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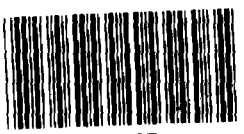

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STATEMENT OF
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HUMAN RESOURCES DIVISION
BEFORE THE

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

Mr. Chairman and Members of the Subcommittee:

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

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

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

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

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

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

CONCERNS WITH NIDA'S METHOD OF PROVIDING FUNDS

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

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

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

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

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

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

NIDA funds are provided through a slot funding concept.

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

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

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

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

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

Unused capacity in treatment programs

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

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

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

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

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

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

Reported utilization rates are inflated

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

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

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

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

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

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

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

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

Low level of treatment provided to abusers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Slot cost ceilings not consistent with actual costs

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

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

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

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

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

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

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

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

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

NIDA IS EXPLORING DIFFERENT TYPES OF FUNDING MECHANISMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--increased paperwork;

--increased cost of monitoring; and

--possible funding instability for some programs.

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

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

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

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

CONCERNS WITH DRUG ABUSE TREATMENT STANDARDS

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

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

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

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

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

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

COMPARISON OF FEDERAL FUNDING CRITERIA AND JOINT COMMISSION TREATMENT STANDARDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NIDA's current efforts

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

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

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

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

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