FINANCING DRUG ABUSE TREATMENT

Treatment in the Private Sector

In the past, when a drug abuser sought treatment there was no guarantee that it would be available, even if one could afford to pay for it. However, in the last several years, large numbers of private drug abuse treatment programs have come into existence to serve those who have the financial means. Many of these programs are affiliated with hospitals that have converted unused capacity to alcohol and drug abuse treatment beds. The American Hospital Association reports that the bed capacity allocated for "substance abuse" has increased from 16,005 in 1978 to 29,235 in 1985. There has been a corresponding increase in hospital-based outpatient substance abuse services. While only 769 hospitals provided such services in 1978, the number had grown to 1,244 in 1985. It is within the private sector that hospital based treatment has grown. In 1978, 64 percent of the hospital affiliated substance abuse units were government owned, compared with 36 percent in 1985. Alcoholism programs have now become "substance" abuse programs and are accepting drug abusers. Adolescent and adult mental health facilities, that would reluctantly accept drug abusers in the past, have now established programs to serve this population. Even publicly funded treatment programs that once were exclusively populated by indigent drug abusers are now competing for referrals and fees from Employee Assistance Programs, Health Maintenance Organizations, and other third-party payors.

To increase the limited insurance coverage for treatment services in the private marketplace, state legislatures have exerted their regulatory authority over insurance carriers and mandated inclusion of benefits for drug abusers. A recent review of the status of insurance coverage for alcohol and drug abuse, conducted by the National Association of State Alcohol and Drug Abuse Directors (1986), indicated that 18 States now have laws that either mandate the inclusion of drug abuse treatment benefits in health insurance plans or that require health insurance providers to at least offer drug abuse treatment benefits for purchase. The Labor Department's Bureau of Labor Statistics estimates that the percentage of employees with health coverage for drug abuse has increased from 37 percent in 1982 to 66 percent in 1986.

The continued climb in general health care costs and the unpredictability of the potential demand for drug abuse services make the future direction of insurance coverage uncertain. The insurance industry has traditionally resisted offering coverage for substance abuse and this resistance is likely to continue. However, if employers can be convinced of the financial benefits of getting valued drug abusing employees into treatment, they will ensure that insurance coverage continues.

Publicly Supported Treatment

Because so many persons in need of treatment have either come from disadvantaged populations, or have become economically disadvantaged as a result of their drug problem, most disabled drug abusers must seek treatment in publicly funded treatment programs. Of the drug abusers who enter clinics supported by public funds, 66 percent are unemployed, and 62 percent have no form of health insurance (National Institute on Drug Abuse, 1987). Publicly funded treatment is not necessarily "free" treatment. Programs that once relied exclusively on government support and donations from the private sector have found it financially necessary to begin charging clients for a portion of their services. Where do unemployed drug abusers get the money to pay for their treatment? Are treatment programs forced to encourage their clients to continue to engage in the same anti-social money raising behavior they are trying eliminate?

An estimated 4,200 to 5,000 treatment programs are supported by public funds. Approximately 42 percent of the financial support for publicly funded alcohol/drug abuse services comes from State and local governments; 21 percent from the Federal government; and 21 percent from private health insurance, donations, client fees, and other sources. Many of these drug abuse facilities are methadone maintenance programs serving heroin addicts. The patient load of methadone maintenance programs generally exceeds their funded capacity, and many programs have waiting lists. Although there are treatment programs in some communities with vacancies, they tend to be inpatient or residential settings, which many hard-core users are reluctant to enter.

Expanding the Treatment Network

The United States has never had the capacity to provide treatment for the estimated 6.5 million disabled drug abusers. At any given time there probably are no more than 250,000 drug abusers in treatment, far too small a number to have a significant effect on the nation's demand for illicit drugs. In addition, the AIDS epidemic among intravenous drug abusers and the continuing growth in chronic cocaine abusers requires a substantial increase in treatment availability. This expansion cannot be absorbed by existing treatment resources. Attempts to increase the number of treatment programs face serious obstacles. Besides a lack of funds and staff, zoning restrictions and strong community resistance stall program development. In New York City, which has the largest population of drug abusers and the worst AIDS problem among intravenous drug abusers, community organizations consistently resist the opening or expansion of drug abuse treatment programs. Treatment providers in other cities face the same problem. Nevertheless, the dangerous consequences of keeping such a large population of infected, criminal and dysfunctional individuals on the street requires that the treatment network be expanded to twicw its current size. This should be accomplished over the next five years.

MONITORING THE TREATMENT NETWORK

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. This reporting system was valuable for planning State and Federal responses to the drug abuse problem. It was a State, regional and national resource for health officials dealing with: (1) high risk populations; (2) shifts in patterns of drug use; and (3) the consequences of drug use. The system was so comprehensive that it provided an annual census of almost every treatment program in the country.

Because of the change to Federal block grants, this previously mandatory reporting system became voluntary. A few States continued reporting patient information to the Federal government; but most, either abandoned the system or so modified it that standardization and nationwide comparability was 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. The restored system need not be as rigid as the original, nor is it necessary that it be Federally operated. Each of the States should be encouraged to develop its own standardized system, but that some of the data be collected in a way that permits national comparability.

MANDATORY TREATMENT

The Link Between the Justice System and the Treatment Network

Contrary to common belief, a major portion of severely dependent drug abusers will eventually seek treatment either voluntarily or under some form of coercion. The challenge is to recruit those abusers into treatment earlier in their drug use careers and to reach those who never enter treatment. Some form of pressure or compulsion is significant as a motivator to enter treatment. Based on a 1985 NIDA survey of admissions to treatment programs in 15 States, it is estimated that about 27 percent of those seeking help in publically supported treatment programs do so under some form of legal pressure. As the AIDS epidemic worsens and the role of intravenous drug abuse in this epidemic becomes clearer, there is a growing interest in compelling intravenous drug abusers to seek treatment for their drug problems as a way of controlling the spread of AIDS.

The concept of legally-mandated treatment is not new. It is used daily in courts around the nation. Judges regularly order drug abusers who appear before them for criminal offenses into treatment, and treatment programs have been providing services to these individuals for years. Research has shown that treatment is equally successful in those who enter because of legal coercion as compared to those who volunteer.

Civil commitment is one form of compulsory treatment that has been suggested for use with drug abusers, especially those who are at risk for contracting and transmitting the AIDS virus. Although mandating treatment is common practice when drug abusers have commited a crime, legally forcing them into treatment on the presumption that they are a danger to themselves or to society (i.e., civil commitment) is not widely practiced today. However, twenty-nine states have laws that provide for involuntary institutionalization of drug addicts for reasons other than the commission of a criminal offense. Three civil commitment programs have received the greatest attention--the California Civil Addicts Program, the New York Civil Commitment Program, and the Federal Narcotic Addict Rehabilitation Act (NARA). While the implementation and outcomes of these civil commitment programs differed to some extent, their intent and enabling legislation were quite similar, as were their commitment procedures. Their purpose was to control and rehabilitate compulsive drug abusers by providing drug abuse treatment, monitoring drug use, and providing reasonable sanctions for program infractions. These Federal and New York State programs were only in full operation for approximately a decade (1965 to 1975) and were largely replaced by a less costly and more efficient system of voluntary drug treatment programs. The California program lodged within the Department of Corrections began in 1961. Its costs compared favorally with the cost of other residential programs and is still in existence.

Making The Case

The premise underlying the use the power of the state to prevent citizens from engaging in harmful behavior is that they will not voluntarily change their behavior, even when confronted with the dangers. Even before AIDS, the health consequences of the unsterile injecting practices of drug abusers was well known. Most long-term chronic drug abusers have either had a personal life-threatening overdose experience, witnessed an overdose death, or had an acquaintance die of an overdose or other drug-related problem. Yet there are estimates that almost 1.1 million Americans regularly inject drugs, and the vast majority of them share needles and other injection paraphenalia in spite of the dangers. Given these facts, why should society expect that drug abusers will voluntarily change their needle-sharing and sexual behavior simply because they know of the AIDS threat? Civil committment advocates would argue that the potential disaster that our country is facing, especially in our minority communities, does not justify a national gamble on the rationality and good sense of compulsive drug abusers. They would advocate that involuntary intervention is the only defensible approach for this group of high-risk individuals.

The Case Against

Those who oppose the idea of compelling IV drug abusers to accept treatment use a wide range of arguments to support their view. The most common of these are compulsory treatment violates human rights; adequate treatment resources are not available to meet voluntary, let alone compulsory, treatment demand; other cost-effective means of encouraging treatment should be tried before resorting to compulsory treatment; forcing drug abusers into treatment will have a negative effect on the therapeutic process; drug abusers are likely to go even further underground if they know that they are vulnerable to civil commitment; and, finally, civil commitment is a cumbersome and expensive process that will fall of its own weight as it did in past attempts.

In May 1987, the National Institute on Drug Abuse convened a group of legal, treatment, and research specialists, and State and Federal officials to discuss the practical problems and value of compulsory treatment as a means of controlling AIDS among IV drug abusers. Participants concluded that civil commitment is constitutionally defensible. However, participants noted that civil commitment statutes for drug abusers that are currently in effect are rarely used. It was also observed that public health laws dealing with communicable and venereal diseases are also available for compelling people into treatment and may be applicable in dealing with the IV drug abuse/AIDS problem.

Irrespective of the legal precedents, treatment specialists rejected the idea of adopting civil commitment as a means of getting IV drug abusers into treatment. They argued that the drug abuse treatment system is already operating at near or above capacity and, without a massive infusion of funds, civilly commited individuals could not be served without pushing out those who

voluntarily seek treatment. Also, there are much less drastic measures for getting IV drug abusers into treatment, e.g., simply expanding the Nation's treatment capacity will bring in thousands of voluntary treatment clients. Participants at the NIDA meeting were also concerned that a National emphasis on civil commitment will displace potentially effective, less costly, and less restrictive approaches to controlling the spread of IV drug abuse related AIDS. Aggressive outreach and education are examples of such approaches. Participants also noted that the *criminal justice* system can very effectively be used to bring IV drug abusers into contact with AIDS education and counseling services as well as the drug abuse treatment network. They recommended that attempts to link the criminal and juvenile justice system to the treatment network be increased. Finally, there was general agreement that there is a substantial need to develop prerelease AIDS education and drug abuse treatment programs for correctional facilities and the probation and parole system.

In conclusion, mandatory treatment cannot be considered a panacea for dealing with the AIDS problem among intravenous drug abusers. Consideration must be given to a variety of techniques for curbing the spread of AIDS infection. Educational, counseling, and outreach approaches are now being implemented to encourage intravenous drug abusers to voluntarily change their drug using and sexual practices and to enter drug abuse treatment. These less coercive approaches hold some promise. Once the nation's treatment network is expanded, mandatory treatment could be considered for those drug abusers who are resistant to voluntary approaches.

NEEDLE AVAILABILITY AND AIDS

Since AIDS is spread among intravenous drug abusers through the shared use of contaminated needles and syringes, a number of individuals and groups have suggested that sterile needles should be made readily available to intravenous drug abusers. While not advocating the widespread implementation of such a program, the National Academy of Sciences has suggested that the impact of making needles readily available should be assessed.

Insufficient data is available regarding the effects of a "free needle" program to support widespread implementation at this time. Such a program may or may not reduce needle sharing, since the act of sharing a needle has symbolic as well as utilitarian significance within the drug abuse subculture. Of particular concern is the possibility that readily available needles may facilitate the initiation of intravenous drug use by non-intravenous abusers. The possible negative consequences are sufficient to require caution. The nation is not yet prepared to initiate a program making needles readily available; however,limited carefully controlled research to assess the effectiveness of such programs might be undertaken.

Another approach to reducing the shared use of contaminated needles among intravenous drug abusers is to inform abusers about steps they can take to sterilize their injection equipment. The National Institute on Drug Abuse is currently supporting demonstration and other research studies to assess the effectiveness of programs that provide information on needle cleaning procedures in changing intravenous drug abusers' behaviors.

CURRENT FEDERAL TREATMENT ACTIVITIES

The current role of the Federal agencies in meeting the Nation's treatment needs is described below.

Alcohol, Drug Abuse and Mental Health Administration

ADAMHA is responsible for the administration of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant programs, providing oversight and evaluation, and reporting on the treatment and rehabilitation efforts carried out by the States. In 1987, $13.9 million was added to the existing $495 million ADMS block grant. Also, under the Anti-Drug Abuse Act of 1986 (P.L. 99-570), ADAMHA received an additional $162.9 million for FY 1987 to expand alcohol and drug abuse treatment. It is estimated that $161.7 million of the resulting 1987 block grant funds will be used by the States for drug abuse treatment and rehabilitation services.

National Institute on Drug Abuse

This Institute is mandated to carry out the Federal research effort to develop effective treatment programs for drug abusers. In FY 1987, P.L. 99-570 provided additional funding to enhance NIDA's research efforts, including evaluation of current drug abuse treatment programs. The Institute will continue to develop new treatment approaches. In cooperation with the Department of Housing and Urban Development, NIDA will explore treatment approaches to meet the needs of public housing residents.

Outreach programs on the streets, in the courts, and wherever else in the community addicts are encountered, are planned. Indigenous workers will be trained and will target IV drug abusers and their sexual partners. Because drug abusers, their sexual partners, and their children are at high risk of contracting AIDS, the outreach programs will include confidential, voluntary HIV antibody testing and counseling to these groups.

Veterans Administration

The VA serves veterans and supports drug dependence treatment programs at 51 medical centers. The majority have both outpatient and inpatient facilities for those whose primary therapeutic need is substance abuse related. In the past few years the VA has introduced sophisticated, state-of-the-art approaches to the treatment of drug dependence including counseling, psychotherapy as appropriate, and the use of pharmacological adjuncts to counteract dependence on specific drugs. Special emphasis is given to veterans dependent on narcotics, and treatment includes methadone detoxification, methadone maintenance, naltrexone maintenance, and treatment in therapeutic communities when appropriate.

The VA also has authority to contract with non-VA community programs for treatment and rehabilitation services for veterans with alcohol or drug abuse dependence and/or disabilities.

In addition, new funding has been received in 1987 for treatment of chronically, mentally ill patients, many, of whom are substance abusers. Forty-three hospitals are participating in these new programs.

To improve the quality of drug abuse treatment, the VA will expand physician training in substance abuse at five VA medical centers.

VA drug dependence treatment programs have long-term goals beyond elimination of nonprescription drug use, including development of work skills, cessation of antisocial (criminal) activity, improvement of family and community relationships, and establishment of posttreatment community contacts to assist them in remaining drug free. The VA also operates 189 community-based "Vet Centers" providing counseling and referral services to Vietnam Era veterans with a wide range of readjustment problems, including drug abuse.

The growing population of homeless includes veterans, many of whom are chronic drug abusers. The VA has recently initiated a program to assist these homeless veterans--the Domiciliary Care Program. The program is funded by $15 million to convert existing under-utilized VA facilities for homeless veterans in need of care.

Health Resources and Services Administration

Three Bureaus of HRSA have responsibilities related to substance abuse: the the Indian Health Service, the Bureau of Health Care Delivery and Assistance, and the Bureau of Resources Development.

Indian Health Service

IHS oversees 250 alcohol/substance abuse programs for American Indians and Alaskan natives, that are conducted by local tribal and Indian organizations. The substance abuse component to these programs was added only in 1985, and they include prevention, education, outpatient, inpatient, drop-in centers, outreach programs, and halfway houses. There are 47 residential treatment centers, some of which are located on reservations. Funding for the programs is obtained by grants/contracts to individual tribes.

Alcohol and substance abuse is the most severe health problem facing Indian peoples, and is the leading generic risk factor among Indian youth. P.L. 99-570, Subtitle C of Title IV, specifically addresses the needs of Indian populations for developing and implementing coordinated programs for prevention and treatment of alcohol and substance abuse. Significant legislative mandates are directed to Indian Youth Programs. The IHS has been charged with responsibility for establishing emergency medical assessment and treatment programs at the local level for every Indian youth detained for offenses related to alcohol or substance abuse. These programs at regional centers include acute detoxification, treatment, and rehabilitation.

Bureau of Health Care Delivery and Assistance

This Bureau is charged with providing a bridge between substance abuse and primary care activities.

Formal agreements and memoranda of understanding have recently been completed between BCHDA and other Federal and non-federal agencies identifying areas for increased cooperation. In February 1987 an agreement was signed between HRSA and ADAMHA that provides for greatly expanded efforts to elicit collaboration between Federal, State and local agencies as well as professional associations, colleges, universities and schools to develop and provide clinical training to health care providers on matters related to early detection/diagnosis and treatment.

As a result of this agreement, 43 pilot projects were approved for funding in August 1987 to integrate substance abuse diagnosis, treatment, referral and follow up services. A goal has been set to establish by September 1988 ten models for primary health care and substance abuse providers in Community and Migrant Health Centers.

Bureau of Resources Development

The Bureau has established an AIDS Service Demonstration Program that supports significant activities aimed at stemming the proliferation of the AIDS virus. Increased treatment services to IV drug abusers are high priorities for HRSA, since it is generally accepted that the IV addict is the major vector for HIV transmission to the general population.

By October 1987, 13 Service Demonstration Projects were funded in metropolitan areas with the highest prevalence of AIDS to coordinate community resources in all aspects of AIDS patient care, including: drug abuse treatment; rehabilitation and education; and training for health care professionals caring for those with AIDS and other HIV-related conditions. Particular emphasis is given to services targeting ethnic minorities and people who are IV drug abusers. These projects are coordinated with six comprehensive community demonstration projects funded by the National Institute on Drug Abuse.

Department of Defense

Illicit drug use emerged as a significant problem to the military services in personnel returning from Vietnam. In 1980 a survey identified that 36 percent of these military personnel had used one or more illicit drugs in the past year. Subsequently a "War on Drugs" was initiated, and treatment programs, primarily for lower ranking enlisted personnel, were provided.

The DOD has a "zero tolerance" of illegal drug use in the military services, and provides treatment only for those individuals evaluated as having potential for future service. Programs include nonresidential and residential treatment, education to raise awareness among personnel to the dangers of

illicit drug use, random testing for drug use, training of personnel with leadership and drug abuse program responsibilities, and evaluation projects that ascertain relevance and effectiveness of these programs.

The policy of the DOD to discharge drug abusers results in significant numbers of individuals being released to communities where treatment of their addiction becomes the responsibility of the VA or local facilities. In FY 1985 more than 16,000 administrative separations from the military for drug abuse were reported. The Department of Defense, with its pre-induction and military personnel drug abuse screening program, has the potential of becoming a fertile referral source for treatment programs.

Bureau of Prisons, Department of Justice

Since 1986 the Federal Bureau of Prisons has offered inmates the opportunity to participate in substance abuse treatment programs. Known as Chemical Abuse Programs, several thousand inmates are now participating voluntarily in treatment for moderate and serious drug abuse problems. The Chemical Abuse Programs are managed by clinical psychologists qualified in substance abuse therapies.

Programs are structured to include a mandatory standardized component that is educational, followed by individualized treatment programs based on the type of drugs abused, and the severity of the dependency.

While participation in the Chemical Abuse Programs is voluntary, a contract is developed with each inmate participant that clearly specifies the responsibilities of the participant for successful completion of each program component. Careful documentation of each inmate's progress is maintained.

To protect communities from released inmates of Federal prisons who are infected with HIV, the Bureau of Prisons currently tests all newly sentenced inmates, all of those scheduled to complete their sentences within 60 days, and any inmate voluntarily requesting the antibody test. Inmates who test positive for the HIV antibody are counseled about their potential risks for infecting others, and probation officers in the appropriate districts are notified of any inmate being released who has tested positive for the HIV antibody. Inmates with serious symptoms of AIDS are transferred to prison medical centers.

In addition to these Federal programs, the DOJ Bureau of Justice Assistance is authorized to make block grants to States for programs that identify and meet the needs of drug-dependent offenders, including treatment. Such programs can be used to provide jails and State prisons with support for pre-release treatment and aftercare.

Social Security Administration

Title II of the Social Security Act covers insured workers and their dependents and provides benefits to such individuals found disabled due to

alcoholism or drug addiction. Title XVI of the Act also compensates disabled drug addicts or alcoholics who also meet certain income and resource requirements. Under both Title II and Title XVI, however, in order to receive disability benefits individuals must follow treatment prescribed by their physician or other treating source if the treatment can restore the individuals' ability to work. If individuals do not follow the prescribed treatment without a good reason, they will be found not disabled, or if they are already receiving disability benefits payments will be terminated. Under Title XVI, the law requires that persons found eligible for Supplemental Security Income (SSI) disability benefits in which alcoholism or drug addiction is a contributing factor material to a finding of disability, must take appropriate treatment for their drug addiction or alcoholism at an approved institution or facility, when this treatment is available. In addition, under Title XVI, disabled drug addicts or alcoholics are not eligible to receive the payment themselves if another party can be designated to receive payment on their behalf. Failure to comply with these provisions will result in nonpayment of benefits for any month in which noncompliance occurs.

As of January 1, 1987, 7,957 persons on the SSI rolls were eligible for drug and/or alcohol benefits. Of these, 82 percent were in pay status. Drug addicts and those with mixed addictions constituted almost one-third of of the group eligible to receive benefits.

REFERENCES

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PART II

A NATIONAL DRUG ABUSE TREATMENT POLICY

MAJOR FACTORS LIMITING THE EFFECTIVE USE OF TREATMENT

The full impact of treatment cannot be felt because only a small proportion of drug abusers are able to get treatment at any given time. Experts agree that the Nation's treatment capacity is inadequate to meet demand--they report that there are waiting lists in most metropolitan areas.

The use of the block grant, as the major mechanism for Federal support of drug abuse programs may not be the most effective way of distributing treatment funds to communities in greatest need.

The large expansion in treatment capacity required to meet the needs of 6.5 million disabled drug abusers cannot be met without adding additional treatment personnel and opening new treatment facilities.

In some areas, community resistance and/or zoning ordinances preclude the es the establishment of new treatment programs.

Methadone maintenance, which is an effective tool for treating opiate addicts, continues to be resisted by some government officials and health-care providers, and members of the drug abuse treatment community itself.

When the Federal Government switched to the block grant mechanism for funding drug abuse treatment, all requirements for data collection were eliminated and the national system for monitoring the treatment network was dismantled. There no longer is an objective method of measuring: the Nation's treatment capacity; how many drug abusers are in treatment; where they are in treatment; who is paying for the treatment; or, what services are being provided.

Large numbers of drug abusers find treatment to be unacceptable, or fail to remain in treatment long enough to bring about a long-term change in their drug-taking behavior.

POLICY

The Nation, no longer willing to tolerate illicit drug use, and recognizing that there is a population of drug abusers who are unmotivated or unable to end their drug-taking behavior, should commit itself to:

> **Use the treatment network to reduce the demand for drugs, slow the spread of AIDS, reduce the need for imprisonment, and decrease crime and the loss of productivity associated with drug abuse.**

Under the leadership of the President and First Lady this policy consists of four strategic elements which incorporate non-governmental efforts at national, state and local levels and governmental initiatives at all levels. These elements are:

Strategy

- Conduct an aggressive program to identify drug abusers and engage them in treatment.
- Ensure the ready availability of drug abuse treatment.
- Stimulate private sector involvement in supporting the Nation's treatment network.
- Undertake research to improve the quality and efficiency of treatment and find new treatments for those who are currently unresponsive.

To implement these strategies, a series of Programs are planned.

Programs

Federal

- Support street and court outreach programs.
- Supplement the ADAMHA Block Grant with a mechanism that permits rapid targeting of communities with special needs.
- Train, new and existing staff of drug abuse treatment programs, in dealing with: polydrug and alcohol abusers; drug abusers with psychiatric problems; and, AIDS.
- Promote community acceptance of drug abuse treatment expansion through a public information campaign spearheaded by the First Lady.

- Continue information programs directed at raising employer awareness of the productivity costs of drug abuse and, thereby, enlist their aid in expanding private insurance coverage.

- Improve treatment data collection and reporting systems.

- Conduct research on improving the efficacy and efficiency of current treatment services.

- Develop new approaches for those for whom treatment appears to have a minimal effect.

- Explore the value of establishing Centralized Treatment Information and Referral Units in metropolitan areas.

- Review current methadone regulations and work with the States to reduce barriers to the use of effective pharmacotherapies.

State

- Facilitate the expansion of treatment programs serving hard-core drug abusers, minorities, the homeless, public housing residents, and prisoners.

- Establish stronger links between the primary health care system, the criminal justice system, and the drug abuse treatment network.

- Work with private sector health-care providers to overcome the administrative, financial, and attitudinal barriers to providing quality treatment to drug abusers.

- Improve the collection of epidemiologic and treatment utilization data.

Local Governments

- Change zoning restrictions that unnecessarily inhibit the establishment of new treatment facilities

- Make abandoned, condemned, or vacant property available for conversion into treatment facilities.

- Institute programs to identify drug abusers among arrestees and divert those picked up for minor crimes into drug abuse treatment programs.

- Improve the accessibility of AIDS testing to IV drug abusers, their sexual partners, and children.

- Use the sanctions available to probation departments to encourage drug abusers to enter and stay in treatment.

- Institute programs to identify young drug abusers who come into contact with social service agencies and encourage their entry into treatment.

Employers and Community Groups

- Employers should encourage insurance companies, HMOs, and other third-party payors to provide coverage for drug abuse treatment.

- Expand the availability of drug screening and Employee Assistance Programs as a means of identifying drug abusing workers.

- Promote community acceptance of drug abuse treatment facility expansion through public information campaigns.

- Aid local drug abuse programs in their fund raising and resource development activities.

- Work closely with local treatment providers to identify community needs and concerns related to drug abuse treatment and develop cooperative solutions.

- Enlist families and friends in a campaign to encourage drug abusers to seek treatment.

ISSUES TO BE RESOLVED

1. What is the appropriate Federal role in supporting the Nation's drug abuse treatment system?

2. Is the block grant mechanism the only appropriate method for the Federal Government to use to finance treatment?

3. Although treatment programs have a tradition of drawing clients from drug abusers going through the criminal justice system, should States be encouraged to implement a civil commitment process for drug abusers?

4. Is the threat of AIDS of sufficient magnitude to warrant limited, tightly controlled studies of the value of making injection paraphrenalia available to intravenous drug abusers?

PART III

CURRENT FEDERAL TREATMENT RESOURCES

EXPLANATORY NOTES

Most of the Federal agencies had difficulty identifying the portion of their budgets that should be allocated to drug abuse treatment activities. Blanks indicate that the given Federal agency was unable to supply the information.

Veterans Administration

The resource requirements for FY 1987, 1988, and 1989 are estimates based on FY 1986 figures and existing budgetary projections for the future. Resource estimates for individual programs are not available.

Health Resources and Services Administration

Bureau of Health Care Delivery and Assistance--"Resource Requirement" figures for FY 1989 are not available.

Department of Defense

The Department can not furnish line item manpower costs by individual program.

Social Security Administration

FTEs are not available.

Department of Justice

Federal Bureau of Prisons--All dollar amounts stated as "Resource Requirements" are estimates.

Lead Agency: Treatment

STRATEGY 1: Conduct an aggressive outreach program to identify drug abusers and direct them to treatment.

PROGRAM 1: NIDA--Street and court outreach program

OBJECTIVES:

(1) Train indigenous outreach workers.

(2) Support outreach to intravenous drug abusers using indigenous outreach workers to inform abusers regarding their AIDS risk and to encourage treatment entry.

(3) Support outreach to sexual partners of intravenous drug abusers to counsel them regarding their AIDS-risk and risk-reduction strategies.

RESOURCES:

	FY 1988	FY 1989
FTE	23.0	30.0
$	35,000	39,247

PROGRAM 2: NIDA AIDS Public Health Control Measures

OBJECTIVES:

(1) Provide confidential, voluntary HIV antibody testing and counseling to intravenous drug abusers.

(2) Provide confidential, voluntary HIV antibody testing and counseling to sexual partners of intravenous drug abusers.

(3) Provide testing and counseling for children of intravenous drug abusers.

RESOURCES:

	FY 1988	FY 1989
FTE	39.0	55.0
$	24,994	29,322

PROGRAM 3: Health Resources and Services Administration, Bureau of Resources Development -- AIDS Service Demonstration Program

OBJECTIVES: (1) Facilitate the development of comprehensive systems of care for people with AIDS and other HIV-related conditions.

(2) Refer identified IV drug abusers to drug abuse treatment resources.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	No Funds Designated	

PROGRAM 4: Department of Defense Biochemical Testing Program

OBJECTIVES: (1) Discourage, through random testing, any use of illegal drugs by military personnel.

(2) Identify, through probable cause, command directed, and medical testing, those individuals who have used illegal drugs.

(3) Monitor those individuals who have been counseled or treated for drug use.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	72,706	77,533

PROGRAM 5: Federal Bureau of Prisons HIV Testing Program

OBJECTIVES: (1) Test all newly sentenced inmates committed to Federal prisons.

(2) Test all inmates scheduled to complete their sentences and return to the community within 60 days of their discharge date.

(3) Provide tests for any inmates voluntarily seeking one.

(4) Provide AIDS counseling and education.

RESOURCES:

	FY 1988	FY 1989
FTE	Not Submitted	
$		

STRATEGY 2: Ensure the availability of drug abuse treatment.

PROGRAM 1: ADAMHA Block Grant--the block grant mechanism is the major source of Federal support for drug abuse treatment.

OBJECTIVES:

RESOURCES:

	FY 1988	FY 1989
FTE	2	2
$	103,444	177,042

PROGRAM 2: The VA operates 51 DDTP's (drug dependence treatment programs). These specialized programs provide for the care and treatment of eligible drug-dependent veterans with special emphasis on veterans dependent on narcotics. Major treatment components include methadone detoxification, methadone maintenance, naltrexone maintenance, and treatment and therapeutic communities. The average length of inpatient stay is 23 days. Outpatient/ambulatory treatment is longer. Section 104 of Public Law 96-22 provided the VA with authority to contract with non-VA community programs for treatment and rehabilitation services for veterans with alcohol or drug dependence and/or abuse disabilities.

OBJECTIVES:

RESOURCES:

	FY 1988	FY 1989
FTE	1762.0	1762.0
$	75,800	77,400

PROGRAM 3: Indian Health Service (IHS)

OBJECTIVES: (1) In accordance with the IHS goal of elevating the health status of American Indians and Alaskan natives to the highest level possible, the Alcohol and Substance Abuse Branch will attempt to lower the incidence and prevalence of alcoholism and substance abuse among American Indians and Alaskan natives to a level at or below that of the general population in the United States within a 15-year period.

RESOURCES:

	FY 1988	FY 1989
FTE	24	
$	13,500	

PROGRAM 4: Bureau of Health Care Delivery and Assistance (BHCDA)--Community Health Center

OBJECTIVES: (1) To reduce drug abuse by providing treatment, education, and prevention services through the Community Health Centers across the country.

RESOURCES:

	FY 1988	FY 1989
FTE	14	
$	2,600	

PROGRAM 5: Department of Defense Residential Treatment Programs

OBJECTIVES: (1) Treat and return to full duty those drug-abusing individuals deemed to have sufficient potential for future service.

(2) Treat those individuals assessed as being dependent on drugs, prior to judicial or administrative action.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	11,764	13,752

PROGRAM 6: Department of Defense Nonresidential Rehabilitation Programs

OBJECTIVES: (1) Assess individuals thought to be illegal drug users for possible dependence, potential for future service, and, if deemed appropriate and necessary, outpatient counseling.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	2,144	2,175

PROGRAM 7: Federal Bureau of Prisons Chemical Abuse Program

OBJECTIVES: (1) To provide chemical abuse programs at all institutions.

(2) To have the Bureau of Prisons Executive Staff review chemical abuse programs during 1987.

RESOURCES:

	FY 1988	FY 1989
FTE	44	44
$	1,400	1,400

PROGRAM 8: Social Security Administration Supplemental Security Income program for drug abusers.

OBJECTIVES: (1) Provide funds to cover costs of referral and monitoring process.

(2) Expand the number of agencies to undertake the referral and monitoring function.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	2,700	3,100

PROGRAM 9: Veterans Administration - Physician training in substance abuse is being implemented through a 2-year university-affiliated fellowship training program, offered at five Veterans Administration medical centers. Plans are under way to expand this program during the coming years.

OBJECTIVES:

RESOURCES:

	FY 1988	FY 1989
FTE		
$	Not Submitted	

Program 10: Department of Defense Education and Training

OBJECTIVES: (1) Raise the level of knowledge and awareness among personnel to the dangers of illegal drug use and its inconsistency with military service.

(2) Train those personnel with leadership and drug program responsibilities in drug abuse prevention, education and counseling.

(3) Provide a structured learning opportunity for individuals who have been involved in a drug-related incident.

RESOURCES:	FY 1988	FY 1989
FTE		
$	8,640	8,781

PROGRAM 11: Social Security Supplemental Security Income (SSI) program for drug abusers.

OBJECTIVES: (1) Provide resources to Title XVI disabled drug abusers who meet SSA's definition of disability until their ability to perform substantial gainful activity is restored, thereby making treatment more attractive.

RESOURCES:	FY 1988	FY 1989
FTE		
$	2,100	5,200

STRATEGY 3: Stimulate private sector involvement in supporting the Nation's treatment network.

PROGRAM 1: White House and Federal Agencies Leadership.

OBJECTIVES: (1) Continue vigorous White House leadership in stimulation of private sector support for prevention and treatment.

RESOURCES: White House and other federal personnel; no additional resources required.

STRATEGY 4: Undertake research to improve the quality and efficiency of treatment, and find new treatments for those who are currently unreached or unresponsive.

PROGRAM 1: Department of Defense Program Evaluation

OBJECTIVES: (1) Evaluate programs to ascertain ongoing relevance and effectiveness.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	2,498	2,508

PROGRAM 2: NIDA--Support State efforts to standardize and improve their treatment data collection systems

	FY 1988	FY 1989
FTE	2	2
$	1,000	200

PROGRAM 3: NIDA--Conduct research on new therapeutic approaches

	FY 1988	FY 1989
FTE	120	110
$	41,536	29,002

PROGRAM 4: NIDA--Review current methadone regulations and work with the States and local governments to reduce barriers to the use of effective pharmacotherapies.

OBJECTIVES:

RESOURCES:

	FY 1988	FY 1989
FTE	2	3
$	200	200

List of Participating Agencies

1.	Action	
2.	Agency for International Development	AID
3.	Agriculture, Department of	AG
	- Agricultural Research Service	AGRS
	- U.S. Forest Service	USFS
4.	Alliance	
5.	Central Intelligence Agency	CIA
6.	Commerce, Department of	COMM
7.	Department of Defense	DOD
	- Defense Intelligence Agency	DIA
	- Direct Operating Costs	DOC
	- Drug Task Force	DOD/DTF
	- Health Affairs	DOD/HA
	- Joint Chiefs of Staff	JCS
	- National Security Agency	NSA
	- Other Appropriations	OA
8.	Drug Abuse Policy Office	DAPO
9.	Education, Department of	ED
10.	Energy, Department of	DOE
11.	Health and Human Services, Department of	HHS
	- Alcohol, Drug Abuse and Mental Health Administration	ADAMHA
	- Natl Inst. on Alcohol Abuse & Alcoholism	NIAAA
	- Natl Institute on Drug Abuse	NIDA
	- Natl Institute of Mental Health	NIMH
	- Office of Substance Abuse Prevention	OSAP
	- Administration for Children, Youth & Families	AGYF
	- Administration for Native Americans	ANA
	- Family Support Administration	FSAD
	- Food and Drug Administration	FDA
	- Health Resources and Services Admin.	HRSA
	- Indian Health Services	IHS
	- Bureau of Health Care Delivery & Asst	BHCDA
	- Bureau of Resources Development	BRD
	- Social Security Administration	SSA

12.	Housing and Urban Development, Department of	HUD
13.	Information Agency, United States	USIA
14.	Interior, Department of	INT
	- Bureau of Indian Affairs	BIA
	- Bureau of Land Management	BLM
	- Fish and Wildlife Service	FWS
	- National Park Service	NPS
15.	Justice, Department of	DOJ
	- Bureau of Prisons	BOP
	- Criminal Division	CRM
	- Drug Enforcement Administration	DEA
	- Federal Bureau of Investigation	FBI
	- Immigration & Naturalization Service	INS
	- Office of Justice Programs	OJP
	- Bureau of Justice Assistance	BJA
	- Bureau of Justice Statistics	BJS
	- National Institute of Justice	NIJ
	- Office of Justice Programs	OJP
	- Office of Juvenile & Delinquency Prevention	OJJDP
	- Support of Prisons	SUSP
	- Tax Division	TAX
	- United States Attorneys	USA
	- United States Marshal Service	USMS
	- Organized Crime Drug Enforce. Task Force	OCDETF
16.	Labor, Department of	LABOR
17.	Mine Safety and Health Administration	MSHA
18.	National Narcotics Border Interdiction System	NNBIS
19.	National Security Council	NSC
20.	Nuclear Regulatory Commission	NRC
21.	Occupational Safety and Health Administration	OSHA
22.	Office of Personnel Management	OPM
23.	State, Department of	STATE
	- International Narcotics Matters	INM
24.	Transportation, Department of	DOT
	- Federal Aviation Administration	FAA
	- Federal Railroad Administration	FRA
	- Maritime Administration	MARAD

24.	Transportation, Department of (Continued)	
	- National Highway Traffic & Safety	NHTSA
	- United States Coast Guard	USCG
25.	Treasury, Department of the	Treas
	- Bureau of Alcohol, Tobacco and Firearms	ATF
	- Federal Law Enforcement Training Center	FLETC
	- Internal Revenue Service	IRS
	- Payments to Puerto Rico	PPR
	- United States Customs Service	USCS
	- United States Secret Service	USSS
26.	Veterans Administration	VA
27.	White House Conference	WHC

Replacement pages for
Tab 7

19, 32-34

alcoholism or drug addiction. Title XVI of the Act also compensates disabled drug addicts or alcoholics who also meet certain income and resource requirements. Under both Title II and Title XVI, however, in order to receive disability benefits individuals must follow treatment prescribed by their physician or other treating source if the treatment can restore the individuals' ability to work. If individuals do not follow the prescribed treatment without a good reason, they will be found not disabled, or if they are already receiving disability benefits payments will be terminated. Under Title XVI, the law requires that persons found eligible for Supplemental Security Income (SSI) disability benefits in which alcoholism or drug addiction is a contributing factor material to a finding of disability, must take appropriate treatment for their drug addiction or alcoholism at an approved institution or facility, when this treatment is available. In addition, under Title XVI, disabled drug addicts or alcoholics are not eligible to receive the payment themselves if another party can be designated to receive payment on their behalf. Failure to comply with these provisions will result in nonpayment of benefits for any month in which noncompliance occurs.

As of January 1, 1987, there were 7957 persons eligible for drug addiction/alcoholism disability benefits on the SSI rolls. Of these persons, 82% were in pay status. Drug addicts and those with mixed addictions constituted almost one third of the group eligible to receive benefits. The remaining persons who were eligible for benefits but not in pay status were "in suspense" for various reasons such as whereabouts unknown, investigation of compliance with Title XVI drug addiction/alcoholism treatment provisions, conviction and incarceration for a felony, representative payee development, etc.

RESOURCES:

	FY 1988	FY 1989
FTE	24	
$	13,500	

PROGRAM 4: Bureau of Health Care Delivery and Assistance (BHCDA)--Community Health Center

OBJECTIVES: (1) To reduce drug abuse by providing treatment, education, and prevention services through the Community Health Centers across the country.

RESOURCES:

	FY 1988	FY 1989
FTE	14	
$	2,600	

PROGRAM 5: Department of Defense Residential Treatment Programs

OBJECTIVES: (1) Treat and return to full duty those drug-abusing individuals deemed to have sufficient potential for future service.

(2) Treat those individuals assessed as being dependent on drugs, prior to judicial or administrative action.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	2,144	2,175

PROGRAM 6: Department of Defense Nonresidential Rehabilitation Programs

OBJECTIVES: (1) Assess individuals thought to be illegal drug users for possible dependence, potential for future service, and, if deemed appropriate and necessary, outpatient counseling.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	11,764	13,752

PROGRAM 7: Federal Bureau of Prisons Chemical Abuse Program

OBJECTIVES: (1) To provide chemical abuse programs at all institutions.

(2) To have the Bureau of Prisons Executive Staff review chemical abuse programs during 1987.

RESOURCES:

	FY 1988	FY 1989
FTE	44	44
$	1,400	1,400

PROGRAM 8: Veterans Administration - Physician training in substance abuse is being implemented through a 2-year university-affiliated fellowship training program, offered at five Veterans Administration medical centers. Plans are under way to expand this program during the coming years.

OBJECTIVES:

RESOURCES:

	FY 1988	FY 1989
FTE		
$	Not Submitted	

Program 9: Department of Defense Education and Training

OBJECTIVES: (1) Raise the level of knowledge and awareness among personnel to the dangers of illegal drug use and its inconsistency with military service.

(2) Train those personnel with leadership and drug program responsibilities in drug abuse prevention, education and counseling.

(3) Provide a structured learning opportunity for individuals who have been involved in a drug-related incident.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	8,640	8,781

PROGRAM 10: Social Security Supplemental Security Income (SSI) program for drug abusers.

OBJECTIVES: (1) Provide resources to Title XVI disabled drug abusers who meet SSA's definition of disability until their ability to perform substantial gainful activity is restored, thereby making treatment more attractive.

RESOURCES:

	FY 1988	FY 1989
FTE		
$	4,800	5,200

Replacement for
Tab 6

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	383.2	2	216.50	100.00
-NIDA	75.7	120	102.7	186	98.0	200	(4.58)	7.53	49.6	15	50.61	7.50
-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	3.8	0	4.8	0	5.2	0	8.33	0.00	0.0	0		
SUBTOTAL, HHS	(293.2)	(138)	(227.0)	(226)	(280.2)	(202)	23.44	(10.62)	(432.8)	(17)	154.46	8.42
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	458.7	6,574	402.0	6,878	463.8	6,844	15.37	(0.49)	432.8	17	93.32	0.25

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

NOTE: ZERO INDICATES NO RESOURCES REQUESTED.

NT STRATEGY SUMMARY
1987-1989
S 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/	313.1	1,847	224.1	1,846	285.8	1,808	27.53	(2.06)	391.1	6	136.84	0.33
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)	41.7	11	130.72	9.57
TOTAL	458.7	1,967 3/	402.0	2,032 4/	463.8	2,008 5/	15.37	(1.18)	432.8	17	93.32	0.85

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.

REDUCING THE DEMAND FOR ILLICIT DRUGS THROUGH TREATMENT

ENHANCEMENT SUMMARY

STRATEGY 1--No Enhancements

Conduct an aggressive outreach program to identify drug abusers and engage them in treatment.

STRATEGY 2--$391,118,000; FTE= 6

Ensure the availability of drug abuse treatment.

Targeted Treatment Expansion--Supplement the ADAMHA Block Grant with 97,618 new treatment slots targeted to communities with special needs ($3,926/slot= $383,248,000; FTE= 2).

Treatment Staff Training--NIDA will train 7,300 new drug abuse treatment personnel to deal with: polydrug and alcohol abusers; drug abusers with psychiatric problems; and, drug abusers with AIDS ($6,670,000; FTE= 2).

Promote Community Acceptance of Treatment--NIDA will promote community acceptance of drug abuse treatment expansion through a public information campaign spearheaded by the First Lady.

Undertake treatment awareness media campaigns in 20 of the cities with the largest drug abuse problem ($1,050,000; FTE= 1).

Provide technical assistance to treatment programs attempting to gain community acceptance for treatment expansion ($150,000; FTE= 1).

STRATEGY 3--No Enhancements

Stimulate private sector involvement in supporting the Nation's treatment network.

STRATEGY 4--($41,700,000; FTE= 11)

Undertake research to improve the quality and efficiency of treatment and find new treatments for those who are currently unresponsive.

Improve State Data Collection--NIDA will support State efforts to standardize and improve their treatment data collection systems by: conducting technical meetings of single State agencies to define data collection needs; and, defraying State data collection, processing, and reporting costs ($6,200,000; FTE= 4).

Research on Therapeutic Approaches--NIDA will conduct research aimed at: drug abusers with co-existing psychiatric morbidity and those with long standing antisocial behaviors and few vocational skills; finding ways of improving the acceptability of treatment to drug abusers; retaining drug abusers in treatment for longer periods; developing model treatment programs for public housing developments; establishing standards, procedures and costs for providing treatment; and, developing new therapeutic approaches for drug abuse ($31,000,000; FTE= 5).

Treatment Information and Referral Units--On a demonstration basis, NIDA will fund the establishment of one, 24-hour central, Treatment Information and Referral Unit in three urban areas with high drug abuse prevalence rates ($1,500,000/Unit= $4,500,000/year; FTE= 2).

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/Formula Grants	161,718	2	103,444	2	0	0	177,042	2	0	0	177,042	2
Targeted Treatment Expansion--ADAMHA	0	0	0	0	187,988	2	0	0	383,248	2	383,248	2
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 Nonresidential Treatment	9,587		11,764		0	0	13,752		0	0	13,752	0
DOD Residential 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	8,920	2	0	0	6,670	2	6,670	2
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)	3,800		4,800		0	0	5,200		0	0	5,200	0
Promote Community Acceptance of Treatment	0	0	0	0	1,200	2	0	0	1,200	2	1,200	2
Subtotal, Strategy 2	313,064	1,847	224,092	1,846	198,108	6	285,750	1,808	391,118	6	676,868	1,814
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	6,200	4	200	2	6,200	4	6,400	6
Research on Therapeutic Approaches	49,050	104	41,536	120	18,600	0	29,002	110	31,000	5	60,002	115
Review Methadone Regulations	200	2	200	2	0	0	200	3	0	0	200	3
Treatment Information and Referral Units	0	0	0	0	4,500	2	0	0	4,500	2	4,500	2
Subtotal, Strategy 4	52,853	108	45,234	124	29,300	6	31,910	115	41,700	11	73,610	126
Total Treatment	$458,720	1,967	$402,026	2,032	$227,408	12	$463,762	2,008	$432,818	17	$896,580	2,025
Control:											0	0