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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

700275
HE006-01

August 22, 1986

NOTE TO THE HONORABLE CARLTON E. TURNER, Ph.D.

Dear Carlton,

Attached is the Health Task Force Report, "Toward a Drug Free Society: Drug Abuse Research, Education, and Intervention."

Barry Clendenin, Chief of the Health and Social Services Branch at OMB, has asked for a copy of the Report. I am enclosing a second copy which you can send to him.

Also enclosed is a draft legislative proposal to eliminate certain earmarks in the Alcohol and Drug Abuse and Mental Health Services Block Grant. Other legislative proposals will follow.

Mac

Donald Ian Macdonald, M.D.

Attachments

DRAFT

ADAMHA:8/22/86

TOWARD A DRUG FREE SOCIETY: DRUG ABUSE RESEARCH, EDUCATION, AND INTERVENTION

Our eventual goal is a drug free society. If we were able to get everyone off of drugs and keep them off there would be no demand for drugs. Unfortunately, the complete elimination of use seems an unrealistic short term goal. We have, therefore, looked at ways to bring about the greatest reduction in drug use within present constraints of limited dollars, personnel, knowledge, and other resources.

The activities we recommend below reflect the need for strong prevention and education activities and for measures designed to encourage -- or force -- drug users out of the market. The backbone of the strategy is based on increased awareness and sensitivity about drugs and the adoption of a societal attitude of utter unacceptability of drug use by anyone at any time.

The aim of this Presidential initiative is to make our schools and workplaces drug-free. The Federal role will be to set an example in its own workplace; recommend and evaluate systems for prevention, intervention and treatment; and stimulate and provide technical support for States and communities to mobilize and coordinate their drug abuse efforts. State and community activities will remain the cornerstone of our efforts. The Federal role in research will be maintained with a special focus on knowledge development needs related to this initiative, including the development and evaluation of new and better treatment and prevention programs.

The concepts of a "drug free school" and "a drug free workplace" did not exist 30 years ago. We assumed at that time -- correctly -- that there was virtually no drug use in those places. In the last 25 years, however, we have seen a spread of drug use from a hard core layer of addiction closely associated with social, economic, psychological, educational and medical factors to a problem involving all strata and ages in our society and with considerable variability in co-existing pathology, social disability, and severity of dependence. We have called this new wave of drug use an epidemic. Our highest priority is to attack this epidemic, this rapid escalation of use in which drugs have invaded the schools and the workplace. When the President leaves office we would like to leave behind as his legacy a substantial decline in this drug using population. Additionally, we will leave in place mechanisms which can benefit the underlying, more severely disturbed population of "traditional" drug users.

Early on in our discussions we raised the question, "Is it better to concentrate on those who are most severely involved and who use the most drugs or to make less involved users the principal focus?" Our decision has been to concentrate on the non-users and the less involved users. We recommend enhancement of our prevention efforts and implementation of a strategy to push early users back into non-use.

There are a number of reasons why we see targeting of the minimally involved user as being the most consistent with the drug free school and workplace goals. Not the least of these is the fact that the more advanced users do not attend school or go to work.

Additionally, pushing minimally involved users out of their drug use makes sense because it involves the majority of drug users, can be seen as a tool of prevention, and is the most cost effective approach.

We may look at removal of the minimally involved drug user from the market as a form of prevention in two important ways. First, because we know that drug use tends to progress, intervention in early stages of use will prevent the experimenter from advancing to more frequent use and addiction. Secondly, we know that epidemics are spread by the minimally involved who seem healthy and have not yet seen their problem advance to the stage where difficulties are most evident. The new user is almost always introduced by a friend, a peer, or a sibling who is already a drug user and seems to show no signs of trouble. With the removal of large numbers of these users from the picture, peer practices and associated pressure will be beneficially changed.

The cost implications of an attack on minimal use are also important. This is the group of users that is most likely to have sources of help that do not rely on Federal dollars -- personal finances, private insurance, and enrollment in jobs with employee assistance programs. An additional cost benefit is that this group of users is the most likely to return to full occupational potential and to payment of associated taxes.

Not surprisingly, the resources necesary to treat the minimally involved are considerably less than those required to treat the most severely addicted. For purposes of assessing resource needs we have broken drug users into four categories (see Table II). Category I consists of those drug users who are least involved, who require limited resources, and who should respond to such limited actions as the threat of urine testing, admonitions of employer or spouse, some counseling, and modest supervision. Category II consists of those drug users who demand modest resources, but resources greater than those required by individuals in Category I. Category III users demand extraordinary resources. At the end of this progression, Category IV consists of those users who have maximal drug demand, who are least likely to respond to treatment, and who would require the most resources to treat. Their social impairment and psychopathology exceed the level that can be successfully addressed by current methods and they require chronic care and, for some, long-term or permanent institutionalization or incarceration.

To illustrate the costs it is useful to look at our experts' "guesstimate" of what proportion of various therapeutic modalities is likely to be necessary for each category of drug use. Looking, for illustrative purposes, at Table III, the first column shows that it is our estimate that 67 percent of cocaine users fall into this "minimal demand" category. Looking down in column I, it can be seen that we estimate that 20 percent of these users can be pushed into non-use with minimal pressure, self-help groups, and no financial outlay. The great majority (75 percent) of category I users, however, fall into a group who would require employee assistance programs, urine screening, and minimal counseling. The cost of keeping such services available would amount to $3000 per slot per year; but the column labeled "throughput" shows that over the year 6 people could use each slot made available. Therefore, the actual cost per person pushed to a drug-free status would be $500. By contrast, looking at the fourth column, it is not surprising to find that the costs of interventions with category IV users are much higher. Looking down the column it can be seen that 30 percent of category IV users would require non-medical residential services at costs of between $4688 and $6250 for a three-week treatment episode. Table IV gives similar information for heroin users.

We estimate that the cost of treating all heroin users would be nearly $1 billion per year and of treating all cocaine users an additional $6-7 billion. It isn't that we don't want to see these people treated. Rather, it is a question of financial limitations as well as the need for new treatment and rehabilitation procedures to reach those who are retractory to currently available procedures.

Although our principal focus is on the less severely involved users we have not ignored the issues of intravenous drug use as a vector of AIDS nor the issue of addicts on waiting lists for treatment. In a separate budget request we have greatly expanded our efforts in research on AIDS in drug users. Research on alternatives to methadone in the treatment of heroin addiction will hopefully help curtail the spread of AIDS. We are also sponsoring AIDS service demonstration projects and consulting on a major AIDS service demonstration project being funded by the Robert Wood Johnson Foundation.

A major problem of heroin and cocaine addiction is lack of ideal treatment. We are recommending an enhancement of research to address this issue. Our major activity, community demonstrations aimed at improving the drug prevention and treatment systems in States and communities should address the issue of waiting lists. Over the long haul our prevention efforts should do more -- they will decrease entry into the pool of addiction.

Federal support for drug treatment services comes in a number of ways. Block grant support has increased 15 percent since the original block grant of 1982. Additional support is given through the Veterans' Administration, disability income payments, food and housing programs. Title XIX funds (Medicaid) match State contributions for treatment for those who qualify -- most heroin addicts do. As cities decide to increase treatment, Federal support will automatically be increased under Title XIX.

Accordingly, we recommend the following activities:

1. Community Systems Development Projects ($70 million, 14 FTEs)

   Provide short-term financial assistance (on a matching basis with a declining Federal share) to communities to assist them in mobilizing comprehensive, integrated efforts to reduce drug use. Build on existing public and private sector institutions. Develop a permanent capability which can be sustained by the States and communities themselves. Anticipated outcomes: integration of alcohol and drug abuse awareness, recognition, and treatment into the mainstream of health care; involvement of all segments of society--the school, the workplace, the church, the health care system, the criminal justice system, civic and voluntary ohol associations, the media, and all levels of Government--to enhance local

2. Agency for Substance Abuse Prevention ($15 million, 18 FTEs)

   Establish an Agency for Substance Abuse Prevention to facilitate and assist public and volunteer efforts and to disseminate knowledge gained from prevention research through a statewide prevention network. Provide immediate aid to communities in drug crisis through rapid response technical assistance, needs assessment, and advice on effective prevention strategies.

3. Epidemiology and Surveillance ($3 million, 8 FTEs)

   Develop enhanced epidemiology and surveillance systems to assure comprehensive tracking of the incidence and prevalence of alcohol and drug use and improved identification of risk factors and risk groups.

4. Research ($33 million, 38 FTEs)

   Develop better and more effective methods of preventing, detecting, diagnosing, and treating illicit drug use and intervening with high risk children and adolescents. Develop alternative, improved, more attractive, and less costly drug detection mechanisms. Develop national accreditation system for laboratory testing.

5. Support for Other Department Efforts ($9 million, 4 FTEs)

   Department of Education/HHS will develop national demonstration projects and an integrative plan to establish and maintain drug-free schools, colleges, and universities in order to maximize the potential for students to become productive citizens. ($4 million, 2 FTEs)

   Department of Labor/OPM/HHS will facilitate the development of Employee Assistance Programs and implement model drug and alcohol demonstration efforts at the workplace. ($5 million, 2 FTEs)

Total: $130 million
82 FTEs

TABLE I

ESTIMATED NUMBERS OF CURRENT USERS (within past 30 days)*

AGE	≤12	12-17	18-25	26-40	>40
DRUG GROUP					
Primarily Opioids	2,500	10,000	190,000	200,000	100,000
Cocaine					
Non-Freebase	(50%)120,000	(55%)380,000	(65%)1,560,000	(78%)655,000	(80%)400,000
Freebase, Including "Crack"	(50%)120,000	(45%)310,000	(35%) 840,000	(22%)185,000	(20%)100,000
Total	240,000	690,000	2,400,000	840,000	500,000
Opioids Complicated by Cocaine	These Individuals are Included in the Two Categories Above				
Primarily Marijuana	886,000	2,660,000	8,990,000	5,859,000	2,511,000
Primarily Alcohol	2,068,000	6,210,000	22,250,000	28,704,000	43,056,000
Primarily Sedatives/ Stimulants/Other	300,000	900,000	2,380,000	1,064,000	116,000
Opioid/Alcohol/Poly-drug	These are Included Among Category IV Opioid/Cocaine Users				

* Because many individuals use more than one substance, there is great overlap and the total shown here far exceeds the number of unduplicated individuals who have used various drug categories.

TABLE II

RESOURCE DEMAND DISTRIBUTION WITH DRUG USE CATEGORIES FOR RECENT USERS (last 30 days)

(Resource demand is a higher order category that incorporate co-existing pathology, social disability, and severity of dependence)

Category	Description of Syndrome and Likely Resource Demand
I	Minimal demand - responds to threat of urine testing, admonitions of employer, wife, etc., some counseling, modest supervision.
II	Modest demand - requires range of drug-related treatment, inpatient, outpatient, detoxification, therapeutic community, oral methadone, drug counseling, private therapy, naltrexone or pharmacological supports for cocaine, etc.
III	Extrordinary demand - severe dependence or psychopathology requiring special services (e.g., psychotherapy beyond that available in clinic settings, but ultimately when such services are provided these individuals respond by improving).
IV	Maximal demand/minimal response - social impairment/psychopathology exceeds the level that can be successfully addressed by current methods - requires chronic care, compulsory confinement.

TABLE III

EXPECTED RESOURCE DEMANDS AMONG INDIVIDUALS USING THIS DRUG CATEGORY OVER LAST 30 DAYS PRIMARILY COCAINE

Resource Demand Categories

67% I	17% II	8% III	8% IV	Intervention Resource Description	Cost/Slot/ Year	Days/Episode	Throughput	Cost/ Epis
20	5	2	1	Self Help	N/A	180	2	N/A
75	0	0	0	Employee Assistance Programs Urine Screening/ Minimal Counseling	3,000	60	6	500
5	30	15	8	Outpatient Psychotherapy	7,500	60	6	1250
0	30	25	17	Outpatient Psychotherapy plus Pharmacotherapy	8,500	90	4	2125
0	6	10	15	Non-medical Residential - Concept House	13,000	120	3	4333
0	25	30	30	Non-medical Residential (e.g. Hazelton)	75,000- 100,000	21	16	468 625
0	3	18	29	Medical/Psychiatric Inpatient	120,000	21	16	7500

*Total cocaine use consists of both free-base (including "crack") and non-free-base forms. Our very rough estimates are that at present about 2/3 of users are still involved with non-free-base forms and about 1/3 are being exposed to free-base, including "crack." The estimates of resource demand shown in this Table are for non-free-base forms. We estimate that for free-base and cocaine, the percentage of those users in category I would drop to 30% and those in categories II, III and IV requiring more extensive services would rise to 70%. The distribution of resource categories also differs by age group and education; thus among Federal workers, we would expect more than 90% of recent users to be in category I.

TABLE IV

EXPECTED RESOURCE DEMANDS AMONG INDIVIDUALS USING THIS DRUG CATEGORY OVER LAST 30 DAYS PRIMARILY OPIOIDS

Resource Demand Categories

15% I	30% II	30% III	25% IV	Intervention Resource Description	Cost/Slot/ Year	Days/Episode	Throughput	Cost/ Episode
5	1	2	0	Other - Private Psychotherapy (psychologist, social worker, etc.)	N/A	90	4	N/A
10	3	3	2	Other - Self Help	N/A	180	2	N/A
0	15	20	20	Outpatient Detoxification (with or without methadone)	3,000	30	12	250
5	10	5	5	Outpatient - Drug Free (primarily non-medical)	2,000	60	6	333
75	10	0	0	Employee Assistance/Urine Testing, On-job Counseling, School Counseling	3,000	60	6	500
5	10	10	10	Outpatient Post-withdrawal Treatment (e.g., naltrexone)	3,500	90	4	875
0	35	10	5	Methadone Outpatient Category II	2,500	180	2	1250
0	2	5	5	Hospital Inpatient Detoxification (approx. $265/day)	120,000	7	52	2308
0	10	10	10	Non-medical Therapeutic Community or Concept House	10,000	120	3-4	2500-3333
0	0	30	50	Methadone Category III & IV	7,500	180	2	3750
0	4	5	3	Medically Augmented Concept House (e.g., Second Genesis)	15,000	120	3	5000

Assumptions about distributions within resource demand categories. Category I, 15% (75,000); Category II, 30% (150,000); Category III, 30% (150,000); Category IV, 25% (125,000).

TABLE V

REHABILITATION COSTS

PRIMARILY COCAINE

	No.	%	Amount	Cumulative No.	%	Amount
Self Help	676,683	14%	0	676,683	14%	0
Employee Assistance Programs	2,346,675	50%	1,173,337,500	3,023,358	65%	1,173,337,500
Outpatient Psychotherapy	480,543	10%	600,678,750	3,503,901	75%	1,774,016,250
Outpat. Psycho. + Pharmacotherapy	395,082	8%	839,549,250	3,898,983	83%	2,613,565,500
Non-med. Res. Concept House	141,034	3%	611,100,322	4,040,017	87%	3,224,665,822
Non-medical Residential	422,635	9%	2,311,390,815	4,462,652	96%	5,536,056,637
Medical/Psychiatric Inpatient	199,409	4%	1,495,567,500	4,662,061	100%	7,031,624,137
Subtotal, Cocaine	4,662,061	100%	7,031,624,137			
Category I	3,128,900	67%	1,368,893,750	3,128,900	67%	1,368,893,750
Category II	785,961	17%	2,274,309,147	3,914,861	84%	3,643,202,897
Category III	373,600	8%	1,547,731,400	4,288,461	92%	5,190,934,297
Category IV	373,600	8%	1,840,689,840	4,662,061	100%	7,031,624,137
Subtotal, Cocaine	4,662,061	100%	7,031,624,137			

PRIMARILY OPIOIDS

	No.	%	Amount	Cumulative No.	%	Amount
Other - Private Psychotherapy	8,291	2%	0	8,291	2%	0
Other - Self Help	19,095	4%	0	27,386	5%	0
Outpatient Detoxification	77,888	15%	19,471,875	105,274	20%	19,471,875
Outpatient - Free Drug	32,663	6%	10,876,613	137,936	27%	30,348,488
Employee Assistance	71,606	14%	35,803,125	209,543	41%	66,151,613
Outpatient Post-withdrawl	46,481	9%	40,671,094	256,024	50%	106,822,706
Methadone Outpatient Cat. II	74,119	14%	92,648,438	330,143	64%	199,471,144
Hospital Inpatient	16,834	3%	38,852,295	346,976	67%	238,323,439
Non-Medical Therapeutic	42,713	8%	124,571,006	389,689	76%	362,894,445
Methadone Categories III, IV	108,038	21%	405,140,625	497,726	97%	768,035,070
Medically Augmented Concept	17,336	3%	86,681,250	515,063	100%	854,716,320
Subtotal, Opioids	515,063	100%	854,716,320			
Category I	75,375	15%	32,818,275	75,375	15%	32,818,275
Category II	150,750	29%	178,429,208	226,125	44%	211,247,483
Category III	150,750	29%	310,725,900	376,875	73%	521,973,383
Category IV	138,188	27%	332,742,938	515,063	100%	854,716,320
Subtotal, Opioids	515,063	100%	854,716,320			

COMMUNITY SYSTEMS DEVELOPMENT PROJECTS

Goals:

- o Enhance public awareness and understanding of the problems of drug and alcohol use.
- o Foster attitude changes that deglamorize drug and alcohol use.
- o Make illicit drug use utterly unacceptable.
- o Create drug free communities

Population Focus: Non-user and early initiator populations

Objective: Support model community systems development projects that feature:

a) coordination of community-wide activities relevant to prevention, education, and early intervention services, including integrative early identification, referral, and services delivery systems

b) linkage of all relevant social and familial institutions (i.e., criminal justice, business and industry, religious, educational, social services)

c) innovative community coalitions of public and private organizations (i.e., community recreational facilities, public housing, volunteer organizations, health care systems, welfare units)

d) focused activities on at-risk populations who exhibit high-risk behaviors. Such targetting has the highest potential for cost-offset and cost-benefit to society.

e) surveillance and monitoring systems to rapidly identify changes in incidence and prevalence rates

f) programs that address the needs of school-age youth who are not in traditional public or private school settings. Specific at-risk groups include runaways, ethnic minority youth, youth in the juvenile justice system, and youth in alternative schools or state training schools.

g) development of community model standards and community intervention guides. This includes adoption of specific local level goals, objectives, and activities according to a community needs assessment profile.

Budget: $70.0 M
14 FTEs

AGENCY FOR SUBSTANCE ABUSE PREVENTION

Goal: Establish within DHHS (ADAMHA) an Agency for Substance Abuse Prevention as the lead Departmental unit for the collection and dissemination of accurate and timely information, model programs, and resources to address alcohol and drug issues. The Agency will be responsible for developing and implementing national training programs, prevention and intervention materials development and dissemination, and clearinghouse functions. This Agency will liaison with other Federal units responsible for elements of the enhanced demand reduction strategy (The President's Initiative on Drug Abuse).

Population Focus: Non-users and early initiator populations

Objective: Develop programs to bring alcohol and drug problem awareness, recognition, and early intervention services into the mainstream of primary health care.

Objective: Disseminate information to State and local organizations in support of their efforts to develop and implement prevention, education, and early intervention programs. Innovative early intervention and prevention programs developed through the research and evaluation component of the initiative will be rapidly disseminated.

Objective: Ensure that accurate programs and messages reach citizens through public print and electronic media (TV, radio, newspapers, magazines).

Objective: Ensure that every State has a broad-based system for coordination of focused alcohol and drug programs. This is to include support of existing networks and organizations (i.e., NPN, NFP) as well as fostering the development of needed coalitions and task forces where gaps exist.

Objective: Establish a national prevention training center to ensure the training of "gatekeepers" at the community level (i.e., police, teachers, probation officers, social workers, judges, parents, clergy, primary care professionals, etc.). This unit will be responsible for developing and disseminating manuals, handbooks, and training materials.

Objective: Provision of rapid response/crisis response technical assistance teams to State and local organizations in support of their immediate needs to develop and implement prevention, education, and early intervention programs. This approach is based on the CDC Epidemic Intelligence Services (EIS) model.

Budget: $15.0 M
18 FTEs

EPIDEMIOLOGY AND SURVEILLANCE

Goal: Improve and expand epidemiologic surveillance systems and investigation capability to ensure comprehensive tracking of the prevalence of alcohol and drug use and related behaviors at the national, State, and local levels.

Objective: Establish new epidemiologic surveillance systems to monitor drug abuse in populations, such as schools and colleges; juvenile and adult criminal justice; military; the workplace; life transition points, such as at time of birth and marriage; and hidden populations, such as high school dropouts, runaways, and the homeless. Evaluate the use of sentinel health events to measure the impact of drug abuse (i.e., criminal activity, motor vehicle accidents, intentional and unintentional injuries).

Objective: Establish rapid turn-around survey methodologies, such as telephone surveys and public opinion polls to measure the impact of drug issues. Work with CDC to enhance drug abuse components of the behavioral risk factor surveillance system (BRFS).

Objective: Establish a demonstration project to test surveillance and other data gathering techniques to permit identification of at risk groups for drug and alcohol use as well as early experimenters with drugs and alcohol.

Objective: Develop an ongoing epidemiologic surveillance and investigation capability to identify new and emerging drugs of abuse by establishing a national reporting database from treatment programs, health facilities, hot lines and crisis centers, and law enforcement offices based on toxicology screenings, urinalysis, street drug analysis, intelligence reports, and ethnographic research.

Objective: Establish the capability to conduct field investigations of acute drug-related outbreaks which threaten public health in the communities and improve epidemiologic surveillance at the State and local community level, by expanding technical assistance and collaboration with State and local officials (rapid deployment mechanisms), providing epidemiology training to community-based drug abuse researchers and other professionals, and encouraging the establishment of a State drug abuse epidemiologist in each State.

Budget: $3.0 M
8 FTEs

RESEARCH

Goal: TO DEVELOP INNOVATIVE, COST-EFFECTIVE TREATMENT PROGRAMS.

Current treatment research has been concentrated on the evaluation of established narcotic treatment techniques. Relatively little research is being conducted on innovative treatments for newer drug problems (cocaine dependence, adolescent drug dependence, AIDS risk reduction). We propose to establish at NIDA's intramural research program (ARC) a model adult and adolescent in- and out-patient treatment research program focusing on cocaine and IV drug users. Extramural research capacity will be increased to develop and evaluate innovative treatment techniques for cocaine and heroin abusers based on new knowledge of the biological and behavioral bases of drug abuse. This will include an emphasis on alternatives to methadone maintenance such as depot naltrexone and buprenorphine. Further expansion of extramural research on cocaine and controlled substance analogs and their toxic effects will also be initiated.

BUDGET: $11,400,000 FTE: (27)

Goal: TO DEVELOP A PROGRAM TO EVALUATE THE EFFICACY OF CURRENT TREATMENT

A variety of treatments, including the use (alone and in combination) of drugs such as bromocriptine, amantadine, imipramine, and behavioral therapy and psychotherapy are currently being used to treat cocaine addiction. Specialized treatment research laboratories will be established to evaluate the efficacy of these treatment approaches. The results of this research will provide a rational basis for choosing the most cost-effective treatment for specific clients.

BUDGET: $8,100,000 FTE: (2)

Goal: TO DETERMINE THE EFFICACY OF PREVENTION PROGRAMS

In collaboration with state and local agencies, programs funded under the Community Systems Development Project will be identified for evaluation. These programs will emphasize the school, the family, and the worksite as points of contact, and the preadolescent, adolescent and young adult as the focus of concern. The efforts will involve both evaluation of efforts to prevent the initiation of drug and alcohol use and the development of early intervention strategies targeted at the potential drug user and his or her family.

BUDGET: $5,700,000 FTE: (3)

Goal: TO IDENTIFY CHILDREN AT RISK FOR DRUG AND ALCOHOL ABUSE

Recent studies have shown that the way children respond to the first year in school is predictive of teenage and adult problems. Aggressiveness, such as not obeying rules, truancy, and fighting with classmates often is associated with problems such as drug and alcohol abuse and delinquency later in life.

We propose to fund research to improve and determine the validity of identification criteria and the effectiveness of various interventions to avert the development of drug and alcohol problems in such high risk children. Further, we propose to expand our current extramural research on the biological and behavioral bases of illicit drug use with special emphasis on investigations of the social, behavioral, genetic, and biomedical factors underlying "invulnerability" to drug abuse.

BUDGET: $4,100,000 FTE: (3)

Goal: DEVELOP VALID AND RELIABLE DRUG SCREENING METHODS AND PROGRAMS

HHS will develop standardized procedures for monitoring quality control for drug testing of urine. Working with the private sector, we will develop procedures to certify the proficiency of laboratories to perform these analyses. Further research will be conducted to develop more sensitive systems of analysis that may be useful as a diagnostic methodology for drug abuse. In addition, non-invasive technologies, designed to assess specific motor and cognitive performance effects of abused drugs, will be developed.

BUDGET: $3,700,000 FTE: (3)

ADAMHA CONSULTATION/TECHNICAL ASSISTANCE WITH OTHER DEPARTMENTS

Department of Education

ADAMHA will provide technical assistance, consultation, and support for the development of a school-based element that focuses on the enhancement of student competencies as well as the development of school climates and support systems (e.g., peers/faculties/teachers) that make children more resistant to drugs and more committed to positive school/social adjustment.

Such efforts will include development and dissemination of 1) a comprehensive program of school health for all children (including instruction in the health and social dangers associated with tobacco, alcohol and drug use) designed to develop self efficacy as a way of making children resistant to social forces that lead to drug and alcohol use (i.e., make children capable of identifying and resisting peer pressure); 2) specific intervention programs designed for youth who present a profile of antecedent risk factors for substance abuse; and 3) specific programs for youth who are early initiators (experimenters).

Budget

$4 M
2 FTEs

Department of Labor/Office of Personnel Management

ADAMHA will provide technical assistance, consultation, and support for the development of public health - business/industry partnerships. ADAMHA will encourage specific expansion of the role of EAPs into preventive activities. Support will be provided for the development of prevention-oriented EAPs in industries that historically have been resistant to developing such programs (e.g., small business).

Such endeavors will encourage worksites to develop support programs for the maintenance of no-use drugs/non-abuse alcohol behaviors of employees who may previously have engaged in casual to moderate use of drugs or alcohol abuse. Model worksite drug and alcohol demonstration projects will be encouraged and supported by this activity.

Budget

$5 M
2 FTEs

22 AUG 1986

DHHS
PUBLIC HEALTH SERVICE
FISCAL YEAR 1988 LEGISLATIVE PROPOSAL

DRAFT

EXTEND AND AMEND THE ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT

Extend and Amend the Alcohol and Drug Abuse and Mental Health Services Block Grant

Current Law: The Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant, authorized under title XIX, part B, of the Public Health Services Act, imposes several significant earmarks on the States' use of block grant funds.

Three of these date from the original enactment of this title in the Omnibus Budget Reconciliation Act of 1981:

(a) 35 percent of substance abuse funds is to be spent for alcohol abuse programs (sec. 1916(c)(7)(A));

(b) 35 percent of substance abuse funds is to be spent for alcohol abuse programs (sec. 1916(c)(B); and

(c) 20 percent of substance abuse funds is to be spent for prevention and early intervention activities (sec. 1916(c)(8)).

Two more were imposed by the Alcohol Abuse, Drug Abuse, and Mental Health Amendments of 1984:

(a) 5 percent of the total grant is to be spent for substance abuse programs for women (sec. 1916(9c)(14)); and

(b) 10 percent of the mental health portion of the grant is to be spent for mental health programs for underserved populations and adolescents sec. 1916(c)(15)).

Proposal: Extend the ADMS Block Grant for an additional five fiscal years and eliminate those earmarks which are counterproductive.

Rationale: It is now time to let the states enjoy the intended advantage of New Federalism by deciding fully how they will use funds under this block grant. The major purpose of the earmarks in the original legislation was to insure that programs which had been previously funded by categorical grants would continue to receive some support under the ADMS Block Grant. This was particularly important during the early transitional phase to block grants when states were still trying to determine the effect of the new funding process on their programs. The later impositions were included to ensure the establishment of programs in specific areas.

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All recipients of ADMS Block Grant funds have reported progress in meeting the statutorily-imposed earmarks. When the current authorization ends at the end of FY 1987, the ADMS Block Grant recipients will have had six years' experience in meeting the earmarks contained in the original legislation and four years of accomplishment toward establishing new programs to meet the 1984 requirements. There has not been a precipitous de-funding of one program area at the expense of the others.

Because Federal funds are a limited and precious commodity States must be as free as possible to utilize these funds as current conditions dictate. For example, States which have an urgent unmet treatment or prevention services need in drug abuse should not be statutorily prohibited from shifting federally provided alcohol abuse funds, prevention funds, and up to 25 percent of their total block grant fund (which includes mental health funds in this base) for those purposes. Similarly, if the State's most pressing need were for alcohol or mental health services, it should not be unduly restricted by having to spend statutorily fixed minimum percentages for services which are less critical or for which other funding sources might be available.

This proposal would extend the ADMS Block Grant for an additional five fiscal years and retain in the law only those provisions which allow the States needed flexibility to administer their programs, while still assuring that the major purpose of providing mental health and alcohol and drug abuse services will be accomplished. Therefore, the proposal would repeal all of the percentage earmarks and the limitation listed above but would retain: (1) the requirement for allocation within States of certain percentages for mental health activities and for substance abuse activities; (2) State discretionto shift up to 25 percent of its total allotment to either the mental health or alcohol and drug abuse portion of its program; and (3) State discretion to use up to ten percent of its allocation to meet administrative costs. State experience has shown that these provisions are sufficiently flexible to meet foreseeable needs within the objectives of the block grant.

This proposal leaves to the States the full measure of flexibility promised in the New Federalism which gave birth to the block grants.

Effect on Beneficiaries: By removing the earmarks from the legislation, the States, territories, and Indian tribes will be provided further opportunity to identify and develop programs needed by their populations. Thus, individuals can be provided the most critical services they need. States have documented in applications and annual reports that because of the restrictive nature of the earmarks, States are unable to provide specific services as their priority setting would indicate. With further removal of earmarks and limitations, States and their citizens will realize the full benefit of the flexibility intended by New Federalism.

Cost:

FY 1988	FY 1989	FY 1990	FY 1991	FY 1992

(TO BE INSERTED BY OMB/DPC)