of abuse was marijuana.

On November 25, 1977 Mr. Robert Roberton, Director, Division of Community Assistance, sent a notice to all program directors stating once again NIDA's policy of limiting treatment to clients whose primary drug of abuse was marijuana to those individuals only if their compulsive use of the drug resulted in their physio-biological dependence on the drug and/or has assumed a central and negative role in their life style and coping mechanisms.

Mr. Roberton again on February 17, 1978 in a notice to all program directors set forth NIDA's policy on treating individuals whose primary drug of abuse was marijuana and went further to stress that programs must first be focusing on those individuals with the most pressing clinical need and ensuring that they recieve treatment priority. (TAB C)

The Project Officers within the Division of Community Assistance in their routine monitoring of programs, review client records to ensure that programs adhere to NIDA's policy. When records of individuals whose primary drug of abuse is identified as marijuana then documentation must be provided that this individual is dysfunctional due to his use or abuse of marijuana.

Programs are subjected to a review by the Division on a quarterly basis as to their utilization of funded slots and are asked to identify the number of individuals who are currently in treatment whose primary drug of abuse is marijuana. Programs are asked to verify that those so identified individuals are in fact dysfunctional because of their use of marijuana and are in keeping with NIDA's policy. Since

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October 31, 1975 the number of persons in treatment in a NIDA funded slot has been reduced from just under 6,000 or 7% to less than 1,000 or 1% as of October 31, 1978. We are assured by the treatment programs that these few individuals do in fact meet NIDA's policy on treating individuals who are dysfunctional.

In addition to our Project Officers, statewide services contractors are required to monitor their subcontractors for compliance to NIDA's policy of treating only those individuals who are having difficulty because of their use or abuse of drugs.

Question: How much longer before LAAM will be a generally accepted substance for treating heroin addiction? Are the processes and procedures which NIDA must follow in getting approval overbearing?

Answer: Most authorities in the drug abuse treatment field have for several years believed that LAAM is an acceptable, and in several ways preferable, alternative to methadone for treatment of heroin addiction. Prior to the current phase III studies, approximately 1,000 patients have been treated with LAAM. In the current phase III clinical trial, over 3,000 patients have been treated with LAAM in over 80 clincics nationwide. Experience in these clinics has generally been that LAAM is acceptable, safe, and effective.

However, LAAM had not as yet been approved for general marketing by the Food and Drug Administration (FDA), which would make it available more widely. NIDA currently anticipates a New Drug Approval Request to be submitted to FDA this fiscal year. Based on our recent experience with FDA and the pharmaceutical industry's historical experience, NIDA anticipates over two years will be necessary to obtain New Drug Application (NDA) approval from FDA.

The processes and procedures which any pharmaceutical company must follow in getting NDA approval from FDA are time-consuming. NIDA is not a pharmaceutical company, although is held accountable as one. But, NIDA has to obtain the capacities of a pharmaceutical company through contracts. This adds an additional set of rules and regulations which further complicates dealing with FDA's processes and procedures because a third party is NIDA's agent. Thus, any unplanned but necessary [illegible] actions or responses to FDA processes and procedures require interactions with contractual processes and procedures, further complicating and delaying progress toward the NDA. Furthermore, FDA has had an ambivalent position in its relations to NIDA regarding LAAM. On one side, FDA speaks of assisting NIDA in this endeavor because of the utility and advantages of LAAM. However, ethically and practically, FDA must treat NIDA and its contractor like all other pharmaceutical companies. This has resulted in a counterproductive situation which we feel has resulted in unnecessary delays in obtaining approval for LAAM.

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Question: Where do we stand with Naltrexone? If Naltrexone were available today, approximately what percent or how many, of those abusers in the NIDA nationwide treatment system would benefit from it?

Answer: We currently have a contract with Endo Laboratories Incorporated, holders of the patent for Naltrexone, to conduct final clinical testing of Naltrexone and to submit a New Drug Application to the FDA. Under that contract, a good deal has been accomplished in planning for the phase III clinical testing of Naltrexone. The contractor has established a competent staff. A medical review committee which is essential for the development of experimental protocols, the review of adverse reactions and side effects, and the ultimate development of the NDA application has been established and has met. Actual protocols for phase III experimentation have been developed, including protocols suitable for use by drug abuse treatment programs with clients who have recently been detoxified from opiates, for clients from the criminal justice system or at risk from becoming dependent on opiates, and for clients who have never been dependent on opiates but are at risk for becoming dependent. A protocol is also being developed to test the use of Naltrexone by private physicians on drug-abusing clients. It is foreseeable that Naltrexone could be a particularly effective drug among health care professionals who have a relatively high incidence of opiate dependence. A new supply of Naltrexone has been manufactured and work has begun on a new formulation of Naltrexone in tablet form.

A letter requesting a show of interest for participating in the phase III clinical trial of Naltrexone has been sent out. The response to that letter has been very encouraging and relates to the second part of the question. Less than two weeks after the letter went out from NIDA, we had received 350 letters of interest from drug abuse treatment programs. By modality the breakdown is: drug-free, 152; methadone/LAAM maintenance and detoxification, 40; combined (drug-free, maintenance and detoxification), 153; and modality unknown, 5. These responses represent 11% of the known treatment programs reporting to NIDA through Endo. Viewed from a different perspective, these responding programs provide treatment services to a minimum of 23,477 patients and a maximum of 67,000 patients. The lower figure was derived by taking 11% of the 213,433 patients in treatment. The higher figure was calculated by estimating the responding programs' average census based on Endo's census and utilization data. We are still receiving letters of interest in Naltrexone.

In estimating the numbers of patients for whom Naltrexone may be a useful treatment adjunct, one must also consider the fact that Naltrexone may be useful in a number of heroin users who are not

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currently being treated because they find the current treatment system unresponsive to their needs. For example, there are opiate-using physicians, pharmacists, nurses, etc., who do not share many of the motivational and rehabilitative problems frequently seen with heroin addicts. It is widely felt that Naltrexone may be an ideal adjunct for this type of patient. Naltrexone may also be of particular use for individuals who are at risk of becoming physically dependent on opiates, but whose problem is not severe enough to allow them to qualify for current treatment or to warrant the major investment of time and resources in a treatment system directed at individuals with severe drug abuse problems.

Our contract with Endo has developed one severe problem. The ongoing, 24-month carcinogenesis bioassay in rats showed a disproportionate incidence of observed tumors in Naltrexone rats at 15 months. This was an inconclusive finding because measurement of actual tumor incidence is not a part of carcinogenesis bioassays until all the animals are sacrificed at the end of the study, 24 months. However, Endo Laboratories felt the liability coverage provided them by the Federal Government was insufficient to protect their company against a possible suit in the future, which although they might win based on evidence, could involve enormous costs to defend. Endo Laboratories thus has attempted to suspend work on the contract until they have obtained unlimited liability coverage from the Government. Subsequent reports from the rat study at 18 and 19 months still show no actual evidence that Naltrexone is carcinogenic. Thus far, more tumors have been observed in control mice than in Naltrexone-treated mice in the mouse carcinogenesis bioassay being run concurrently.

WHAT TREATMENT WORKS

Question: We understand that the present HEW Inspector General examination has raised some questions as to the clarity of NIDA's admission policy for drug abusers. Can you tell us about any State, or States, which have especially good admission policies--perhaps they are able to build on your general policy.

Answer: Specifically, the HEW Audit Agency's draft Report on Program Results Achieved by Six Drug Abuse Programs funded by the National Institute on Drug Abuse for the period July 1976 to March 1978 recommended that NIDA:

--Promulgate a specific admission policy for all programs that expounds on drugs of abuse and frequency of use. The policy could be tested at several programs for a minimum period of several months, evaluated by NIDA and the several programs, and then implemented, preferably through a policy statement and incorporation in manuals and guidelines. In this way, acceptance of "casual" drug users and non-drug users would be decreased and treatment slots would be reserved for users of high-risk drugs and compulsive users.

While PHS's response to the HEW Audit Agency's draft report is still undergoing Departmental clearance, our response to this specific recommendation was as follows:

We do not concur. We agree with the basic concept that all drug programs should have admission policies. However, we do not believe that the Federal Government should promulgate a specific admission policy for all programs that expound on drugs of abuse and frequency of use. The needs of the drug abuse treatment field are constantly changing. The field not only experiences change over time, but there is also great variation in client population, drugs of abuse, and patterns of abuse, between programs and areas of the nationwide treatment network at any one point in time. The Federal Government has to take into account, and to allow for, this variation in order to be responsive to the needs of the community-based treatment network. NIDA will continue to provide guidance while allowing for flexibility and individualized responses so that treatment programs can meet local needs, demands, and priorities.

The decision as to whether an individual is a "casual" drug user is a clinical decision. As such, an overall definition of "casual" would be inappropriate, even if tied into drug of abuse and frequency of use. For example, a single exposure to many drugs (e.g., PCP, hallucinogens, inhalants) could result in severe behavioral toxicity or other adverse reactions. Also, a continuing use of other drugs, even if on a frequency basis of one a week or less, could also result in behavioral toxicity or other adverse reactions.

. WHAT TREATMENT WORKS

Continued

The Federal Funding Criteria, in Section 1402.03(c), requires that programs develop criteria for the admission of patients and the termination of services to them. Admission criteria must be applicable only to those individuals with a primary drug abuse problem other than alcohol. NIDA will continue to request that the prime contractors ensure, and will continue to monitor this aspect to further ensure, that drug treatment programs have admission policies and that the clients admitted to these programs reflect the admission policies of the individual programs. We believe that this will meet the objective which both NIDA and the HEW Audit Agency share of ensuring that treatment slots are best utilized in terms of the treatment of individuals within the drug treatment network who are identified as being most in need of treatment.

(The Institute does not feel that it is in a position to make a judgmental decision on the quality of State admission standards. We cannot, therefore, supply you with examples of States with especially good admission standards.)

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NATIONAL EVALUATION EFFORTS

Question: We have heard on several occasions that about 20 percent of those entering treatment complete treatment. Will you tell us about what the success rate is today?

Answer: Providing a unified and comprehensible explanation of treatment effectiveness requires a bit of background information. The Drug Abuse Reporting Program (DARP) conducted by the Institute of Behavioral Research (IBR), Texas Christian University (TCU), Ft. Worth, Texas, under the direction of Dr. Saul Sells, has been in operation for a decade. During the initial years (1969-1974), admission and bimonthly intreatment demographic and outcome data were collected on approximately 44,000 clients entering federally-funded treatment programs. During the first two years, the predominant modalities that were funded were methadone maintenance and methadone detoxification. Few nonaddicts received treatment. During the next two years, in response to a changing legislative mandate, additional treatment units were funded, and their treatment services were directed to nonaddicts. This trend has continued to the present time.

In 1975, it became apparent that a followup study would be necessary to determine treatment effectiveness during the years in which the Federal Government had initially expanded its role in providing treatment services for drug abusers. A sample of clients being admitted to treatment during the years 1969-1972 was developed. This random stratified sample was interviewed during the years 1975-1977, on the average, 4 years after their admission to the DARP treatment experience. These clients had, by and large, long histories of opioid abuse, criminal activities, and lacked employment, and often even basic socialization skills--reading, writing, and simple arithmetic.

The attached 3-year post-DARP outcome by performance criteria is presented. The sample is 2938. The treatment outcome is divided into four outcome levels of performance: favorable, moderately favorable, moderately unfavorable, and unfavorable. Each outcome level is subdivided to be more responsive to inquiries about the relative level of performance on each of five outcome variables: opioid use, nonopioid use, employment, criminal activity (arrests and time in jail), and readmission to drug abuse treatment.

A conservative answer to the question of treatment success would be answered by only those clients performing at the Outcome Level 1--Favorable--31.7 percent. However, it would be more realistic and operationally meaningful to include Outcome Levels 1 and 2. This overall criteria would then include more than half of all clients (53.4 percent).

Question: Does your response mean that you now know why treatment worked for one abuser, or perhaps what you need to do differently so that the other 75-80 percent of the abusers complete treatment?

Answer: Completion of treatment is defined by the program providing the service. It does not necessarily reflect the practical success or failure of services provided to a given client. A client may terminate treatment, drop out because it is interfering with a new job. Is this a treatment failure, or is it a success? The operational categories of outcome variables provided on the accompanying tables may assist in the reader's development of his or her own criteria for success or failure. Even returning to treatment, recidivism to treatment may not be considered a treatment failure, when the client returns to treatment instead of committing criminal activities and while maintaining his or her employment and constructive role in the community.

Profiles of clients with specific outcome criteria can be developed. The third page of the attachments to this series of questions has been developed from data on 1923 black and white males admitted to treatment in federally-funded drug abuse treatment programs during the years 1969-1972. The outcome has been compared by the types of modality/environments in which they have received their treatment. This table gives the appearance of detoxification not being of any practical value. It appears that the clients who detoxify are no different from those who receive Intake Only, which is to say, no treatment. This is not the case. These clients are different. They are chronic abusers of opioids, usually heroin. They differ from intake-only clients with regard to their drug abuse utilization patterns, their criminal behavior, and their productive activities (employment) histories. Detoxification is a public health measure. It was never designed or intended to be a definitive treatment for heroin abuse. A heroin abuser spends several years developing a lifestyle that is based on the procurement and consumption of opioids. It would be foolhardy to surmise that a brief detoxification lasting 21 days could alter a person's entire lifestyle. A diabetic may learn to take the appropriate amount of insulin that is needed to control his disease, but that does not mean after 2 or 3 weeks the diabetic is cured or will never have to consult a physician again. The same applies to the drug abuser. Several experiences have to demonstrate to the client that prolonged treatment will lead to a more comfortable and productive lifestyle. Detoxification provides an introduction to longer-term treatment modalities and provides a short-term control that permits a drug abuser with a heavy addictive habit to survive until he is ready to seek alternative and more definitive treatment.

Question: Please bring us up to date on the nationwide evaluation research efforts which Texas Christian University handles on your behalf.

Answer: As noted in the above questions, and on the attached data summary sheets, treatment does appear to provide substantial relief to the drug abuser and to the community in which he or she resides. The drug abuser often requires multiple treatment episodes to learn to develop alternative lifestyles, but the pattern of improvement exists for almost all but the most hardened addict. The average death rate for drug abusers using heroin daily is approximately 1.3% per year. Thus, of 100 heroin addicts who have continuously used their drugs for a period of six years, only 92 will remain.

Question: Since the University's evaluation research concluded that drug-free treatment was not effective for heroin abusers, have you made any change in your admission policies?

Answer: It appears that drug-free outpatient treatment is not less effective for nonopiod abusers. However, heroin abusers usually will have an episode or two of drug-free outpatient treatment before they are able to convince themselves that they are more appropriately treated in another environment or modality. Currently, the treatment programs can develop profiles, similar to those developed by the DARP system. However, in the final analysis, it is the client who determines: (1) whether or not he or she wants treatment, (2) will remain in treatment, and (3) the type of treatment they wish to receive. Often clients have heard street rumors about a given treatment program and its regimen. It then becomes necessary for the drug abuser to determine whether or not the folklore applies to himself or herself. Clients often have to develop some treatment experience and personal awareness before an episode appears to yield satisfactory results.

Most treatment programs strongly suggest that the regular heroin user seek treatment in methadone detoxification and then methadone maintenance treatment programs. However, they can not refuse to provide the severe heroin abuser with drug-free outpatient services if that individual insists.

Drug-free outpatient slots are primarily occupied by clients whose primary drug problem is nonopioid. These clients do well in this modality. They are, by definition, not eligible to receive treatment in methadone treatment programs. (TAB D)

Question: In a study published by NIDA covering treatment given in New York City and Washington, D.C., the conclusion was reached that those who were treated for 1 year had no better outcomes than those that were treated for 1 day. Can you comment on the validity of such a conclusion?

Answer: As is pointed out by the authors in the report of those studies issued by NIDA, there are several factors that help to explain findings from the New York and Washington studies. On the one hand, it must be recognized that the "non-treatment" group was considered as such for the convenience of the study only. Significant numbers of those clients became invested in treatment after the specific time of admission under study here and before the time that the followup interview was conducted. Thus, 42 percent of clients in the New York program and 20 percent of clients in the Washington program became invested in treatment prior to followup interview. Consequently, the designation of that body of persons as involved in a single day of treatment only is obviously suspect.

Moreover, it seems reasonable to posit that those individuals who volunteer for treatment, but elect after exploration of the treatment facility not to enlist in that treatment regimen, differ in some significant ways from individuals who do choose to maintain an association with program. Thus, one is led to believe that these individuals do not represent typical program admissions. More pointedly, there is no reason to assume that, because individuals do not enter treatment programs, they are any less determined to achieve personal change. It seems equally fair to assume only that these individuals have made decision to seek such change through means other than the formal drug abuse treatment program. In this configuration, the person sufficiently motivated to present him or herself to the treatment program is deemed still interested in seeking personal change, but has rejected the treatment program as the only or necessary agent of such change.

Finally, it should be noted that major studies conducted by Sells, et al., by DeLeon and Andrews, by Stimmel, by Dole and Joseph, etc., have found length of time in treatment positively related to treatment outcome.

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Question: Will the current study, the Treatment Outcome Prospective Study, reach a clear-cut understanding of why treatment works for some people?

Answer: The Treatment Outcome Prospective Study (TOPS) and its Intreatment and Followup Phases, is designed to examine what happens to clients over time. It provides a natural history of the life of drug abusers. This is especially important if one is to address the methodologic problems that appear to arise when one's initial data point is the immediate pre-treatment performance. Longer pretreatment data collection periods, and serial time periods during and subsequent to treatment will provide a more meaningful assessment of what it is that occurs prior to treatment that facilitates or impedes a client seeking treatment, and what happens as a result of treatment. Serial post-treatment interviews will provide a data base for time/trend analysis. This analysis will permit the development of more refined profiles of which type of client does well receiving what types of services. However, this type of analysis is a statistical model, which may not be applicable for a given individual.

Question: You have submitted a request for FY 1980 which cuts demonstration monies very significantly. In fact, in the area of demonstration, the FY 1978 money was $11 million, the FY 1979 money was $7 million, and the FY 1980 request is $3.7 million. Please explain why?

Answer: The actual amount of funds obligated in FY 1978 for demonstration projects amounted to $10.1 million. The current estimate for FY 1979 is $7.0 million, and the budget request for FY 1980 is $3.7 million.

During the above period of time the budget for drug abuse community project grants and contracts has remained level at $161.0 million. The demonstration program shares this sub-budget activity with treatment service projects, research treatment projects, treatment support projects, and prevention. In order to maintain direct Federal support of a nationwide treatment network of approximately 95,000 slots, it is necessary to budget for and fund an inflationary increase of about 5 percent in the total cost of a treatment slot each fiscal year. Constrained by the level budgets for this total sub-budget activity during the FY 1978-80 time frame, it has been necessary to reduce the funding for all other categories of projects in order to maintain the nationwide treatment network at a stable level.

Question: Are you saying that, without a budget increase, it is NIDA's judgment that the 100,000 nationwide treatment slot system should stay static at the expense of future demonstration projects:

Answer: Yes, the maintenance of a static treatment network has the highest priority of programs within this sub-budget activity. This is not to say that we do not place a high value on the other programs. However, given the choice between providing for the immediate need of an addict on the street for treatment assistance and developing and testing, for example, a vocational rehabilitation model, the decision has been to fund the program with the most immediate impact. All the programs are needed, it is a matter of how much can be done within limited resources.

Question: Why are the DARP evaluation studies funded from demonstration monies, and the TOPS evaluation studies funded from research monies?

Answer: The Drug Abuse Reporting Program (DARP) was originally conceived of as a survey to be used in analyzing the effectiveness of NIDA supported treatment programs in order to permit the Institute to design and test, in a limited environment, those elements of treatment which seemed best suited to effective management of drug abuse problems in specific populations. The DARP evaluation studies were begun at a time when the responsibility for such design and testing rested primarily with NIDA's Demonstration Branch, therefore, funding and management of DRAP was provided by that unit.

Since DARP's inception, however, this form of treatment effectiveness has shifted to a broader research context hence the location of TOPS in the Research Division. The Institute has considered transferring the DARP evaluation project to its Division of Research. However, as the funding of the project will terminate at the end of this fiscal year, it is impracticable to transfer responsibility for this project at this time. As the Demonstration Branch works closely with those units of the Division of Research which are involved in the development and use of research treatment evaluation tools, including TOPS, a cohesive integration of these activities has been assured.

Question: About how much is allocated to each (DARP and TOPS) for FY 1979 and FY 1980?

Answer: In FY 1979, DARP is expected to receive $224,000 in funding which will complete this project. Therefore, there is no projected funding for DARP in FY 1980. It is estimated that TOPS will receive $2,500,000 in FY 1979 funding which is sufficient to support this project through FY 1980. Likewise, there is no projected funding for TOPS in FY 1980.

Question: We learned that two NIDA manuals covering the subject of self-evaluation have had, at best, mixed reaction from the States' providers. NIDA has a (sic) MBO to learn, through a contract, what has been the reception in the field. Is such a followup procedure routinely done by NIDA? What is the estimated cost of this followup effort?

Answer: The MBO referred to, and the contract in association with that MBO, have as only one relatively small portion of them, the exploration of the reception and use in the drug abuse field of the two NIDA evaluative manuals. The core of both the MBO and the study is an investigation of the extent to which evaluation is conducted and of the evaluative process as seen in a large random sample of drug abuse treatment programs (N=500). In addition, study will focus on the tools of evaluation, the process whereby results of evaluation are communicated, the use to which evaluation is put, and the impact of evaluation on program planning and conduct in a subsample of 30 exemplary drug abuse programs. As a portion of that total study, effort will be made to understand the extent to which the NIDA self-help evaluative monographs are known and are used to support evaluative efforts within the drug abuse treatment field.

Since its inception, NIDA has placed hugh emphasis on the use to which program evaluation can and should be put in planning for improved service delivery to clients. This represents the first major effort by NIDA to understand the extent to which the evaluative process is, in fact, carried out and the way in which it is carried out. The contract to explore the 500 programs with regard to a variety of evaluative issues has a cost of $70,773.

It might be noted that this study is being undertaken by the Division of Resource Development acting in conjunction with staff of the Division of Community Assistance. It might be further noted that the Division of Resource Development does, in fact, have as a part of its policy the evaluation of use and impact of the publications it issues.

Question: Does NIDA believe that its funding ceiling for providers is adequate to permit the providers to pay for the resources necessary to implement the self-evaluation manuals?

Answer: Yes, NIDA feels that its funding ceiling is adequate to permit paying for the resources necessary to implement the self evaluation manuals. If adequate client records are being maintained only very limited additional time is required to implement the manuals at an elementary level and even fully implementing the manual could probably be done with less than 8 hours of secretarial time per month per hundred clients. The major problem in implementing these manuals is obtaining the complete commitment of the program management to initiate these or other self evaluation procedures and to use the results of the evaluations for program management purposes.

Question: Does NIDA have a written policy calling for a cost benefits study of new approaches and ideas it wishes to have the States and the providers implement?

Answer: NIDA is currently assessing alternative methods for funding drug treatment services. Each alternative funding method will have both strengths and weaknesses, and there is no "perfect" method of funding. It is important that the alternatives which are developed and assessed not diminish the aspects of the present funding method that contribute to the Institute objectives in terms of stability of funding and continuity of the nationwide treatment services network. It is also essential that modifications or enhancements to the NIDA funding method be practical to implement at the Federal, State, and treatment program level while taking into account and addressing the concerns identified with the current funding method. In this way, this assessment is, in essence, a cost benefit study.

The product, the funding method selected, will be established through an Institute administrative policy statement.

National Institute on Drug Abuse Response to
Testimony General Accounting Office Presented
to the Subcommittee on Alcoholism and Drug Abuse,
Committee on Human Resources, United States Senate,
by Gregory J. Ahart, Director, Human Resources Division

The General Accounting Office presented preliminary findings based on the review of the drug abuse treatment system administered by the National Institute on Drug Abuse (NIDA). In their view the slot cost method of reimbursement may contribute to:

- o unused capacity in treatment programs
- o inflation of reported treatment utilization rates
- o low levels of treatment provided to some abusers
- o funding levels that do not reflect actual costs of treatment.

The testimony concluded that standards for controlling the design and operation of drug abuse treatment programs should be clarified and upgraded, and that plans for States to establish standards should move more rapidly.

I. SLOT COST

Funding of drug abuse treatment programs may contribute to creating unused treatment capacity. We concur that more drug abusers could be served within the existing treatment system. However, our method of funding allows us to establish, monitor, and take appropriate action concerning utilization rates. Rather than contributing to the problem of unused treatment capacity, it has allowed us to increase and maintain a higher level of utilization than ever existed prior to our establishment of the Institute. To that end, NIDA reviews the utilization of its funded treatment programs on a quarterly basis, and works with programs which are underutilized in order to increase their capacity to serve individuals in need.

Where programs are unable to maintain an 85 percent utilization target figure, the Institute adjusts the total treatment slots contributing to the program's funding. This underutilized capacity is then made available to other programs where the need for additional treatment slots has been exhibited.

Treatment utilization varies within and between programs over time. The health service delivery field generally considers an 80-85 percent utilization rate as an indicator of "full" utilization. This Institute is perhaps unique in requiring that programs exceed such a standard of performance.

II. INFLATION OF REPORTED TREATMENT UTILIZATION RATES

We do not believe that NIDA's method of funding contributes to the inflation of reported treatment utilization rates any more than any other method of funding contributes to a program's attempt to put itself in the most favorable light. This does not mean that the situation of inflated reporting is one which is accepted by, or acceptable to, NIDA. However, this phenomenon is not unique to, or inherent in, the Institute, or to its funding methods.

In the testimony, GAO states that while the problem remains, they are cognizant of several steps taken by NIDA to upgrade the quality of the data reported. NIDA continues to work toward resolution of this problem to the greatest extent possible. However, no agency is in a position to totally eradicate a situation which is endemic to the entire services delivery field.

NIDA is progressing with its plans to improve and refine our quarterly review system so that computer generated utilization reports are produced at the grant/contract and program/management levels on a monthly basis. These reports will then be used as a part of the quarterly program reviews. Completion of this project is scheduled for 1979.

NIDA Project Officers are responsible for monitoring program compliance with contract/grant requirements, including utilization. However, only a small number of clinics can be visited by the Project Officers due to limited manpower and the large number of clinics funded. In the case of the Statewide Services Contract, the prime contractor is the entity which has the major monitoring responsibility. This reduces but does not eliminate the need for Project Officer monitoring. The Project Officers' monitoring of programs and clinics is primarily to verify the work of the contractor.

NIDA's Division of Community Assistance is currently developing additional guidance for Project Officers as to the frequency of monitoring programs and clinics, and as to the procedures to be used for such monitoring. These are examples of actions which NIDA has taken, and which we will continue to take, in order to minimize the problem of inflated reporting.

III. LOW LEVELS OF TREATMENT PROVIDED TO SOME ABUSERS

We do not agree that low levels of treatment are provided to some abusers. Interviews with treatment program staff and clients have let us know that adequate services are being provided. What has been a problem in the past is that clinic records do not always reflect the full scope of services provided; we are assisting in making improvements in the record keeping area.

The Federal funding criteria require that in addition to drug abuse treatment sources that a client receive individual, group or family counseling therapy and other support services; such as education, job training and employment counseling as well as social services such as housing, financial and legal assistance. The provision of these services, which can be obtained by referral to other programs, is monitored by State drug abuse agency staff and the NIDA program development specialists.

The Institute has already begun an examination and assessment of the current funding method, variations in this funding method, and new funding methods. By September 30, 1981, NIDA will have examined and assessed possible variations of the existing treatment slot system and other possible funding systems, including the field testing of some of the major alternative methods.

IV. FUNDING LEVELS WHICH DO NOT REFLECT ACTUAL COSTS OF TREATMENT

NIDA recognizes that the slot ceilings are lower than the actual costs incurred by treatment programs and, indeed, NIDA does not have the financial ability to support the total costs of drug treatment services. The Institute must operate within the limits of its budget to maintain a nationwide level of treatment slots.

In order to reduce the impact of inflation on the ability of drug treatment programs to provide services, our Institute has requested and been successful, and will continue to request, that HEW permit the inclusion of an inflationary increase in NIDA's budget. NIDA has also recognized the difficulties programs may encounter in obtaining funds to meet the gradual year-by-year reduction in the Federal share matching funds and has established a floor level for the Federal share at 60 percent. We will also continue to work to gain acceptance of drug abuse as a chronic disorder with legitimacy in the general health care system as exemplified through coverage by third party payors.

It has never, though, been the intent of the Federal Government to provide for the total cost of treatment services. This is a joint responsibility of Federal, State, and local governments as well as of the treatment programs throughout the country. In our examination and analysis of possible variations of the existing treatment slot system, and other possible funding systems, we are looking at the feasibility (within the existing budgetary and slot limitations) of more closely tying funding into the treatment service regimen provided clients.

V. THE NEED FOR CLARIFICATION AND UPGRADING OF NIDA's STANDARDS FOR CONTROLLING THE DESIGN AND OPERATION OF TREATMENT PROGRAMS

Several actions undertaken by NIDA during the period of the GAO review have impacted on the treatment standards issue. We have revised contractual requirements contained in NIDA's Statewide Services Contracts. In February 1979 we wrote treatment program directors encouraging and spelling out procedures necessary for Joint Commission on Accreditation of Hospitals accreditation.

In our February 19, 1979, letter to Program Directors, NIDA extended its policy of accepting State standards for the certification or licensure of drug abuse treatment and rehabilitation programs--which are substantially consistent with the Federal Funding Criteria--for use in lieu of the Federal Funding Criteria to programs which have received Joint Commission on Accreditation of Hospitals accreditation. Where Joint Commission on Accreditation of Hospitals accreditation has been received, the accredited program may have the Joint Commission on Accreditation of Hospitals standards substituted for the Federal Funding Criteria. In this letter we also encouraged programs to obtain Joint Commission on Accreditation of Hospitals accreditation and pointed out that the cost of the accreditation process is allowable under NIDA's treatment services grants and contracts.

With the existence of the Joint Commission on Accreditation of Hospitals accreditation standards, and the various State treatment standards, we do not believe that it is appropriate, at this time, to reconstruct the Federal Funding Criteria (which are minimal treatment standards) and thereby superimpose still another set of standards on the treatment field. Rather, we may be able to exert the necessary level of control over the operation of treatment programs through methods which are associated with the funding mechanism used by NIDA. In essence, an increase in the specificity of the items which we will reimburse will lead to a similar effect as that of increasing the minimal requirements of the Federal Funding Criteria. This is being examined in our ongoing evaluation and analysis of alternate funding methods.

VI. NIDA'S PLANS FOR STATES TO ESTABLISH STANDARDS

The crux of this problem lies in the fact that P.L. 94-63 repealed the requirement which was established in P.L. 92-255, that States develop and implement licensing and accreditation procedures. NIDA has encouraged (and assisted) States to develop treatment standards. To this end, NIDA has told State authorities that their standards will be accepted in lieu of the Federal Funding Criteria if they are substantially consistent with them. Since it is not mandatory, all we can do is to continue to encourage and assist States to move toward this goal.

CORRECTIONS TO THE TESTIMONY

There were a few misleading statements contained in the testimony. On page 6 of the testimony we find "Based on criteria and legislation, NIDA's share can range from 90 percent to 60 percent." Our legislative base does not spell out the matching rate, this matching rate has been administratively established.

On page 8 of the testimony we find the statement that "There is no incentive for a program to increase its utilization rate because NIDA customarily pays for its full share of slot costs regardless of a program's utilization rate." We find this a misleading statement, as NIDA will reduce the number of slots allotted to a program if their utilization falls below the 85 percent target figure. It is true to the extent that a treatment slot is considered utilized if there is at least one face-to-face client-counselor contact per month. Currently, there is no differentiation in funding based upon the extent of the utilization of services within a treatment slot.

On page 14 of the testimony we find the statement that ". . . they (NIDA) do not plan to change the funding mechanism." NIDA is examining and analyzing its current funding mechanism.

CONCLUSION

The General Accounting Office statement presents problems of which we have been aware, and on which we have been working. We would like to point out that some of the testimony indicates the need for our change in some areas over which NIDA has no control, (additional treatment dollars) and in some areas which are not completely resolvable (inflated reporting). NIDA has been working on these problems and we will continue to exert an active leadership role in concert and in partnership with State and local governments, and with the programs.

We have developed management and reporting systems for treatment programs and provided oversight and technical assistance to maximize the effectiveness of these programs.

That we can and should go further is recognized and understood. However, we have established what is perhaps a unique monitoring and reporting system for health programs, which enables us to identify and work on various problems. We have developed a system of drug abuse treatment resources, in concert with State and local governments, to meet a social need. We have tried to be very self-conscious about our own behavior in setting up this system, to spot inaccuracies and difficulties. The testimony of GAO confirms our ability to spot problems. We thank GAO for its time and energy and its input, and we will continue to work hard to correct the deficiencies which have been identified.

NATIONAL INSTITUTE ON DRUG ABUSE
MANAGEMENT BY OBJECTIVE PROGRAM
Fiscal Year 1979

Revised 1-30-79

OBJECTIVE DCA 11:

BY SEPTEMBER 30, 1981, ASSESS THE ADVANTAGES AND DISADVANTAGES OF THE "TREATMENT SLOT" CONCEPT AS THE BASIS FOR FUNDING TREATMENT PROGRAMS IN COMPARISON TO ALTERNATIVE FUNDING MECHANISMS. CONDUCT STUDY, INCLUDING FIELD TESTING ALTERNATIVE METHOD(S) IN SELECTED STATES, ANALYZE DATA, AND MADE FINAL DETERMINATION IF NEW MECHANISM WILL BE USED, AND IMPLEMENT DECISION.

DESCRIPTION:

Since its inception, the Division of Community Assistance (DCA) has used the "treatment slot" concept to fund treatment programs. As with any mechanism, certain weaknesses, as well as strengths, have been detected during its use. The present study is designed to determine the relative effectiveness of this mechanism versus possible alternative funding strategies.

MEASURE(S):

A. Define alternative mechanisms available and establish criteria for evaluation.

B. Collect information on, and field test some, alternative mechanisms in selected States, collect baseline information and collect and analyze new data on alternative funding strategies.

C. Make determination if new mechanism will be used.

PARTICIPATING FEDERAL AGENCIES:

- Department of Health, Education, and Welfare
  - Alcohol, Drug Abuse, and Mental Health Administration
    - National Institute on Drug Abuse

OBJECTIVE: DCA 11

BY SEPTEMBER 30, 1981, ASSESS THE ADVANTAGES AND DISADVANTAGES OF THE "TREATMENT SLOT" CONCEPT AS THE BASIS FOR FUNDING TREATMENT PROGRAMS IN COMPARISON TO ALTERNATIVE FUNDING MECHANISMS. CONDUCT STUDY, INCLUDING FIELD TESTING ALTERNATIVE METHOD(S) IN SELECTED STATES, ANALYZE DATA, AND MAKE FINAL DETERMINATION IF NEW MECHANISM WILL BE USED, AND IMPLEMENT DECISION.

NATIONAL INSTITUTE ON DRUG ABUSE
OBJECTIVE AND OPERATING PLAN
FISCAL YEAR: 1979

Revised 1-30-79

ORGANIZATION: Division of Community Assistance

PROJECT OFFICER: Mr. Erwin S. Bloom

MILESTONES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
I. ASSESS "TREATMENT SLOT" CONCEPT OF FUNDING TREATMENT PROGRAMS AND INITIATE STUDY OF ALTERNATIVES.												
A. Review Existing Funding Mechanisms.					△							
B. Define Alternatives and Initiate Study.					△							
1. Establish Criteria for Evaluation.						△						
2. Select Alternatives for Further Analysis and and Field Testing.						△						
3. Establish Information Requirements.						△						
4. Collect Information about Alternatives Currently in Operation.									△			
5. Review Proposals and Select States for Test of New Mechanism(s).												△
6. Establish State Field Test Implementation Plans.												△
II. CONDUCT STUDY OF OTHER FUNDING METHOD(S).												

ADAM 615-1

OBJECTIVE: DCA 11

NATIONAL INSTITUTE ON DRUG ABUSE
OBJECTIVE AND OPERATING PLAN
FISCAL YEAR: 1979

Revised 1-30-79

MILESTONES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
A. Field Test.												
1. Collect Baseline Data - September-October 1979.												
2. Implement Alternative System(s) in Selected States - September-November 1979.												
3. Collect Field Test Data - April-May 1980.												
4. Review and Analysis of Data - May-June 1980.												
III. DECISION ON USE OF ALTERNATE FUNDING MECHANISM - July 1980.												
IV. IMPLEMENTATION OF ALTERNATE FUNDING MECHANISM PHASE-IN - October-September 1980-1981.												

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE ON DRUG ABUSE
5600 ROCKVILLE PIKE
ROCKVILLE, MARYLAND 20852
AREA CODE 202 TEL 655 4000

July 25, 1975

Dear Program Director:

As you know, NIDA's FY 1976 treatment and rehabilitation budget is a maintenance level budget. There are no monies for new projects and no monies to expand existing projects, and it will be necessary to raise the non-Federal match just to carry on our existing commitments and on-going programs. Under these circumstances we will attempt to maintain the same level of funded treatment slots as was supported in FY 75. This, combined with the effect of inflation on the cost of providing services, makes it imperative that every program examine and maximize its cost-effectiveness in order to maintain the quality and quantity of services delivered. The very limited NIDA treatment and rehabilitation funds must be targeted exclusively on those seriously drug-dependent individuals whose needs cannot be effectively met in other health and prevention programs.

I ask that you take a particularly close look at two areas within your programs. The first area is that of inpatient detoxification. Generally, opiate detoxification can be accomplished on an outpatient basis or in a residential program. If inpatient (by which we mean in hospital) beds are being used for opiate detoxification, the practice should be seriously questioned in most circumstances. There is no evidence to demonstrate that inpatient detoxification is more effective than outpatient detoxification or residential detoxification in helping the patient maintain a drug-free state after detoxification. However, inpatient detoxification is considerably more expensive.

In regard to the circumstances under which the inpatient (or hospital) detoxification setting should be the setting of choice, the following points should be kept in mind. All barbiturate-dependent individuals (i.e., individuals using more than 400 m.g. of pentobarbital or its equivalent daily) may experience life-threatening complications (especially seizures) if they are not carefully detoxified. Currently, most physicians prefer to detoxify barbiturate-dependent patients within an inpatient (hospital) environment. Also, those poly-drug- (including opiate-) dependent individuals whose medical, surgical, psychiatric,

or obstetrical status requires that they be hospitalized for detoxification should be considered for inpatient admission. The admitting physician is required to document such need for hospitalization in the patient's charts. In cases other than those above, however, outpatient detoxification should be used.

The second area of concern is that of the treatment of individuals whose primary drug of abuse is marihuana. (Individuals who use any drug, including marihuana, should be occupying a treatment slot only if their compulsive use of the drug(s) has resulted in their physio-biological dependence on the drug(s) and/or has assumed a central and negative role in their life style and coping mechanisms.) It is these clients who are most likely to suffer the most severe adverse personal and social consequences as a result of their drug use. Individuals who do not use drug(s), e.g. marihuana, in this compulsive and destructive manner could more appropriately receive alternative services in other components of the traditional health care or prevention systems, e.g. educational-informational or mental health programs.

While the above issues need to be stressed in your self-evaluations, they represent only two, albeit major, areas where cost-effective adjustments can be made. I urge a thorough review of all program practices so that together we may maintain a nationwide network of drug treatment programs of which we can be proud.

I hope you will let me know what you think of these issues. I will particularly welcome other suggestions for how we can more effectively use our limited treatment resources.

Sincerely yours,

Robert L. DuPont, M.D.
Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE ON DRUG ABUSE
5600 FISHERS LANE
ROCKVILLE, MARYLAND 20857
AREA CODE 202 TEL: 443-6500

November 25, 1977

Dear Program Director:

I have been advised that questions are being raised on whether Institute funding can be used to treat casual, recreational drug users who are not likely to suffer adverse personal and social consequences as a result of their drug use.

This issue came about during a discussion on the treatment of non-opiate abusers at the ADAMHA State and Territorial Conference held in Washington, D.C., November 15-16. Robert L. DuPont, M.D., Director of the National Institute on Drug Abuse, assured the State directors that the Institute supports treatment of non-opiate abusers and pointed out that around 40 percent of our CODAP admissions fall within this category.

However, this statement should not be interpreted as a change in our policy on who should occupy Institute funded treatment slots. Our policy in this regard continues to be the same as articulated in Dr. DuPont's letter of July 25, 1975, which specifically states that:

> "Individuals who use any drug, including marihuana, should be occupying a treatment slot only if their compulsive use of the drug(s) has resulted in their physio-biological dependence on the drug(s) and/or has assumed a central and negative role in their life style and coping mechanisms."

I hope this will serve to clarify any misunderstanding which may exist on this issue. If you have any further questions, please let me know.

Sincerely yours,

Robert J. Roberton
Director
Division of Community Assistance

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE ON DRUG ABUSE
5600 FISHERS LANE
ROCKVILLE, MARYLAND 20857
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February 17, 1978

Dear Program Director:

I am writing to clarify the National Institute on Drug Abuse's (NIDA's) policy regarding admission of drug abusers to Institute-funded drug treatment programs under Section 410 of Public Law 92-255. It has been, and it continues to be, NIDA policy that Institute-funded drug treatment programs admit drug abusers with the greatest clinical need first, on a priority basis. This is in keeping with the White Paper recommendation that agencies in drug abuse treatment give treatment priority to abusers of high risk categories of drugs (i.e., heroin, barbiturates - especially when mixed with other drugs, and amphetamines - particularly when administered intravenously), and to compulsive users of drugs of any kind.

Our policy statements on this topic (i.e., Dr. DuPont's letter of July 25, 1975, and my letter of November 25, 1977, to Program Directors) are not intended to serve as definitions of drug abuse. They set forth a subset of drug abusers who should be receiving treatment priority, and on whom our programs should first focus. This subset, drug abusers whose compulsive use of a drug(s) has resulted in their physiobiological dependence on the drug(s) and/or has assumed a central and negative role in their life style and coping mechanisms, is one for whom treatment certainly should be available on a priority basis.

NIDA-funded drug treatment programs may be addressing other types of drug abusers, but they must first be focusing on those individuals with the most pressing clinical need and

ensuring that they receive treatment priority. The programs may then focus on those with the next highest level of clinical need, and so forth. However, casual, recreational drug users should be in alternative services and not in a drug treatment slot.

Sincerely yours,

Robert J. Roberton

Robert J. Roberton
Director
Division of Community Assistance

THREE-YEAR POST-DRUG ABUSE REPORTING PROGRAM (DARP) OUTCOME BY PERFORMANCE CRITERIA
(A 2938 Sample from 1969-1972 Admissions)

PROFILE DESCRIPTION

OUTCOME LEVEL I - FAVORABLE (31.7%)

(15.0%) Opioid and nonopioid abstinence
High level of employment, no arrests and no days in jail
No subsequent drug abuse treatment

(11.3%) Opioid and nonopioid abstinence
High level of unemployment, minimal criminal activity
No subsequent drug abuse treatment

(5.4%) Opioid and nonopioid abstinence
High level of employment, no arrests and no days in jail
100% readmission rate to drug abuse treatment programs

OUTCOME LEVEL II - MODERATELY FAVORABLE (21.7%)

(9.5%) Opioid abstinence with moderate-high nonopioid use
Moderate-high unemployment, moderate criminal activity
Moderate readmission rate to drug abuse treatment programs

(12.2%) Moderate opioid use, no nonopioid use
High unemployment, no arrests and no days in jail
100% readmission rate to drug abuse treatment programs

OUTCOME LEVEL III - MODERATELY UNFAVORABLE (31.5%)

(9.5%) Moderate opioid use, no nonopioid use
Moderate-high unemployment and criminal activity
Moderate readmission rate to drug abuse treatment programs

(8.0%) Moderate-heavy opioid use, no nonopioid use
Moderate-high unemployment, moderate criminal activity
Moderate readmission rate to drug abuse treatment programs

(14.0%) Moderate opioid and nonopioid use
Moderate-high unemployment, moderate criminal activity
Moderate readmission rate to drug abuse treatment programs

Page 2

OUTCOME LEVEL IV - UNFAVORABLE (15.3%)

(5.8%) Moderate-heavy opioid and nonopioid use
High unemployment, moderate criminal behavior
Moderate readmission rate to drug abuse treatment programs

(4.2%) Moderate-heavy opioid use, moderate nonopioid use
High unemployment and criminal activity
Low readmission rate to drug abuse treatment programs

(5.3%) Heavy opioid use, moderate nonopioid use
High unemployment and criminal behavior
100% readmission rate to drug abuse treatment programs

NOTE: Alcohol consumption patterns were minimal in each of the groups, with the less favorable outcome groups having slightly higher rates of consumption than the more favorable outcome groups.

Percentage Distribution of Treatment Outcome Groups in Four Outcome Levels
Black and White Males (1923 clients Admitted to DARP Treatment Programs
1969 - 1972)

OUTCOME LEVEL	TOTAL*	METHADONE MAINTENANCE	THERAPEUTIC COMMUNITY	DRUG FREE	DETOXIFICATION	INTAKE ONLY
I - FAVORABLE	31.1	29.5	36.9	34.4	19.6	21.0
II - MODERATELY FAVORABLE	20.3	25.6	15.9	19.9	15.6	16.1
III - MODERATELY UNFAVORABLE	32.2	30.8	31.1	31.1	39.3	38.4
IV - UNFAVORABLE	16.4	14.1	16.1	14.6	25.5	24.5
Sample Size	1923	773	613	241	153	143

The Drug Abuse Reporting Program (DARP) Followup Study is a four-year followup study of clients initially entering Federally funded drug abuse treatment programs during the years 1969-1972. The data presented below are based on a sample of 3131 clients (70% are male, 11% are hispanic, 44% black). Measurement points were at admission to treatment, and approximately five years after that particular admission). The sample selected was 4107. Of those not known to be dead (3831), 81% were located and interviewed (3131). Less than 3% of those located refused to be interviewed (119).

The following table summarizes the results of all treatment modalities:

	Percent of sample in two-month period prior to interview at time of:	
Criterion	Admission to Treatment	Four-Year Followup Interview
Daily Opioid Use	74	6
Any Nonopioid Use (Except Marihuana)	56	24
Employment	37	63
Any Illegal Means of Support	47	18
Any Drug Abuse Treatment	(Lifetime) 60	26
Any Time in Jail or Prison	(Lifetime) 68	21

DRUG ABUSE REPORTING PROGRAM (DARP)

	Pre-Treatment (two months prior to treatment)	During Treatment (Performance during average two-month period)	Post DARP* Year 1	Year 2	Year 3	At Four-Year Followup (two months prior to interview)
Daily Opioid Use	74	--	35	26	22	6
Any Nonopioid Use (Except Marihuana)	56	28	39	35	33	24
Employment	37 (64)**	61	66	71	72	63
Any Illegal Means of Support	47	15	N/A	N/A	N/A	18
Any Drug Abuse Treatment	(Lifetime) 50	--	35	34	33	26
Any Time in Jail or Prison	(Lifetime) 68	9	26	27	26	21

* - Based on the highest frequency of use in any one month at risk

** - Any employment in year before treatment

N/A - Not Available

Mr. BESTEMAN. I would like the chairman's permission to very briefly summarize in the record, not now, the efforts that the Institute has been doing, and will continue to be doing in response to the major problems that GAO pointed out.

Senator RIEGLE. That would be very, very helpful to us.

[The prepared statement of Dr. Klerman and the summary statement of Mr. Besteman follow:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

GERALD L. KLERMAN, M.D., ADMINISTRATOR

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

FRIDAY, MARCH 2, 1979

Mr. Chairman and Members of the Subcommittee, I am delighted to be here this morning to present the views of the Department of Health, Education, and Welfare on the extension and amendment of the Drug Abuse Office and Treatment Act of 1972, as amended, for a period of 3 years. I am accompanied by Karst J. Besteman, Acting Director of the National Institute on Drug Abuse (NIDA). I have a brief statement which I will deliver for the record, after which I will be pleased to answer the questions you might have.

General Background

The national cost of drug abuse, estimated in excess of $10 billion, hardly reflects the immeasurable social costs in terms of lives ruined due to poor health, criminal conduct, economic dependence, and incompetence in discharging work and family responsibilities.

In 1972, when drug abuse legislation was enacted at the Federal level an a large scale response mounted, the national drug problem was viewed as the widespread use of heroin by young men in our Nation's urban centers. However, American attitudes about drug use have been radically altered in recent years--reflecting a broader public experience with drugs, a wider range of drugs that are currently abused, and an increased use of drugs by youth, racial and ethnic minorities, women, and the middle class. Recent data indicate, for example:

- The American public has had more experience with marihuana than with any other psychoactive drug. It has been conservatively estimated that 43 million Americans have used the drug at least once and 16 million have used it within the month preceding the survey.

- There is a startling and continuing growth in use of marihuana by youth, particularly the lower end of the age group 12-17 and by young girls, nearly closing the gap in use rates with boys.

- More than 7 million Americans have used PCP. Last year the drug was associated with over 2,795 emergency room visits and at least 85 deaths.

- The use of cocaine is increasing, especially in the group aged 18-25 years. Our last National Survey (1977) reported that 19.1 percent of this age group have used cocaine.

- The nonmedical use of available psychoactive drugs--the sedatives, stimulants, and tranquilizers--whether for euphoria, in suicide attempts, or for self-medication is increasing, particularly among young adults aged 18-25 years. A recent review of one class of these drugs--the barbiturate/sedative hypnotics--indicated that over 3 million persons used the drugs annually outside of medical supervision and that approximately 1,700 deaths were associated with its use in 1976.

- Racial and ethnic minorities are over represented in the drug abuse treatment system as compared to their percent in the total population. According to 1977 statistics, 48 percent of admissions to NIDA-funded treatment programs were racial or ethnic minorities.

- A 1977 survey confirmed increased drug use among female adolescents. Female use of cigarettes, tranquilizers, and stimulants nearly equaled that of males.

- The problem of drug use combined with alcohol use is increasing. The greatest number of emergency room mentions from the Drug Abuse Warning Network (DAWN) occurs for the combination of alcohol and diazepam (Valium^{R}).

Federal Programs

Enactment of the Drug Abuse Office and Treatment Act of 1972 established a national commitment toward addressing the drug abuse problem and stimulated a major investment in drug abuse prevention, treatment, research, and training by Federal and State governments. Federal leadership has been vital in the total effort.

- It has given visibility and accorded priority to our drug abuse problems.

- It has aided in the development of a viable network of single State agencies and a national treatment system that serves 71,236 heroin-addicted persons in community-based programs. These persons represent 44 percent of the clients in federally-funded treatment.

- It has provided the linkages between the drug abuse and criminal justice systems to provide methods for early identification, treatment, and rehabilitation.

- It has established a national manpower and training system to provide drug abuse workers with the knowledge, skill, and sensitivity necessary to delivery quality service to drug abuse clients.

- It has provided a research program of quality that has led to dramatic advances during the last several years including the discovery of opiate receptor sites and endorphins in the human brain. Also, as our capacity has developed scientifically we have been able to dispel widespread myths about drug addiction.

Coordination

Due to the complexity and widespread phenomenon of the national drug abuse problem, it is critical that we continue to coordinate drug abuse policies, resources, and activities. Since the termination of the

Office of Drug Abuse Policy in the White House last April, we have increased the formal and informal coordinating mechanisms. For example, Federal drug abuse officials meet bimonthly to share information and to prevent a division of purpose or fragmentation of effort. The officials include: the Administrator of the Drug Enforcement Administration, the Commandant of the Coast Guard, the Senior Advisor to the Secretary of the State, the Commissioner of Customs, the Special Assistant to the Secretary of HEW for drug abuse issues, and the Director of NIDA. The meetings are held as a result of the leadership of the Associate Director for Drug Policy of the Domestic Policy Staff.

Within the Department, Secretary Califano has designated me to serve as the focal point and coordinator of drug abuse policy. In joint cooperation with his Special Assistant Robert Deitz, we have begun to meet informally with officials from various components of the Department whose programs contain elements which require coordination. I believe that our fruitful exchanges and activities will continue, and will be felt in future policy directions of the Department.

Signs of Progress

In recent years, we have observed important signs of progress in the drug abuse field:

- NIDA estimates a significant drop of 20 percent in heroin addiction since 1975. This represents a decrease from 540,000 to just under 440,000.

- It has encouraged State governments to increase their drug abuse budgets, and through the services contract mechanism to coordinate resources available at State and local levels with Federal funds.

- Heroin deaths have declined from 1,823 in 1976 to 778 in 1977. The reduction in heroin addicts and heroin-related deaths has been attributed to the success of drug abuse treatment, the opium poppy eradication of the Mexican government--a major source of the drug, and increased enforcement efforts which decreased the incidence of heroin smuggling in the United States.

- Heightened public awareness of drug abuse has made us sensitive to the adverse effects of the nonmedical use of drugs. Consequently, broader segments of the population are seeking treatment and professional assistance.

- A network of physicians and statisticians known as the Community Correspondents Group have initially reported to the Institute that greater numbers of women have entered drug abuse treatment programs in the latter half of 1978.

Recent Activities

I would like to describe the Institute's activities very briefly in the following areas--treatment, prevention, research, and training.

Treatment

NIDA-funded drug abuse treatment programs across the Nation serve 161,900 annually. About half of the clients are 25 years or younger at the time of their admission. Over one-half of all clients are white and one-third are black.

Over $518 million in funds were allocated for drug abuse treatment services nationally. The largest providers of treatment funds were State governments contributing $164 million, and NIDA providing $133 million for treatment services and $10 million for treatment support activities. Other sources of funds were third party reimbursements ($74 million), local governments ($58 million), other Federal agencies ($47 million), private contributions ($25 million), and client fees ($18 million). These funds provided for 240,019 budgeted treatment slots and 213,433 clients in treatment as of April 30, 1978.

Over 90 percent of all clients in treatment were being treated in one of three modality/environment combinations: 48 percent in drug free/outpatient; 35 percent in methadone maintenance/outpatient; and 8 percent in drug free/residential.

Prevention

We have adopted a number of complementary primary prevention strategies, including information, education, alternatives, and early intervention. The continuum proceeds to treatment and rehabilitation.

The NIDA program for the coming year emphasizes the development of new knowledge, the dissemination of that knowledge to the field, and technical assistance to communities and States that need help in prevention program development.

Under a new program of support for State prevention coordinators, NIDA will fund either slots in State agencies for prevention coordinators or, where those already exist, will provide prevention support in other designated ways. Thirty-one States have funded a prevention coordinator. In addition, a new NIDA prevention project is the National Prevention Evaluation Resource Network. This network is being developed by NIDA in conjunction with a consortium of States. It will provide States with the prevention evaluation information, technical assistance, and prevention evaluation expertise they need to effectively assess their prevention programs.

Research

There have been dramatic advances during the past several years involving the discovery of opiate receptor sites and endorphins in the human brain. At this point it is difficult to project how extensive and in what specific ways this accelerating area of discovery will impact on our understanding of drug abuse and treatment approaches in the areas of substance abuse.

The endorphin research is one of the most exciting endeavors on the scientific scene today. Three NIDA research grantees were presented with one of the highest honors in the sciences--the Albert Lasker Medical Research Awards. These prestigious awards were given to scientists working under NIDA sponsorship studying the enkephalins, the natural opiate substance produced in the human brain.

A major initiative in the research area this year involves the transfer of NIDA's Addiction Research Center (ARC) from Lexington, Kentucky to a location on the grounds of the Baltimore City Hospital. This move will permit us to resume our studies of the abuse liability of drugs and initiate several major new programs under the auspices of the ARC, including psychosocial laboratory and a neurosciences program.

The extramural investigatory-initiated grant-supported research program has been and continues to be the major focus of our research activity and will continue to receive the majority of our research dollars. The President's Commission on Mental Health and the Administration have recommended significant increases in research funds, which are reflected in this year's budget and in next year's proposed budget.

Training

In the manpower and training area, efforts will be made to ensure that drug abuse workers who meet certification, licensure or credentialing criteria in one State can obtain reciprocal certification in other

States. Special emphasis on NIDA's training efforts are planned for nurse practitioners and physician assistants, training of American Indians and the minority internship program over the next year.

In 1979, NIDA will establish a State criminal justice support pilot project in five States. This effort will provide a criminal justice coordinator for the State drug abuse agency. NIDA continues to provide technical assistance through "Project Connection" encouraging development of new interagency linkage programs and the establishment of a network for informational exchange between the drug abuse and criminal justice agencies at the State level.

NIDA is currently developing a comprehensive training program (as opposed to one course) for all components of the criminal justice system--police, courts, jail, probation, and parole personnel. This year NIDA will study programs which provide successful services and referral to treatment direct from uniformed officers and the local precinct. Since a large number of drug-abusing criminal offenders, mostly property crime offenders, come into frequent contact with police and are not charged but simply released without benefit of treatment, this study of programs may prove invaluable. If these diversion efforts seem feasible and applicable, NIDA plans to follow up with appropriate resource material and training for the police and the drug abuse treatment agencies.

Administration Proposal

The legislative authorities for NIDA were extended in the last Congress for a period of 1 year and terminate on September 30, 1979. We will soon propose a 3 year extension of Section 410 authorities until September 30, 1982. This proposal will strengthen authorities for cooperative agreements for statewide treatment systems. It will focus demonstration and prevention project grants on activities that will improve knowledge and treatment of drug abuse. We will also propose a consolidation of the formula grant authority to the States with separate but similar authorities for alcohol abuse and alcoholism and mental health. The authorization level proposed for this consolidated program is $99 million for FY 1980 and such sums as may be necessary for the following two fiscal years.

By consolidating these programs into a single broader, more flexible authority, we hope to achieve three objectives:

- facilitate a comprehensive approach to the design, planning and management of alcohol, drug abuse, and mental health programs;

- reduce complexity, undesirable duplication and fragmentation of human services programs; and

- increase State and local flexibility in responding to the changing needs of communities.

The Administration is not proposing a separate authority for prevention and demonstration activity. In 1980, the Administration proposes $161 million for drug abuse service activities, of which $152.5 million is for community drug treatment programs and $8.5 million is for prevention and demonstration activities. This reflects the high priority given to treatment programs and its successful evolution from individual project grants to statewide systems. It also reflects continued efforts in the areas of prevention and demonstration. In addition, the Administration will again propose repeal of Titles I, II, and IV of the Narcotic Addict Rehabilitation Act of 1966.

Conclusion

We seek to continue, Mr. Chairman, in our efforts to increase public awareness of our national drug abuse problems, to increase the effectiveness of our programs, to coordinate our policies and activities to prevent waste and fragmentation, and to stimulate greater interest and participation in the public and private sectors. Our testimony reflects the Administration's commitment. We look forward to working with you and other Members of Congress in this vital undertaking.

Mr. BESTEMAN. We have been aware of them, we have studies ongoing, we have some remedial action going on, and I would like that for the record so that we understand the seriousness of some of the items that they have pointed to.

Senator RIEGLE. Very good, I appreciate your patience today. Please understand that the desire here is to figure out how best to work our way forward in these areas. So I think the more we talk and think together, the better the results will be in the end, and I appreciate your testimony.

We will be looking forward to hearing from you soon.

Finally, Mr. George Vaughn, who has arrived, who is the executive director of the Narcotics Addiction Rehabilitation Coordinating Organization in Detroit, Mich. We are pleased to have him here.

Let me welcome you to the committee.

Why do you not pull that microphone up as close to yourself as you can? What I would appreciate your doing, if you have a prepared statement, you can make that a part of the record, but if you can give me some summary thoughts about your feelings in the areas that we have been discussing, that would be very helpful to the subcommittee.

STATEMENT OF GEORGE L. VAUGHN, EXECUTIVE DIRECTOR, NARCOTICS ADDICTION REHABILITATION COORDINATING ORGANIZATION, DETROIT, MICH.

Mr. VAUGHN. In the interest of time, I do have a brief prepared statement, and I will provide that for the record. It is no more than 5 minutes long.

Senator RIEGLE. Why do you not go ahead and deliver it, then?

Mr. VAUGHN. Members, Chairperson, Senator Riegle, our agency appreciates this opportunity to appear before you regarding the issues which we all share concern.

My name is George L. Vaughn, and I am the executive director of NARCO, an acronym for Narcotics Addiction Rehabilitation Coordinating Organization.

NARCO was incorporated in Detroit in 1969, and serves Oakland, Macomb, and Wayne Counties. It is supported by the United Fund Foundation. It is a nonprofit, private health planning and educational agency which serves the three counties. Our agency is governed by a board of directors which is made up of business, industry, labor and education leaders, and substance abuse professionals. Our agency has been working in the drug field for some time and is more than appreciative to accept the invitation to share our observations with you.

There is considerable debate, discussion, disagreement, misconception, and apprehension among drug abuse professionals as to what direction the field should take in providing a diversity of treatment modalities for heroin addiction. The changing incidence and prevalence of heroin addiction, and the human losses obligate the planners and providers, as well as the recipients, to review our past, reexamine our present, and redesign for the future.

Heroin remains a persistent menace. Although one occasionally hears of lower treatment slots, decrease in arrest, lower admission rates, this does not necessarily mean "light at the end of the tunnel" pronouncements. For example, in Wayne County the following is reported from the Wayne County Department of Substance Abuse Services: Example 1. Admissions to heroin treatment programs: 1973, 2,349; 1974, 3,661; 1975, 4,623; 1976, 6,143; 1977, 5,677.

This might appear that the incidence and prevalence is on the decline. However, in 1977, New Detroit Inc., a community, industry and labor coalition, indicated in a report entitled "A New Approach to Address the Heroin Problem," that there are an estimated 30,000 addicts in Wayne County. When the admissions count is compared to this estimate it is astounding. But even if the increase in addiction has, in fact, declined, the ingestion and inhalation of deleterious substances continues at a prodigious rate. Certainly, it causes us to question how effective we have been to educate against or prevent drug abuse.

Senator RIEGLE. You mean it is increasing in terms of the numbers of people, is that what I understand you to say?

Mr. VAUGHN. No; it appears to be decreasing in the numbers of persons since 1976. But with the estimate, 30,000 addicts in the Wayne County area, and with only approximately 5,000 addicts in treatment, the question is, Where are the other 25,000? We know that some of them are employed, and are in treatment programs. But their unemployment rate is estimated at 60 percent.

In the cities alone, and also the counties, the question is, Where are these people?

Senator RIEGLE. So we do not know whether the 30,000 figure has gone down or not? We just know that the number of people coming for treatment has gone down?

Mr. VAUGHN. Certainly. And it suggests that we need greater outreach in trying to find abusers; and it certainly would indicate that if they are not employed, if our estimates are correct, that they must be supporting that habit some way.

The average habit in Detroit approximates now about $25 a day. You can get by at that price.

Senator RIEGLE. That is with heroin?

Mr. VAUGHN. For heroin. When you multiply that $25 a day times 30,000, you are talking about a business as big as General Motors or Ford Motor Co. The purity rate, and I am summarizing at this point, the purity rates from the Detroit Narcotics Unit on the streets today, appear to be a rate of 1 to 3 in Detroit and 1 to 5 in the out-county area, Macomb and Oakland.

Senator RIEGLE. Why do you not take a minute to describe for the record what you mean by that?

Mr. VAUGHN. The pure heroin on a scale of 1 to 10. Ten is top shelf, the quality heroin The lower the number, the lower the purity, and the greater the incidence that it has been mixed with any number of substances that might be dangerous to the body if injected or inhaled.

What we have found is that the purity rate that the user gets, is much lower than the purity rate that the pusher gets. The pusher gets 2 to 3, and sometimes 3 to 4. To increase his profits, he dilutes this heroin and puts it out on the street. So we are talking about a tremendous health hazard, because they are mixing it in with everything, much like marijuana and other substances.

Moreover, we find that—and I am probably reiterating things that others have stated here today—but just for the record, it is much more difficult to withdraw from methadone than it is to withdraw from heroin.

Compared with the low quality of heroin that we find on the street today—from 1 to 3 quality—methadone is 100 percent opiate. The physical dependence is much greater than heroin; therefore, it is found that the persons withdraw from heroin more rapidly than a person on methadone.

Senator RIEGLE. What conclusions has that caused you to reach, as a professional in the field? How would you summarize your own attitude toward methadone maintenance programs?

Mr. VAUGHN. In summary, it would suggest that we are—well, I suppose you would have to talk about why methadone was introduced in the first place. Methadone was introduced to politically contain persons in high crime rate areas, particularly minority persons, by taking them off one drug and maintaining them on another; that we could readily provide them a substance. This it was felt would have an effect on the crime rate, because at that particular time there existed a comparison betwen crime and drugs. That is the political reason why methadone exists. Because methadone is just as physically destructive to the body as heroin, it just seems to me to be commonsense that we need to get away from methadone as a treatment.

It is my professional observation and it is certainly the position of my agency; however, persons who now manage methadone clinics, who are reimbursed through third party payments, or subsidies from the State, or NIDA, et cetera, find that economically not feasible to change from a methadone modality, to try to experiment with another kind of alternative to provide a different kind of strategy or technique for rehabilitation.

So we are talking about providing the treatment for a client, and also talking about the continuing economic existence of an agency. So the commitment to maintain methadone maintenance is as strong. In Detroit, methadone is the principal modality now; however, it seems to be moving away from methadone maintenance, and getting more to other types of alternatives.

Senator RIEGLE. May I ask your thoughts on another point, because we have had relatively better economic situations nationally than Michigan. As you well know, I am sure you have been reading the newspapers, as I have, and there is some evidence that we may be on the verge of a recession. Some economists are predicting that, maybe later this year.

It would be my guess that when recession time comes around, like in Detroit, and metropolitan areas of Detroit, on the whole, the employment picture changes, which causes all kinds of new stresses, and strains. I would think there is probably a very marked parallel increase in the use of drugs, alcohol, what have you.

So I am also wondering, too, in terms of the improvement in numbers that we have seen recently, if that may not be somewhat related to the fact that, you know, opportunities generally have improved in our metropolitan community of Detroit. If we find ourselves back in hard times, I hope we do not, but if we should, we may find ourselves with those numbers changing just for that reason alone.

Mr. VAUGHN. I think so. If I could just dispense with these notes, and just address your questions.

The unemployment rate, as you know, in Detroit, when it is high in the Nation, it is almost double in Detroit, particularly in the Wayne County area. To the degree that persons who are coming out of treatment do not have employment opportunities, to the degree that recession may come, and to the degree that minorities have always been at the low end of the totem pole in terms of job opportunities, suggest that in a period of high unemployment that the stress level created by the loss of income, the head of the household not being able to work, with all of the good old American traditions associated with a person working, that because of these stresses, it would certainly create a greater incidence of drug abuse, and certainly a greater preference of heroin.

I might add that we are finding in Detroit the lifestyle of the addict is changing. There is no longer a person solely addicted to heroin, or a person solely addicted to alcohol. In Detroit, now, the sclerosis deaths on the national scale is one figure, and in Detroit it is double that number. So we are finding alcohol is much greater than the drug abuse. In Detroit, drugs have been the primary target.

But minorities also have alcohol problems. Many domestic squabbles and much of the murder, rape, when we were compared to Atlanta and other big cities, were attributable to domestic problems and alcohol.

Also, a thing that concerns me—being a member of a school board in Detroit—is that since 1961 we have averaged from 8,500 to 9,000 students dropping out of school per year, from grades 9 through 12.

Now, taking this with the unemployment rate, taking this with the availability of drugs, and looking at this in terms of lack of educational achievement, and attainment, and lack of educational opportunities, certainly, it does not paint a very good picture for the future in terms of what are we going to do, in terms of prevention and treatment. But methadone maintenance is certainly not the way to go. It is certainly not the modality to emphasize. We have to have much more moneys allocated in demonstration, experimental programs.

Senator RIEGLE. You know, in Michigan, the State of Michigan divides up its revenue moneys across the State. Is it your view that that is done on a proportionate basis? Does Detroit get the share of

money proportionate to the number of drug addicted persons that are in Detroit, or is there a——

Mr. VAUGHN. I can certainly not represent the city, but I can give an unofficial answer to the record. My own documentation suggests that Detroit has not had the dollars it needs to address the kinds of problems of drug abuse and dependency.

We met with some members of your staff not too long ago. In that meeting, we provided you with some of the information of the kinds of things that are happening—certainly favorable. Detroit is becoming its own regional coordinator in terms of substance abuse programs which might add a different light on the way Detroit approaches the heroin problem.

I am not sure of what the ramifications of that split will be, but it is certainly something that we will need to keep our eyes and ears close to.

But, no; Detroit does not get, in my professional judgment, the kind of dollars that it needs to address the kind of problems that it has.

Senator RIEGLE. Let me ask you this. Your working background is narcotics addiction. You are aware that the administration has made a recommendation to the Congress, that rather than treat the alcoholism programs separately, and drug abuse programs separately, which has been our practice up until now, they want to take the money that has been avilable to States to work on these problems, add mental health to them in one bloc grant. The States would then have to figure out how to spread it among these three competing areas of efforts.

The hooker is the number of dollars for three is roughly going to be the same number of dollars for the two existing ones. So anybody that has been working with the problems of alcoholism or drug abuse can see that by adding mental health, which is a problem in its own right, that they are going to muscle in for some share of that money, which means that the other program areas are going to get less. It has to work out that way. That is what the mathematics tell us, and it has been conceded as such by the administration witnesses.

As a professional in the field, how do you feel about the idea of maybe just combining all these functions? We have come through a long history where we decided to split them apart because they were different. We had Doctor Klerman here, in a precise statement, say that alcoholism does not necessarily bear any relationship to mental disorder, that the two have to be thought of separately.

In any case, how do you feel—how do you react to that notion? Do you think the administration is on the right track here? Would you endorse that position?

Mr. VAUGHN. Well, it is my experience that consolidation is not always the best way to go. Sometimes, after consolidation you find that it sounded good, but in practicality it was a mistake, and I think that much can be lost in the consolidation of these programs under the Department of Mental Health.

Professionally, I think that they ought to remain separate. We are a society that is mostly existing on chemicals. Our chemical dependency is much more than what we realize. The food intake,

and so forth, is all chemicals. But we are talking about alcohol and drugs, we are talking about a changing life style, and changing profile of the alcoholic person and the drug person.

So I think much would be lost if that consolidation takes place. I think they ought to remain distinct. Historically, when problems as distinct as alcohol, drug abuse, and mental health have been under the same umbrella, there was a lot lost, and the impact of each area was certainly not expressed as it should have been, and certainly the problem went long and long unnoticed, and I think to do that again would mean that the kind of thing that we are going to be facing in the future, in terms of alcohol and drugs would begin to get so absorbed that they would become unnoticed.

Senator RIEGLE. You have the advantage of being both involved in drug abuse areas as well as being on the school board, so you have those two together.

Are we doing what we should be doing in the schools to help young people weigh these questions and try to make better decisions to avoid using these things?

Mr. VAUGHN. I would have to say emphatically no. We are trying in the Detroit public school system to begin to look at the curriculum, particularly the health curriculum, to see how we could fuse in prevention, personal life management, to try to offset the incidence of drugs in the schools.

We do not have an adequate system of referral; we do not have an adequate system of detection. Teachers are not trained, the administrators are not trained, and certainly our curriculum does not address, to a great degree, any kind of educational material that would provide more awareness of the student to know what the alternatives are. We have gone through a period where we tried to scare students. We showed them blood and addicts sticking needles in their arms and overdosing, and we showed them moving pictures that have done nothing but glamorize the whole drug scene.

Senator RIEGLE. We get that on television every day. That is part of the commercial fare that we serve up. Kids are immune to it, because they get a steady dose of it. I agree with you I do not think it has the necessary impact, because it seems unreal.

Mr. VAUGHN. And drug dealers have been glamorized.

Senator RIEGLE. You mean in movies and such as that?

Mr. VAUGHN. In life. They drive the big cars. When there is a bust made in Detroit, they tell what the drug dealer had. The reason why they made the bust—diamond-studded dashboards, a safe in the trunk, 500 suits in the closet, $50,000 in cash in the bedroom, $10,000 in cash on himself, three Rolls Royce's in the garage. These are things those kinds of kids dream of.

"Why school?" they ask. "I can go out and sell marijuana, I can go out and sell cocaine." So we are trying to address these kinds of things in the school system, and I think the reluctance to do so has been a lack of awareness of the severity of the problem, and certainly the fear that no one knows really what to do, so that they are afraid to try anything.

Senator RIEGLE. I think that has been a part of our problem. It has been one of the avenues that I think has been open. I think you are right, it has been over glamorized, and I think it has

attracted more people to it, because it is a get-rich-quick strategy for some young people to follow.

Any other observations that you think are important for us to consider at this point?

Mr. VAUGHN. Yes, one. I think I have to really reiterate employment has to be the focal point. There is no mechanism available through NIDA or NIAAA to provide demonstration grants, to assure that a person who comes out of treatment has employment opportunity.

Also, I think we are going to have to really look at the categorical grants. When you have a person coming in who is addicted to two drugs, which slot do you treat him under, and leaving out programs competing after the person. I do not know, I do not have all the answers, but I do know that the drug field has become big business illegally, and also big business legally, and when you talk about big business, you have to talk about competing for the services, and you have to talk about competing to provide the services and to compete for the consumer.

Programs need standards. You might have a program with a high slot rate. Maybe they are giving the person the high milligram of methadone, whereas a program that is giving low dosages of methadone would have a low utlization count. So it is not to say that the low-utilization-count program is a poor program and the high-utilization program is a bad one.

Senator RIEGLE. It is a key point, and I appreciate your stressing it, and that is the kind of thing that this committee—that this subcommittee wants to do a better job of monitoring, in a qualitative sense. The oversight responsibilities that we want to exercise, are going to be much stronger and much more present in terms of the way these programs are carried out and measured, performance measured, cost justified, and so forth, along those lines.

Mr. VAUGHN. One last thing, sir: The cities, as I know, do not have a lot of input into the State plan. It might be that you might want to consider whether or not it would be feasible to have big cities like Detroit, New York, Chicago, receive their moneys directly from NIDA and NIAAA, and whether that relationship should be a direct line, as opposed to going through States.

Senator RIEGLE. How would you make the grade? Would you do it on the size of the community, the size of the client population? How do you decide that Detroit participates, and Flint does not, for example?

Mr. VAUGHN. Well, being from a big city, I think it would be equitable to go by the city's population, and if you had a minimal population for a city then that would be the scale. That would be my recommendation.

I do not know how practical it is.

Senator RIEGLE. Maybe another way to do it is if the States were divvying up the money for drug abuse, on a per addict basis, to make a profile of where the addicts were in a State, and if they found in a given jurisdiction, a city, Detroit, say, that some fraction might be, say 15-percent minimum, 20-percent minimum of addicts are in that area, that what they would do in that case is they would split off that percentage piece of the State's available funds,

turn that over to the city involved, to conduct a program to meet its situation.

Maybe you could set a cutoff percentage that way, 20 percent, 15, 30, whatever. But that might be one way to get at that. Because my hunch is that there probably is some relationship between the size of the city, the stress levels of the city, and that communities like Detroit or Flint, where I come from, that have had more than their share of problems, probably have a disproportionately larger population of people who are drug abusers. That might be one way to get at it.

Mr. VAUGHN. That sounds like a good idea. The only thing that probably, as we look at that idea, that we have to look at very carefully, is whether or not if you establish x dollar rate per addict, whether or not that would be equitable and fair. It might require more support services for an addict who is in a depressed environment than for an addict who is not in a depressed environment, or who comes from one family lifestyle as opposed to another family lifestyle. Lifestyles come to bear on the services that an addict should get, to get him to rehabilitate himself.

So, sometimes those are not equitable.

Senator RIEGLE. You know, the President has proposed in his budget cutting the CETA program substantially. It is going to mean something close to 5,000 jobs for Michigan, and equivalent cuts in other big industrial-type States, with lots of problems like we have in Michigan.

My hunch is, if they knock out close to 5,000 CETA jobs in Michigan, that one of the effects of that is going to be that you are going to have a larger drug addict population to deal with. Not one for one, but just thinking about how the system works in terms of people out of work, competing for what is left of available jobs and what goes with the lack of things that you cited that was so crucial, namely, job opportunities. If that whole picture really gets much worse for us, I have a hunch that what you are going to find is that we are going to be handling a bigger drug problem.

Do you follow us?

Mr. VAUGHN. I think so. I think you have stated it very well.

Senator RIEGLE. Hopefully, when the Congress and the Budget Committee take up the question of these CETA job slots, which are sort of targeted job slots, that these kinds of implications are the ones that will not be forgotten.

Mr. VAUGHN. It was my understanding that the new CETA title 7 for the public center program has not been funded yet, but that one of the targets of that program was supposed to be to develop jobs for the disadvantaged, and if I am not mistaken, that was supposed to come through the National Alliance of Businessman's office.

We are looking at that program as being another avenue, perhaps, to develop job opportunities for rehabilitated addicts. But there are just no job opportunities for them that are meaningful.

We put so much stress on a person's work and type of job.

Senator RIEGLE. Now, let me just ask you one other thing—you have been patient—and it is late in the day: When you say a job that is meaningful, I think I understand what you are saying, but I think it is important for you to define what you mean on the

record. There are always those people who pick up the want ads and will say, here are jobs. What do you mean jobs that are meaningful? Is this what is available? Why does not this person go take this job, and that would be the answer to the problem.

Mr. VAUGHN. I hate to answer that. I am uncomfortable in trying to define what a meaningful job is, and the reason is that our society has put so many labels on so many jobs. We have had reports coming out called the "blue collar blues", with persons working in the automotive industry, but not everybody who works on the line considers their job unmeaningful.

If you tell a person working in an automotive factory, sticking a screw in a hole, makes $7 or $10 an hour, that his job is not a meaningful job, then you are telling him that he is not meaningful. You have to reeducate our whole society.

Because you wear a tie and a shirt does not mean that you have a meaningful job. I know a number of people who work in the automotive factories who carry a briefcase, and wear a suit and tie to work, they take a shower after work is over, and take the briefcase and wear their tie and shirt back home, and the people in the neighborhood think that they have a meaningful job; however, they work on the assembly lines at Ford and General Motors and Chrysler.

So, for a person who is satisfied cleaning stools—I am not saying that that is a degrading kind of job—that job is important. I like to sit on clean stools, and go in clean bathrooms, but if you tell that person this job is not meaningful, then they are going to think that they are not meaningful.

I think in many, many instances we have been cruel to our children. Teachers have stated to children openly, you had better learn English, and you had better learn math and, if you do not, you are going to be digging ditches, or you are going to be a DPW worker—cleaning the streets, and cleaning out sewers. Those people make as much as Congressmen and Senators.

So I do not know what is a meaningful job. It depends on the individual. If he feels some dignity in providing for his family, and some personal worth, then I think he or she has a meaningful job. I think a person has to be realistic in the things that he can attain educationally, and professionally.

Senator RIEGLE. I think that it is tough to sell some—for the reasons you say, it is tough to sell some of those jobs that you just described if there are avenues open to have these custom-made cars with the diamond-studded dashboards by pushing drugs. That obviously makes that whole problem more compelling.

I am delighted to have you here today. We appreciate your coming. Your testimony has been helpful to us.

Mr. VAUGHN. Thank you very much.

[Additional material supplied for the record follows.]

March 2,1979

TESTIMONY OF THE

NATIONAL ASSOCIATION OF PREVENTION PROFESSIONALS

PRESENTED BY FRANK LAMONT

BEFORE THE SENATE SUBCOMMITTEE ON ALCOHOL AND DRUG ABUSE

The National Association of Prevention Professionals (NAPP) shares the view of Dr. Gerald Klerman, Administrator, Alcohol, Drug Abuse & Mental Health Administration that "Now is the time for prevention." We realize, at the same time, that strains on the Federal budget make this a difficult time to convert these sentiments into the dollars which are needed to realize them. Accordingly, we believe that the next few years are critical ones for prevention, years in which it is appropriate to set long range goals and to begin the development of a comprehensive strategy for how prevention services should be delivered,while consolidating present prevention efforts. NAPP is pleased to have this opportunity to present in brief to this committee a framework which we believe is helpful moving towards these objectives and which we hope is helpful to this committee in considering authorizations for Fund Year 1980.

NAPP is an organization founded in 1977 with chapters in 45 states, whose members include individuals working in drug, alcohol, mental health, delinquency, health and other prevention fields. As the interdisciplinary nature of our membership suggests, we view prevention broadly and positively as an effort to promote the full psycho-social potential of individuals, an effort whose goals and methods, stressing education, counseling,

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development of peer and community support systems and self-help, have more in common accross disciplines than not. We believe it is unfortunate that, for historical reasons, prevention has frequently been viewed and administered as the junior partner of treatment in a number of different fields, each with different professional structures, credentialing requirements, theoretical orientations and funding sources. As one who, in my own work, deals daily with youth whose development is threatened by multiple problems --incipient drug use and alcohol use, an abusive parent, a poor school record, and trouble with the police, all present in one case-- I see both the theoretical and the concrete problems with such fragmentation.

Long Range Goals

Given this fundamental view, we believe that in the long run prevention programming and funding must be based on the following goals and principles:

- Recognition of prevention as a distinct service modality whose emphasis on the promotion of healthy development clearly distinguishes it from the treatment or remediation of pathology.

- Funding and programming of prevention as an integrated field which cross-cuts the disciplinary and bureaucratic barriers which now exist between drug prevention, alcohol prevention, preventive mental health services, delinquency prevention, drop-out prevention, etc.

- Funding in "equilibrium" with treatment, by which we mean, optimally, the point at which the mix of treatment and prevention resources maximizes public benefits.

I should hasten to add that where this equilibrium point lies is by no means calculable, given present knowledge, with any precision, but surely the limited resources at national, state and local levels, which are currently directed to prevention, have not achieved it. An ounce of prevention may be worth a pound of cure, but you couldn't prove that by current funding practices. In NAPP's view, there are many contributing factors to this failure, with which, ultimately a national prevention strategy must come to grips. For one, a relatively small constituency demands prevention as compared to the constituency demanding remediation of the ills in the human condition. This is not surprising in a here-and-now crisis-oriented society where visible problems overwhelm the wisdom of "an ounce of prevention", and this is a kind of pervasive double standard in the allocation of resources to remedial and preventative activities. Remedial programs are funded because the problem is there, and the funding flows whether or not effectiveness can be demonstrated. But prevention advocates are constantly asked "where is the research which proves that prevention works." This is both a double standard and a Catch 22, since little support is given to research and one can hardly test the effectiveness of prevention, evenwith research dollars allocated, without sufficient funding of programs!

Short Range Actions

Prevention is a long way from achieving"equilibrium" funding as a distinct, interdisciplinary activity. What can and should be done, realistically to consolidate present efforts and to set a foundation for moving in this long range direction?

NAPP believes the following basic considerations should shape FY 1980 funding. First, given the scarcity of both treatment and prevention dollars, we believe that separate budgets for prevention must be maintained in the 3 institutes which are part of ADAMHA. Efforts to move to block grant funding at this time, while perhaps desirable in future years, would simply set off dysfunctional and disruptive competition among treatment and prevention programs in the present climate of shrinkage.

Secondly, despite the long-range desirability of integrated prevention programming, that the three institutes and their respective prevention branches should be preserved in the short run future for similar reasons and scarce dollars could set off dysfunctional competition among prevention advocates from existing fields who do not all, as yet, share the views of NAPP concerning integrated services - especially when cutting of the pie is involved.

Thirdly, we believe that the modest budget increases for prevention proposed in the ADAMHA forward plan should be authorized. In particular, NAPP is concerned that NIDA, which has been a strong supporter of the concept of prevention, receive the $16 million prevention budget allocated to it, rather than

the cutbacks which, it is my understanding, the Office of Management and Budget has urged. Such a modest allocation should permit NIDA to maintain the excellent technical assistance it provides prevention programs through Pyramid; it should permit expanded funding of research and demonstration activities, and it should permit NIDA to provide modest funding to states to assist in implementing the development of state prevention plans, using a planning process which the institute has developed toward that end.

Fourthly, we believe there are two important kinds of activities which, even with modest funding, can be undertaken to begin to move prevention programming in the long-term directions set forth above. For one, there should be encouragement, support and perhaps fiscal incentives to states to develop mechanisms for beginning to integrate these plans and activities. Such plans should address - with projected resource allocations - steps each state will take towards achieving "equilibrium" funding for prevention. Such state actions can begin to lay the institutional foundation for a national prevention strategy.

And finally, the double-standard, double-bind needs to be broken by increasing research and demonstration activities which are directly funded by the three institutes. Such demonstrations can provide a means for testing the concept of integrated, interdisciplinary approaches to prevention, as well as providing the opportunity to refine research methods and increase knowledge concerning the effectiveness of prevention activities.

I would submit to you that there is a network of programs accross the country which have been widely acclaimed as "model" programs in their field. I think of such programs as THE BACK DOOR in Brighton, Michigan; BERGENFIELD Department of Health, Division of Alcohol, narcotics and Drug Abuse Control in Trenton, New Jersey; QUEST, INC., in Findley, Ohio; DOVER YOUTH SERVICE, Dover, New Hampshire; and the COTTAGE PROGRAM in Salt Lake City, Utah. These programs have developed reputations on the basis of observational assessments, with only a few having had the resources to develop hard research-validated information about effectiveness. They (and others I have not mentioned) provide the nuclei, I would submit, for a research and development strategy which could test and help shape the programming approaches and concepts on which a long-rang national prevention strategy can be developed.

NASADAD

National Association of State Alcohol and Drug Abuse Directors

March 14, 1979

Senator Donald W. Riegle, Jr.
Chairman, Subcommittee on Alcoholism
and Drug Abuse
Senate Human Resources and Labor
Committee
Washington, D.C. 20510

Re: Senate Bill 525, "Drug Abuse Prevention, Treatment and Rehabilitation Act of 1979."

Dear Senator Riegle:

This letter represents NASADAD comments on S.525 which you introduced for yourself and Senate Harrison Williams on March 1, 1979. NASADAD comments on S.525 are in some ways similar to those submitted on S.440 but are presented in a separate letter for ease of analysis by your staff.

Let me repeat what I say in my other letter concerning S.440. The technical and substantive quality of S.525 is exceptional. You and your staff are to be congratulated both on your imaginative ideas and the way you have crafted them legislatively in this proposal. There are several points which the Single State Agencies find especially pleasing and I note them in my section by section analysis which follows.

In Section 2 amending Section 101 of the bill you add two additional Congressional findings and modify one. The items you added are most appropriate and the States applaud you for adding those. In addition, you might wish to consider adding in this section a finding concerning the need for coordination for international activities of the Federal Government as well as coordinating international and domestic activities. This function is already carried out by the Domestic Policy staff which is the subject of Title II of your bill, but there is no explicit statement about its authority in the international field. Such a statement would be appropriate and an even more clear statement of Congressional intent about the need for continuing coordination of drug abuse policy.

NASADAD has no substantive comments on Section 3 of the bill except to thank you for continuing the Congressional intent in high level policy coordination. NASADAD has been most pleased with the continuation to date of the functions of the Office of Drug Abuse Policy and feels that proposing existing practices for statutory enactment and making explicit provision for executive modification is timely and appropriate.

NASADAD is naturally most interested in Section 6 of your bill which amends Section 409(e) of the basic legislation. The changes which you propose to assure adequate representation by various minority and poverty groups, women, youth and the aging, are appropriate, as are other changes which you propose requiring the States to keep their plans up to date in accord with the changes in drug abuse among the State's population. The State drug abuse agencies are also pleased that you allow and encourage cooperation with State alcohol authorities, which in most States are the same agencies, in surveys designed to determine the need for drug abuse services.

The change which you propose for paragraph 7 of Section 409(e) to allow local political subdivisions prior review and comment on the State plan and to assure that those comments are submitted to the Secretary for consideration presents one administrative problem. Already the State planning process is a lengthy one requiring coordination with Health Systems Agencies, State Health Planning and Development Agencies, State Health Coordinating Councils, and other State-mandated functions, as well as the Federally mandated ones. To require one more review and comment cycle during the planning process may lengthen an already overly long process.

Thus, NASADAD requests that a State be allowed to provide for such local political subdivision review and comment simultaneously with submission of the plan to the Secretary and that the State then forward such comments prior to approval by the Secretary. Whether you choose to propose allowing such an option or not the statutory language should include a time limit of sixty days or less for local political subdivision comment so that there need be no delay by HEW in considering plans while waiting for such comments. Alternatively, you might wish to consider that the representation of local policial subdivisions on HSA governing bodies as required by P.L. 93-641, and review and comment by HSAs on the drug abuse portion of local health plans is sufficient to satisfy this requirement. A third alternative might be for a State to provide the Secretary assurances that public hearings on the plan were held with participation by officials of local political subdivisions and to provide a summary of these hearings with the State plan.

It is NASADAD's desire to allow local political subdivision appropriate time to review and comment on the State plan and to participate in its development, but we do not wish to lengthen the already burdensome plan review process.

The change which you propose to paragraph 10 of Section 409(e) is one which will place State drug abuse agencies in awkward position since it calls on them to evaluate what other State agencies and political subdivisions throughout the State are doing in the drug abuse area. In practical terms, it is difficult, if not impossible, for some State drug abuse agencies which are parts of much larger human services department to evaluate what their superiors and their colleagues in that department may or may not be doing. Likewise it may be a practical difficulty to evaluate what large cities and counties are doing in a

particular State. I request that you consider that the State agency be required only to provide an analysis or survey of the other State agency and local political subdivision efforts rather than being required to evaluate them as well. Such a change would make the requirement a more appropriate one for the Single State Agencies for Drug Abuse Prevention.

The new paragraph 13 proposed for addition to Section 409(e) calls for a complete inventory of the resources available in the State to be submitted each year and bring the drug abuse plan into conformity with the alcohol plan. I request that you make it clear that once a State has submitted such an inventory, all it needs to do on an annual basis is to provide an up-to-date listing of the changes that have occurred, including deletions and additions. Otherwise printing a massive directory each year might be a difficult burden, especially for the States in which rapid changes occur in programs.

Your proposed new paragraph 15 under Section 409(e) is a welcome one, designed to encourage occupational drug abuse programming. Certainly the States wish to encourage such programming, however there is one requirement imposed in paragraph 15 which will present a very real difficulty. Paragraph 15(c) will require that the States furnish technical assistance as requested. A large number of requests could easily overwhelm the resources of a small State. I suggest that you change the language to require that technical assistance be furnished "as feasible." Thus, the requirement will be one which would be welcome and quickly implemented by the States.

Section 7 of your bill which amends Section 410 of the Act is to be especially applauded. Paragraph (4), which emphasizes the need for prevention and treatment program replication, is especially appropriate, given the need for prevention services.

Section 10 in your bill proposed to amend Section 413(b) of the Act to require NIDA to encourage occupational programs is also a welcome one. I note, however, that NIDA is mandated to provide technical assistance upon State requests. Again, that requirement may not be a feasible one in all instances for NIDA and you may wish to modify the language in there as well.

Section 15 of your bill amends Section 502 of the legislation concerning technical assistance. NASADAD is especially pleased that in this bill as well as in S. 440 you encourage coordination between NIDA and NIAAA so that activities can be coordinated between the two Institutes, and that such coordination will be encouraged at the State level as well. I do have some questions concerning the provisions of the technical assistance and how it is to be paid for under S. 440 which I have raised in my separate letter to you concerning that bill. I do not feel that I should repeat that here.

Again, let me thank you and your staff for the fine job which you have done in putting together this piece of legislation in such a short time period. NASADAD

has already testified to the Subcommittee concerning the NIAAA renewal and the impact that the Administration's proposal for formula grant consolidation would have on the States and on the fields of alcoholism and drug abuse. It is clear that you have already recognized many of the States' concerns. I very much appreciate your recognition of these concerns and that your staff have demonstrated an ability to act responsibly and responsively.

I also have one concern about the testimony submitted by the General Accounting Office concerning the NIDA statewide service contracting process. My concern relates to their findings on the need for more stringent Federal standards for drug abuse programs and their suggestion that the Joint Commission on the Accreditation of Hospitals (JCAH) standards be examined. Two issues are involved: the appropriateness of those standards and the propriety of a hospital and medically dominated organization being the accrediting body. There are several States which have developed standards which I believe are more appropriate than those of JCAH. Some of them have already been approved by NIDA to be used in lieu of Federal funding criteria, but many States have not seen it to their advantage to change details of their standards and submit them to NIDA for approval. I and many others in both the alcohol and drug abuse fields have many concerns about the new proposed consolidated standards on alcohol, drug abuse and mental health programs which JCAH now has in draft form. I urge that you and your staff examine those standards carefully and consider whether or not you find them appropriate for drug abuse programs rather than relying on the recommendation of the General Accounting Office.

The lack of ongoing representation for the drug abuse community on any advisory or policy making body within JCAH is also a problem with these standards. As they now exist, they relate more to physical facilities and program management than they do to standards that involve quality of care. Thus, State licensure standards designed by those familiar with drug programs rather than hospitals, may in fact have more positive impact on quality of care. A state accreditation program would certainly be less costly and probably more effective.

Thank you for affording me the opportunity to comment on the legislation which you have proposed for yourself and Senator Williams. Either Diana Tabler or I of the NASADAD staff will be most happy to answer any questions which you or your staff may have.

Again, I have enjoyed working with you to date and look forward to your continued leadership in the fields of alcoholism and drug abuse. The fields look to you as their spokesman in the Senate, and you have demonstrated amply your ability to carry out this role even though your tenure in your present position has been only brief.

Sincerely,

Carl Akins
Executive Director

cc: Kenneth Eaton

bcc: Nancy Olson

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NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION

CONCEPT PAPER

Since the enactment of the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), mayors of large cities and their drug abuse program coordinators have been attempting to address the near total absence of any sustained and systemmatic major city governmental participation in the state drug abuse planning process and in the formulation of federal drug abuse policies.

This de facto isolation of cities from federal administrators works to the disadvantage of both levels of government. The *federal* policymakers establish funding and programming goals without direct representation from the most intensely-affected settings.

The *states*, which are theoretically advised to take into account local needs through substate planning, have shown near-unanimous reluctance to directly involve city governments in the planning process. State political realities have effectively produced a non-urban drug services orientation, often ignoring or avoiding the states' major drug problem sites, their large cities, and there has been no effective administrative mechanism for producing greater state sensitivity.

In 1973, the National League of Cities (NLC) and United States Conference of Mayors (USCM) formed a Mayors' Task Force on Drug Abuse Treatment and Prevention, which issued a report in 1975 calling for remedial legislation to redress the inter-governmental imbalance in making and implementating drug policy. It also called on the Administration to restore a city role which had been arbitrarily usurped by the Single State Agency (SSA) mechanism. However, the seeming intransigence of the federal and state governments to make the needed and appropriate modifications to the current system continues.

While state planning has proceeded with substantial federal funding, major cities which have the most documented need are excluded from the formal planning process. Cities now need the support to develop the planning and administrative capabilities to implement a comprehensive services network to address the urban drug problem. It is particularly important that cities develop this capability now, not only to relate to designated single state agencies in drug and alcohol fields, but also to promote effective planning through the newly developing health services agencies (HSAs).

The National Association for City Drug Coordination (NACDC) is a consortium of city drug program coordinators representing mayors of cities with major drug-involved populations. The Association has been formed to effectively document, present and pursue the urban perspective in drug abuse planning. The goals of the NACDC will include:

1. To present to the public and to the federal government the appropriate role for cities with large concentrations of drug abuse;

2. To establish more beneficial governmental relationships in the drug planning process, including the relationship of cities to federal policymaking and cities to state planning in the drug (including alcohol) abuse and health fields;

3. To initiate policy development and appropriate funding perspectives for the problem of urban drug abuse;

4. To identify those cities with the highest concentrations of drug, alcohol or similar substance abuse problems, and to support initiatives to ameliorate drug abuse in those areas;

5. To investigate, analyze and disseminate information to the public concerning the causes, effects and societal consequences of the misuse of drugs (including alcohol) in cities; and

6. To provide technical assistance, training and research support to member cities.

In pursuing these goals , the NACDC will look to the National Institute on Drug Abuse (NIDA) to reconsider its sole reliance on the SSA mechanism and increase its flexibility to address the special urban populations through the recognition of a local city government role as a "prime sponsor".

The NACDC will suggest that NIDA organize its staff to be more responsive to urban issues, and will work with NIDA to encourage the federal government to better coordinate the activities of the several departments which provide support services for the drug abuse. The Association will recommend that a number of cities directly receive block grants for planning and for services to permit them to utilize the funds from a number of federal programs for drug abuse prevention and rehabilitation.

The NACDC would further expect that it could help re-define the state-city relationship, through which major cities would be directly involved in the preparation of the annual drug abuse plans. Certainly, in this manner we could expect to see state funding and programming priorities revised to focus on critical urban needs.

The NACDC also intends to act as a stimulus to local initiatives, encouraging interested cities, with the need and capability, to commit resources to developing comprehensive programs. However, this local activity will not be productive unless the federal and state liaison issues are resolved. To the extent that this can occur without legislation to amend P.L. 92-255, the NACDC will work with appropriate administrations. But the history of this matter suggests that a congressional review is also indicated, and the NACDC will offer its collective expertise of its membership to appropriate Senate and House members.

In all of these activities, the National Association for City Drug Coordination will be seeking a revitalized federal-state-city partnership so that those in greatest need may be helped.

# # #

RUSS FAULKINBERRY
NATIONAL CHAIRPERSON

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TASK FORCES

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The National Chairperson of the National Drug Abuse Conference is spokesperson for some 60,000 drug abuse workers in the United States and the Trust Territories. As the official representative of this dedicated group, we would like to go on record as commending the National Institute on Drug Abuse for providing the machinery with which drug abuse workers can operate in performing their respective jobs to combat drug misuse and abuse throughout the country.

With the ever-escalating rise of high-risk behavior in this country, the Institute is faced with the incredibly difficult task of continuing to design a network of data and resource banks and a framework of national guidelines that can augment the effort of those of us in the field in rechanneling human lives. In spite of the limited funds, NIDA has been able to achieve this goal with a great degree of success. It is quite evident that continued financial support from Congress of all the programs under NIDA is crucial to the drug abuse field.

Please note, however, that special attention should be given top priority areas: prevention, rural drug abuse, and special populations. Whereas, research and rehabilitation remain important combatants of substance abuse, we in the field do not have the manpower and resources necessary to service the increasing number of abusers. It is our belief that more emphasis should be directed toward developing a strong national prevention and education program. This is the only remaining alternative to effectuate an impediment to continued drug abuse growth.

The federal effort is currently emphasizing central city areas. Although heavy drug abuse started and remains a serious problem in urban areas, it has rapidly spread throughout suburbia and the rural areas. We strongly urge that more attention be given to the special problems and issues of substance abuse as a truely national issue. It is our suggestion that a continual national needs assessment be conducted in order to provide the taxpayers with a realistic picture of the extent of the existing problems.

Russ Faulkinberry
Russ Faulkinberry
National Chairperson

Andrew Evans
Andrew Evans
Administrator

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Senator RIEGLE. The committee will stand in recess.

[Whereupon, at 1:15 p.m., the subcommittee adjourned, subject to the call of the Chair.]

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