BRIEFING BOOK

TREATMENT COMMITTEE STRATEGY PRESENTATION

NOVEMBER 24, 1987

TREATMENT COMMITTEE STRATEGY
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TREATMENT COMMITTEE MEMBERSHIP

National Institute on Drug Abuse (Lead Agency)
Department of Health and Human Services
Department of Defense
Department of Labor
Department of Education
Department of Justice
Department of Housing and Urban Development
Department of State
Veterans Administration
Social Security Administration
National Institute on Mental Health
National Institute Alcohol Abuse and Alcoholism
Federal Bureau of Prisons
Health Resources and Services Administration

AGENDA
NATIONAL DRUG POLICY BOARD
THURSDAY, NOVEMBER 24, 1987
10:00 A.M., ROOSEVELT ROOM
THE WHITE HOUSE

I. Introductory Remarks
(Attorney General Meese, Chairman)

II. Overview Statement
(Dr. Donald Ian Macdonald, Chairman, Prevention and Health Coordinating Group)

III. TREATMENT Committee Strategy Presentation
(Charles R. Schuster, Ph.D.)

A. Strategy Overview

B. Significant Issue Identification

C. Discussion

IV. New Business

AGENDA FACT SHEET
NATIONAL DRUG POLICY BOARD
TUESDAY, NOVEMBER 24, 1987
10:00 A.M., ROOSEVELT ROOM
THE WHITE HOUSE

Treatment Committee Strategy Presentation

I. Introductory Remarks
(Attorney General Meese, Chairman)

II. Overview statement
(Dr. Donald Ian Macdonald, Chairman, Prevention and Health Coordinating Group)

III. Treatment Committee Strategy Presentation
(Charles R. Schuster, Ph.D.)

The Treatment Committee is chaired by Dr. Charles Schuster, Director of the National Institute on Drug Abuse.

The membership includes representatives from the Departments of Defense, Education, Health and Human Services, Housing and Urban Development, Justice, State, as well as the following agencies: Veterans Administration, Social Security Administration, National Institute on Mental Health and the National Institute on Alcohol Abuse and Alcoholism, Federal Bureau of Prisons, Health Resources and Services Administration.

IV. New Business

TREATMENT COMMITTEE STRATEGY
NDPB STAFF OUTLINE

The Treatment strategy focuses on the policies, strategies and programs targeted at the "hard-core" drug user. This population is divided into four categories, each with its own requirement of intervention resources.

Severity	Intervention
Mildly Impaired	Responds to personal drug crisis; threat of urine testing; or, admonitions of employer, or family. Treatment is usually not required.
Moderately Disabled	Many respond to self-help groups (e.g. A.A., N.A.) or minimal counseling or supervision. Most require a planned program of outpatient or residential treatment consisting of drug counseling, detoxification, and/or pharmacological support (methadone, naltrexone for opiate abuse or anti-depressants for cocaine).
Severely Disabled	Severely socially disadvantaged or diagnosable psychopathology requiring special services (e.g., psychotherapy, vocation or other rehabilitive services), but when such services are provided these individuals show substantial improvement.
Extremely Disabled	Social impairment and/or psycho-pathology exceeds the level that can be successfully addressed by current methods and may require chronic care, or compulsory confinement.

The strategy is a report of existing programs and their effectiveness. It is the aim of this chapter to delineate what programs should be expanded to double the current number of treatment slots to 500,000; and expand services, both educational and treatment, to the I.V. drug abusing population, particularly in light of the AIDS epidemic; and expand research to increase the quality of treatment programs.

Highlights of the Treatment strategy document include identification of:

- Current existing forms of treatment and their impact on both the short and long-term abuser. These include: self-help groups, detoxification, residential treatment and therapeutic communities, drug-free outpatient treatment and methadone maintenance.

- That treatment works. It has a positive impact on the public health and social consequences associated with drug abuse and is cost-effective, both in economic and social costs.

- That treatment alone cannot work with the severely or extremely disabled population. A host of ancillary issues are relevant, including crime and AIDS and IV drug use, as well as the co-morbidity factors: illiteracy, poverty, lack of skills, and other psychiatric disorders.

REDUCING THE DEMAND FOR ILLICIT DRUGS THROUGH TREATMENT

EXECUTIVE SUMMARY

An estimated 70 million Americans have tried an illicit drug at least once. The vast majority of them only experiment briefly, soon recognizing that drugs play no positive role in their lives. Some, however, stop only when motivated by external disapproval or by discomfort over the physical and psychological harm caused by illicit drug use.

Because drug abuse is a complex problem involving biological, psychological and social factors, a variety of approaches are needed to break its grip on our Nation. Aggressive law enforcement can limit the availability of illicit drugs. Education efforts, including media campaigns, can help to discourage people from trying drugs. Workplace programs and drug testing can motivate occasional abusers to stop using drugs. However, drug abuse treatment is the key to reaching those severely dependent drug abusers who have not responded to other approaches. Only a national drug abuse treatment strategy can control the impact of these severe cases on society and reduce the market for illicit drugs.

About 9 percent of illicit drug users (6.5 million) become severely dependent, cease to function in legitimate social roles, and usually engage in criminal behavior as part of their drug-using lifestyle. This group accounts for the bulk of the social and economic problems commonly associated with drug abuse. It provides a continuing market for the illicit drug distribution system.

Acquired Immunodeficiency Syndrome (AIDS) has added new urgency to the need to address the nation's intravenous (IV) drug abuse problem. Because shared needles can transmit the AIDS virus, IV drug abusers constitute the second largest group at risk for the disease, comprising 25% of all adults with AIDS. More and more of the one million needle-using drug abusers in major metropolitan areas are testing positive for the AIDS virus. In New York and northern New Jersey, approximately 60 percent of recent entrants into treatment programs for heroin addiction are infected with the AIDS virus. The prevalence of infection is lower in most other parts of the country, but can only stay under control if needle-sharing is eliminated. One controversial approach is to provide IV drug abusers with sterile needles. It has been suggested that limited, carefully controlled research in this area should be considered.

AIDS must be prevented from spreading among IV drug abusers and between IV drug abusers and their sexual partners. Since many IV drug abusers have non-drug-using sexual partners and many prostitutes are IV drug abusers, the virus will spread inevitably to the general population. We must reduce the rate of spread to minimize the tragedy of lives lost and the immense National economic costs.

Drug abuse treatment is highly effective in reducing drug abuse and related maladaptive behaviors. It also increases desirable behaviors such as school attendance and employment. Treatment of IV drug abuse is effective in reducing the sharing of contaminated needles and, consequently, the spread of the AIDS virus. Indeed, one study in the New York area has reported markedly lower rates of seropositivity among heroin addicts in methadone maintenance programs (23 percent) than heroin addicts not in treatment (47 percent).

Since drug abuse is a chronic, relapsing disorder, many abusers require multiple episodes of treatment before they achieve permanent abstinence. Therefore, one research goal is to find ways to improve the acceptability of treatment and retain addicts in treatment for longer periods. Currently available treatment modalities include self-help groups, detoxification, residential treatment and therapeutic communities, drug-free outpatient treatment, and methadone maintenance. For those drug abusers who do not respond to any of the current forms of treatment, a goal is to develop new therapeutic approaches.

Contrary to common belief, most severely dependent drug abusers eventually do seek treatment, either voluntarily or as a result of coercion. Also, with some dissenting voices, there is increasing interest in mandatory treatment for IV drug abusers to limit the spread of AIDS. The dual challenge is to recruit people into treatment early in their drug careers, and to ensure that treatment is available when they need to use it.

In the last several years, many private drug abuse treatment programs have been developed to serve people who are able to pay. State legislatures have assisted by mandating inclusion of benefits for drug abuse treatment in insurance policies. However, the insurance industry has traditionally resisted offering such coverage. Those employers who are convinced that drug abuse treatment offers them financial benefits by rehabilitating valued but drug-abusing employees should insist on such insurance coverage.

Most people in need of drug abuse treatment seek it in publicly funded treatment programs. Eighty percent of all treatment is funded by Federal, State or local governments. Some drug abusers have few vocational skills and no work history; others have lost their social and economic supports due to drug abuse. Of those who enter clinics supported by public funds, 66 percent are unemployed, and 62 percent have no form of health insurance. In most cases, the treatment programs also have had to charge clients for services, since public money has not been sufficient to meet expenses.

The United States has never had adequate capacity to provide treatment for its estimated 6.5 million disabled drug abusers. No more than 250,000 people are in treatment at any given time, and major metropolitan areas report large waiting lists. Among the stumbling blocks to treatment expansion are zoning restrictions and strong community resistance. For example, New York City, with the largest population of

drug abusers and the worst AIDS problem among IV drug abusers, struggles constantly with community organizations that resist the opening or expansion of drug abuse treatment programs. A public information campaign spearheaded by the First Lady will address this problem by promoting community acceptance of drug abuse treatment expansion. Local governments can facilitate treatment expansion by eliminating restrictive zoning laws and making property available for conversion into treatment facilities.

Human resource problems also contribute to the disparity between the numbers of people in need of treatment and the numbers who receive treatment. Many more trained counsellors will be needed during the next several years. In addition, existing staff must be trained to deal with polydrug and alcohol abuse, drug abusers who have psychiatric problems, and the issues surrounding drug abuse and AIDS.

The treatment network should be expanded within the next five years to accommodate 500,000 clients at any given time. This will be a giant step ahead, but may not be fully responsive to the need. A major concern in designing a treatment strategy is that sufficient data be available to permit adequate delineation of the drug abuse problem. Prior to 1982, States were required to participate in a national treatment reporting system as a condition of Federal funding. This system collected data on patients in treatment, types of drugs being abused, and the outcome of the treatment process. The reporting system was valuable for planning State and Federal responses to the drug abuse problem.

This reporting system became voluntary with the advent of Block Grant legislation. Some States continued to report patient information to the Federal government, but many either abandoned the system or so modified it that standardization and nationwide comparability were lost. There is now a general consensus by both State and Federal officials that the loss of this resource was unfortunate and should be restored.

In summary, drug abuse remains a serious national problem. One of the most effective ways to reduce the demand for illicit drugs is to engage the drug abusers in treatment. To that effect, an expansion of treatment services is essential, and community acceptance of such programs must be promoted. Further research is needed to identify improved treatment modalities and ways to ensure access to service. Data should be collected in such a way that they will be useful to State and Federal planners. It is hoped that intensive efforts will lead to a significant decrease in the twin epidemics of AIDS and drug abuse that threaten our society.

SIGNIFICANT ISSUES

Issue

1. User Responsibility
2. Distribution of Clean Needles
3. Mandatory Treatment for I.V. Drug Users
4. Establishment of stronger links between the treatment and law enforcement communities
5. Expansion of programs to study and react to co-morbidity factors
6. Regulatory changes

User Responsibility

How can User Responsibility be applied to the Treatment population?

Would a program requiring those seeking a driver's license be tested for drugs prove effective? What are the legal ramifications of such a program? Could a drug-free test be a condition upon receiving car insurance?

Distribution of Clean Needles

Should the policy of clean needles be considered?

Is the distribution of clean needles cost effective? Should a limited study of such a program be initiated?

Other diseases have been spread by using dirty needles; would the possibility of contracting AIDS really be a deterrent to the i.v. drug user?

Should Federal, State and local governments be seen as contributing to the use of i.v. drugs?

Most i.v. drug users have seen or been in contact with someone who has died of a drug overdose. Why should the fear of AIDS make any difference?

Should clean needle education be considered?

Mandatory Treatment

Given the national AIDS epidemic, shouldn't mandatory treatment of i.v. drug users found to be carrying the disease be considered?

Should those found HIV positive be treated before those who did not tested positive and are seeking treatment voluntarily?

What are the cost implications? Besides treating for drug abuse, is the federal/state/local government also responsible for the treatment of AIDS related symptoms?

If mandatory treatment is just as effective as voluntary treatment (saying both groups are unable to pay/both are able to pay), and given the statistic that only 15% of those entering treatment voluntarily reach the treatment goal, wouldn't it be cost effective to require mandatory treatment?

Under mandatory treatment, wouldn't we be able to ensure that the treatment goal is reached?

Is it fair given the limited number of slots to exclude those who want to enter treatment voluntarily? If expansion of resources is possible, should both options be implemented or considered?

Stronger links between the treatment and law enforcement communities

Should stronger links be established between the treatment and the law enforcement communities?

Given the fact that recent studies have shown that drug abusing offenders account for a disproportionate share of all crime, should drug testing be a condition of pre-release, bail, parole?

Should more resources be focused on further developing and initiating programs that test detainees for drug use (i.e., Washington, D.C. program)?

Should programs such as Treatment Alternative to Street Crime be further implemented?

Expansion of programs to study and react to co-morbidity factors.

In light of the contributing societal impacts (i.e., teenage pregnancy, illiteracy, broken homes) on the treatment population, should medical centers that deal with all the problems be utilized instead of focusing solely on treatment clinics?

Who would act a lead in developing such centers?

Would such centers be cost effective?

Would such a program receive better response from those neighborhoods that now negatively react to treatment facilities in their areas?

Wouldn't it be cost effective to combine those federal programs which target this specific population?

Regulations

Use of block grants for conversion of abandoned, condemned, or vacant property into treatment facilities.

Structural changes in the block grants to ensure that funds are received by States in the quickest way possible.

Structural changes in the block grants to enable some sort of data collection to determine cost effectiveness of treatment programs.

Expansion and streamlining of methadone maintenance programs.

TREATMENT COMMITTEE STRATEGY
PENDING LEGISLATION

Two bills have been introduced relating to drug abuse:

The Waxman Bill - H.R. 3187
The Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments Act of 1987.

Some key aspects of the bill are:

(Sec. 1945) Requires the Secretary, through Administrator, ADAMHA, to develop and evaluate substance abuse treatment programs to determine most effective treatment, doing so through grants, contracts, and cooperative agreements, to assess comparative effectiveness and costs of various treatment forms.

(Sec. 509D) Requires Secretary, through Administrator, to collect through representatives sampling date for each year on the incidence, by the State and metro area, of the various forms of mental illness and substance abuse.

The Rangel Bill - H.R. 3292
The Intravenous Substance Abuse and AIDS Prevention Act of 1987

Some key aspects of the bill are:

- Authorizes $200 million for the Secretary of HHS to make grants to public and private non-profit entities for treatment services to intravenous substance abusers.

Requirements:

Applicants in providing treatment services must make available to I.V. substance abusers and their sexual partners the following services: counseling and education services on prevent the transmission of HIV; and testing to determine if the substance abuser is infected with the virus. Testing may not be a condition for receiving treatment.

Priority for services will be given to geographic areas where the incidence of IV substance abuse is substantial compared to incidences in other areas, as well as areas where the incidence of HIV infection is relatively substantial. Seventy-five percent of the funding will be reserved for this area.

Demonstration Projects:

Testing for women who are I.V. substance abusers and who are pregnant, or who may become pregnant; as well as for women whose sexual partners are I.V. substance abusers.

TREATMENT AGENCY SUMMARY
FY 1987-1989
(DOLLARS IN MILLIONS)

AGENCY	FY 1987 $	FY 1987 FTES	FY 1988 $	FY 1988 FTES	FY 1989 OMB REQUEST $	FY 1989 OMB REQUEST FTES	% CHANGE $	% CHANGE FTES	ADDITIONAL ENHANCEMENTS $	ADDITIONAL ENHANCEMENTS FTES	% CHANGE $	% CHANGE FTES
DOD	89.5	4,607	97.8	4,846	104.8	4,836	7.16	(0.21)	0.0	0		
HHS												
-ADAMHA	161.7	2	103.4	2	177.0	2	71.18	0.00	0.0	0		
-NIDA	75.7	120	102.7	186	98.0	200	(4.58)	7.53	0.0	0		
-IHS	49.4	12	13.5	24	0.0	0	(100.00)	(100.00)	0.0	0		
-BHCDA	2.6	4	2.6	14	0.0	0	(100.00)	(100.00)	0.0	0		
-SSA	1.8	0	4.8	0	8.3	0	72.92	0.00	0.0	0		
SUBTOTAL, HHS	(291.2)	(138)	(227.0)	(226)	(283.3)	(202)	24.80	(10.62)	0.0	0		
DOJ-BOP 1/	1.4	44	1.4	44	1.4	44	0.00	0.00	0.0	0		
VA 2/	74.6	1,785	75.8	1,762	77.4	1,762	2.11	0.00	0.0	0		
TOTAL	456.7	6,574	402.0	6,878	466.9	6,844	16.14	(0.49)	0.0	0		

1/ EXCLUDES RESOURCES FOR THE HIV TESTING PROGRAM.
2/ EXCLUDES RESOURCES FOR THE PHYSICIAN TRAINING PROGRAM.

NOTE: ZERO INDICATES NO RESOURCES REQUESTED.

TR[redacted]RATEGY SUMMARY
[redacted]7-1989
(DOLLARS IN MILLIONS)

STRATEGY	FY 1987 $	FY 1987 FTES	FY 1988 $	FY 1988 FTES	FY 1989 OMB REQUEST $	FY 1989 OMB REQUEST FTES	% CHANGE $	% CHANGE FTES	ADDITIONAL ENHANCEMENTS $	ADDITIONAL ENHANCEMENTS FTES	% CHANGE $	% CHANGE FTES
STRATEGY 1 1/	92.8	12	132.7	62	146.1	85	10.10	37.10	0.0	0		
STRATEGY 2 2/	311.1	1,847	224.1	1,846	288.9	1,808	28.92	(2.06)	0.0	0		
STRATEGY 3	0.0	0	0.0	0	0.0	0	0.00	0.00	0.0	0		
STRATEGY 4	52.8	108	45.2	124	31.9	115	(29.42)	(7.26)	0.0	0		
TOTAL	456.7	1,967 3/	402.0	2,032 4/	466.9	2,008 5/	16.14	(1.18)	0.0	0		

STRATEGIES

1. CONDUCT AN AGGRESSIVE OUTREACH PROGRAM TO IDENTIFY DRUG ABUSERS AND DIRECT THEM TO TREATMENT.
2. ENSURE THE AVAILABILITY OF DRUG ABUSE TREATMENT.
3. STIMULATE PRIVATE SECTOR INVOLVEMENT IN SUPPORTING THE NATION'S TREATMENT NETWORK.
4. UNDERTAKE RESEARCH TO IMPROVE THE QUALITY AND EFFICIENCY OF TREATMENT.

FOOTNOTES

1/ EXCLUDES RESOURCES FOR BOP'S HIV TESTING PROGRAM.
2/ EXCLUDES RESOURCES FOR VA'S PHYSICIAN TRAINING PROGRAM.
3/ EXCLUDES DOD'S 4,607 FTES WHICH CAN NOT BE BROKEN BY STRATEGY.
4/ EXCLUDES DOD'S 4,846 FTES WHICH CAN NOT BE BROKEN BY STRATEGY.
5/ EXCLUDES DOD'S 4,836 FTES WHICH CAN NOT BE BROKEN BY STRATEGY.

NOTE: ZERO INDICATES NO RESOURCES REQUESTED.

COMMITTEE ON TREATMENT
FEDERAL SECTOR WORK GROUP

Submitting Agency Contact
Name:
Telephone:

RESOURCE SUMMARY BY PROGRAM ($000)

PROGRAM	FY 1987 Estimate		FY 1988 Program		FY 1988 Increases		FY 1989 Request to OMB		Additional New Proposals For FY 1989		Total FY 1989 Desired Resources	
	Dollars	FTEs	Dollars	FTEs	Dollars	FTEs	Dollars	FTEs	Dollars	FTEs	Dollars	FTEs
1. Identify Drug Abusers and Engage Them in Treatment												
Street and Court Outreach--NIDA	$10,180	5	$35,000	23	$0	0	$39,247	30	$0	0	$39,247	30
AIDS Public Health Control Measures--NIDA	15,123	7	24,994	39	0	0	29,322	55	0	0	29,322	55
AIDS Service Demonstration--BRD	0	0	0	0	0	0	0	0	0	0	0	0
Biochemical Testing--DOD	67,500		72,706		0	0	77,533		0	0	77,533	0
HIV Testing--BOP											0	0
Subtotal, Strategy 1	92,803	12	132,700	62	0	0	146,102	85	0	0	146,102	85
2. Ensure the Availability of Drug Abuse Treatment												
ADAMHA Block Grants	161,718	2	103,444	2	0	0	177,042	2	0	0	177,042	2
Targeted Treatment Expansion	0	0	0	0	0	0	0	0	0	0	0	0
VA Drug Dependence Treatment Programs	74,600	1,785	75,800	1,762	0	0	77,400	1,762	0	0	77,400	1,762
Indian Health Service	49,400	12	13,500	24	0	0					0	0
BHCDA Community Health Centers	2,600	4	2,600	14	0	0					0	0
DOD Residential Treatment	9,587		11,764		0	0	13,752		0	0	13,752	0
DOD Nonresidential Rehabilitation	2,134		2,144		0	0	2,175		0	0	2,175	0
BOP Chemical Abuse Program	1,400	44	1,400	44	0	0	1,400	44	0	0	1,400	44
Treatment Staff Training	0	0	0	0	0	0	0	0	0	0	0	0
Supplemental Security Income (Title II)	1,012		2,700		0	0	3,100		0	0	3,100	0
VA Physician's Training											0	0
DOD Education and Training	7,825		8,640		0	0	8,781		0	0	8,781	0
Supplemental Security Income (Title XVI)	788		2,100		0	0	5,200		0	0	5,200	0
Promote Community Acceptance of Treatment	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Strategy 2	311,064	1,847	224,092	1,846	0	0	288,850	1,808	0	0	288,850	1,808
3. Stimulate Private Sector Involvement												
White House and Federal Leadership	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Strategy 3	0	0	0	0	0	0	0	0	0	0	0	0
4. Research to Improve Treatment												
DOD Program Evaluation	2,492		2,498		0	0	2,508		0	0	2,508	0
Improve State Data Collection	1,111	2	1,000	2	0	0	200	2	0	0	200	2
Research on Therapeutic Approaches	49,050	104	41,536	120	0	0	29,002	110	0	0	29,002	110
Review Methadone Regulations	200	2	200	2	0	0	200	3	0	0	200	3
Treatment Information and Referral Units	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Strategy 4	52,853	108	45,234	124	0	0	31,910	115	0	0	31,910	115
Total Treatment	$456,720	1,967	$402,826	2,032	$0	0	$466,862	2,008	$0	0	$466,862	2,008
Control:											0	0

DRUG ABUSE PREVENTION AND HEALTH COORDINATING GROUP

COMMITTEE ON TREATMENT

REDUCING THE DEMAND FOR ILLICIT DRUGS THROUGH TREATMENT

November 19, 1987

PARTICIPATING AGENCIES

Alcohol, Drug Abuse, and Mental Health Administration

Department of Defense

Federal Bureau of Prisons

Health Resources and Services Administration

Housing and Urban Development

National Institute on Drug Abuse

Social Security Administration

Veterans Administration

Chairperson:

Charles R. Schuster, Ph.D.
Director
National Institute on Drug Abuse

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PART III--CURRENT FEDERAL TREATMENT RESOURCES

PART I

TREATMENT AS A DEMAND REDUCTION STRATEGY

NATURE AND EXTENT OF DRUG ABUSE IN THE UNITED STATES

Recent surveys have estimated that 70 million Americans have tried an illicit drug at least once in their lifetime. The vast majority of these persons briefly experiment with drugs and, recognizing that drugs play no positive role in their lives, refrain from further use. Some continue to use until it comes to the attention of employers or family, or until they are motivated to stop because of the physical and psychological harm that illicit drug use causes. With a little help, these individuals can become drug free. A proportion of illicit drug users (6.5 million) become severely dependent, cease to function in legitimate social roles and usually engage in criminal behavior as part of their drug-using lifestyle. It is this group that accounts for the bulk of the social and economic problems commonly associated with drug abuse, i.e., the $47 billion per year for health care, reduced productivity, costs of law enforcement, and theft and destruction of property (Harwood et al., 1984). This is the group that ensures that the illicit drug distribution system always has a market.

Personal and social problems related to drug abuse are not specific to any single category of substance. While, in the past, heroin was singled out, drug dependence is just as real and just as debilitating with drugs such as cocaine. Any drug can be used in ways that will have deleterious personal and social effects.

Acquired Immunodeficiency Syndrome (AIDS) has added a new dimension to the nation's drug abuse problem. Needle sharing among intravenous drug abusers can result in rapid transmission of the AIDS virus, and intravenous drug abusers constitute the second largest risk group comprising 25% of all adults with AIDS. Of the more than one million needle using drug abusers in major metropolitan areas, increasing numbers are testing positive for the AIDS virus. In New York and northern New Jersey, approximately 60 percent of recent entries into treatment programs for heroin addiction are infected with the AIDS virus. For the present, the prevalence of infection is lower in most other parts of the country. Preventing further spread of AIDs among IV drug abusers and from IV drug abusers to their sexual partners and on into the general population must be a priority. The fact that many intravenous drug abusers have non-drug using sexual partners and that many prostitutes are intravenous drug abusers gives a sense of inevitability about the spread of the virus to the general population. The issue is no longer whether it will occur, but how to reduce the rate of spread so as to minimize the tragedy of lives lost and the immense National economic costs.

MATCHING TREATMENT TO THE DRUG ABUSER

Because drug abuse is a complex problem involving biological, psychological and social factors, a variety of approaches are needed to break its grip on our Nation. Aggressive law enforcement is essential for limiting the availability of illicit drugs. Information, education efforts, and anti-drug abuse media campaigns help prevent the initiation of new users. Workplace programs and drug testing can motivate occasional abusers to stop drug use. However, drug abuse treatment is the critical element to reach those severely dependent drug abusers who have not been successfully dealt with by other approaches. Only treatment can control the impact of these severe cases on society and reduce the market for illicit drugs.

Studies over the last 15 years consistently show that drug abuse treatment has a positive impact on both drug use and antisocial behavior. What has also emerged from these studies is the realization that, within the overall gains brought about by treatment, some who sought treatment improved with relatively little help; others did well, but only with long-term treatment or specific pharmacological interventions; still others showed little or no improvement even when provided with a variety of treatment approaches.

Those who improved with brief treatment tended to be the least impaired psychologically, had held legitimate jobs sometime in their past, and had been able to establish stable relationships with others. Studies have also shown that those who are severely psychiatrically disturbed tend to do poorly no matter which of the currently available programs they enter. The prevalence of psychiatric disorders in severely dependent drug abusers is quite high, with about 80 percent of patients entering substance abuse treatment programs having had a diagnosable mental health problem at some time in their lives. A drug abuser with a psychiatric disorder can have a much-improved treatment outcome if the psychiatric condition is properly diagnosed and treated. However, most drug abuse treatment programs (especially those that are publicly financed) do not have the professional personnel to provide these services.

Additional factors that reduce the likelihood of successful response to treatment are an absence of educational and vocational skills, a history of multiple criminal convictions, and the absence of stable interpersonal relationships. These findings imply a need to focus additional research on new treatments and on those patients who have multiple problems and poor prognoses.

For purposes of projecting needs for different types of treatment and associated costs, it is helpful to attempt to subdivide the population of illicit drug users in need of some form of intervention into several categories. The categories are based on the liklihood of eliciting a positive change in drug related behavior and the resources needed to bring about that change. These categories are summarized in Table 1.

The treatment system that exists in the United States for problems of drug abuse is not unlike what exists for most forms of human distress or illness: a great deal of self-help, self-diagnosis, and help and advice from friends and family, with only the more severe situations calling for formal treatment. Even in more serious situations, only the most severe and most complicated cases require the more costly specialized treatments.

Table 1
Categories of Drug Abusers and Intervention Resources Required

Severity	Intervention
Mildly Impaired	Responds to personal drug crisis; threat of urine testing; or, admonitions of employer, or family. Treatment is usually not required.
Moderately Disabled	Many respond to self-help groups (e.g., A.A., N.A.) or minimal counseling or supervision. Most require a planned program of outpatient or residential treatment consisting of drug counseling, detoxification, and/or pharmacological support (methadone, naltrexone for opiate abuse or anti-depressants for cocaine).
Severely Disabled	Severely socially disadvantaged or diagnosable psychopathology requiring special services (e.g., psychotherapy, vocational or other rehabilitative services), but when such services are provided these individuals show substantial improvement.
Extremely Disabled	Social impairment and/or psychopathology exceeds the level that can be successfully addressed by current methods may require chronic care, or compulsory confinement.

HOW WELL DOES TREATMENT WORK?

Drug abuse treatment is highly effective in reducing illicit drug abuse and criminality, and increasing desirable behavior (school attendance, employment). Many abusers require multiple episodes of treatment before achieving permanent abstinence, and a few are not seemingly helped by any of the currently existing forms of treatments. Like many chronic disorders, long-term drug abuse rarely yields to short-term therapeutic interventions.

Self-Help Groups

Self-help programs usually take the form of groups in which addicts act as resources to one another to maintain their resolve to remain drug abstinent through continuing contact and regular meetings. Alcoholics Anonymous and Narcotics Anonymous are the best known examples of these groups. Recently, attempts have been made to bridge the gap between "pure" self-help approaches and more structured treatment regimen. One such attempt involves "professionally guided self-help," in which a professional acts as a facilitator in a series of skills training sessions used to give clients the intellectual resources to cope with those factors that precipitate relapse. In controlled tests of this approach, improvements were produced in skills to avoid drug and alcohol use, skills to cope with drug relapse, consequential thinking skills, and social skills. Self-help approaches can be an effective intervention for the moderately drug disabled or for those who have successfully completed a course of treatment and are simply in need of peer support.

Detoxification

Detoxification is a procedure designed to render the patient drug free with a minimal level of discomfort or danger from life-threatening withdrawal symptoms. Detoxification from some drugs (e.g., opiates and barbiturates) is accomplished by giving decreasing doses of drug over a period of time. With others (e.g., marihuana and cocaine) drugs can be stopped abruptly. Depending on the nature and severity of the problem, detoxification can take place in an in-patient hospital setting, residential facility, or in an outpatient program.

Detoxification should only be considered a preliminary step in the treatment process, except for those who are only moderately involved in drug use. It does not deal with the psychological and social difficulties that contributed to the development of the drug abuse problem. Most studies comparing addicts before and after short-term detoxification, with no other intervention, have found little or no long-term decrease in drug-taking behavior.

Residential Treatment and Therapeutic Communities

In these programs, clients live in a highly-structured setting. The programs are aimed at producing deep and permanent attitude and value changes as well as a committment to a drug-free life. The duration of such programs varies from several months to two years. The shorter-term programs (Hazelden, Betty Ford Center) seem to be geared to older patients with fewer economic and psychological problems and little criminal involvement. They have evolved from programs aimed exclusively at those who abuse alcohol, to programs for treating sedative, cocaine, opiate, and cannabis dependence. Their utility for treating the severely dependent, or culturally disadvantaged, or long-term heroin or cocaine users is uncertain. The traditional longer-term programs (Phoenix House, Daytop Village) evolved from programs originally aimed at younger, criminally involved hard-core illicit drug users. The short-term residential programs are usually far costlier, on a per day basis, than the longer term programs which in turn are about three times more costly than intensive outpatient programs.

The effectiveness of long-term programs has been well established. In one assessment; drug use, criminal involvement, and employment status were compared in drug abusers who completed treatment (graduates) and those who did not (dropouts). Graduates and dropouts showed few differences prior to treatment, but substantial differences at followup. Especially striking are decreases in opioid use (less than 5 percent of graduates reported any use of opioids during a five-year followup period, compared to 95 percent prior to treatment) and criminal involvement (81 percent of graduates reported criminal involvement at one year prior to treatment compared with 6 percent at three years after treatment). For dropouts, reductions in opioid use and criminal involvement were less dramatic, yet still substantial. Significant changes were also seen in the arrests, conviction rate, and months in jail and employment for graduates and dropouts (De Leon, 1984).

The longer the drug abuser is in treatment, the more successful the outcome. The problem with long-term residential treatment is that the retention rate is low. The high dropout rate in therapeutic communities is at least partly related to initial program intensity, with new admissions having difficulty in adjusting to the strict rules of the community, being confronted by other residents about drug use, etc. In fact, dropouts are typically highest in therapeutic communities within the first 14 days of treatment.

Drug-Free Outpatient Treatment

The drug-free outpatient modality includes a wide variety of approaches to treatment. It is the most widely used treatment modality accounting for about 40 percent of the drug abusers in treatment, many of whom are non-opiate drug abusers. Programs vary widely from casual drop-in centers to highly structured programs providing counseling and psychotherapy. They are called "drug-free" to distinguish them from outpatient programs that dispense methadone. As with residential treatment, drug-free outpatient treatment has

been found effective in reducing opiate and nonopiate drug use, increasing employment, and decreasing criminal involvement. However, as with therapeutic communities, retaining hard-core drug abusers in treatment is a problem. In one study, only 20 percent of heroin addicts remained in drug-free outpatient programs for the recommended one year of treatment (Simpson).

These evaluations were done prior to the development of new therapeutic techniques for preventing relapse. Relapse prevention techniques offer promise of increasing retention and making outpatient drug-free programs even more effective.

Methadone Maintenance

Methadone is a legal drug that can substitute for heroin and prevent opiate withdrawal symptoms. Administered orally, on a daily basis, it allows many opioid (heroin) addicts to function normally without constant craving for heroin. Methadone maintenance, in and of itself, cannot be considered rehabilitation. However, by reducing the physiological craving for heroin and the fear of withdrawal, the methadone maintained client is able to focus attention on work, family and rehabilitative activities.

Methadone maintenance programs typically operate on an outpatient basis, require medical supervision and provide both counseling and some general medical care. Methadone maintenance is readily accepted by a high proportion of heroin addicts and approximately 74,000 addicts are in treatment at any time. Retention rates are higher than in other modalities, with one-year retention rates ranging from 55 to 85 percent in different clinics (Cooper et al., 1983).

Entry into methadone maintenance programs is associated with a dramatic reduction in illicit drug use and criminal behavior, and an increase in social adjustment and productivity. In a recent study of seven methadone maintenance programs in three cities, 66 percent of those who had recently entered the programs had used illicit opiate in the past month of treatment, whereas only 23 percent of those in treatment for 1-5 years and only 8 percent of those in treatment for 5 or more years showed similar evidence (Ball et al., 1987). In addition to reducing illicit opiate use, methadone maintenance has been found to reduce other types of drug use as well. However, abuse of other drugs such as alcohol or cocaine continues to be a problem, requiring the development of new approaches for these multiple drug abusers.

In addition to decreases in drug use, criminal activities decrease and productive activities increase during methadone maintenance. In one large scale evaluation, illegal income of heroin addicts declined threefold as a result of treatment. In the two months prior to treatment, 49 percent of clients derived income from illegal sources, while only 18 percent of clients had such income at any time during treatment.

Unfortunately, when clients terminate prematurely from methadone maintenance programs, they usually return to opiate use within several months. On the

other hand, of those who relapse to heroin use, most subsequently reenter treatment.

Finally, it is clear that methadone maintenance can significantly reduce the transmission of AIDS among intravenous drug abusers. By reducing intravenous drug use, methadone maintenance is effective in reducing the sharing of contaminated needles. Indeed, one study in the New York area has reported markedly lower rates of seropositivity among heroin addicts in methadone maintenance programs (23 percent) than heroin addicts not in treatment (47 percent) (Novick et al., 1986). Other studies have reported significantly lower seropositivity rates for addicts enrolled in methadone maintenance programs for several years than for addicts recently admitted to treatment programs.

Barriers to the Use of Pharmacological Maintenance Therapies

Heroin addicts clearly do better when they remain in methadone maintenance programs and do not terminate before the goals of the treatment program are achieved. Because rehabilitation of a hard-core drug abuser is a lengthy process and requires more time for some addicts than for others, long-term methadone maintenance is becoming more accepted as a treatment strategy for addicts. Indeed, some addicts have been maintained on methadone for as long as 20 years without apparent adverse medical consequences (Kreek, 1983). Nevertheless, there is a substantial public prejudice against methadone in many areas. This prejudice persists, irrespective of the evidence of its acceptability to addicts, its demonstrated effectiveness in reducing drug use and crime, and its potential for stemming the spread of AIDS.

Public Law 98-509 places rigid standards on how methadone is used in therapeutic settings. The Food and Drug Administration and the National Institute on Drug Abuse has recently stremlined the Federal regulations to make them more responsive to the legitimate needs of the treatment community. However, there is still concern about the appropriateness of the federal government dictating treatment practices. The need for the regulations could be obviated if a strong standard setting program were undertaken by the states. Until such time the Federal government must continue to regulate the use of methadone and any future pharmacological maintenance therapy.

The Need for Research

As discussed there is little doubt that treatment has a substantial beneficial effect on drug taking behavior and its adverse consequences. But, it is also obvious that the benefits of treatment can be greatly enhanced if treatment programs were able to retain their clients for longer periods. Finding methods to improve retention rates must be given a high priority in our drug abuse research efforts.