S. HRG. 108–296

REAUTHORIZATION OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

EXAMINING PROPOSED LEGISLATION AUTHORIZING FUNDS FOR THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, FOCUSING ON THE IMPORTANCE OF SUBSTANCE ABUSE PREVENTION

JULY 15, 2003

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REAUTHORIZATION OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

TUESDAY, JULY 15, 2003

U.S. SENATE,
SUBCOMMITTEE ON SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES, OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:08 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Mike DeWine (chairman of the subcommittee) presiding.

Present: Senators DeWine, Reed, and Murray.

OPENING STATEMENT OF SENATOR DEWINE

Senator DEWINE. Good morning. We welcome all of you today to the first hearing of the new Subcommittee on Substance Abuse and Mental Health Services. I am honored to be the chairman of this subcommittee. I think this is an important subcommittee.

I look forward to working with my friend and colleague from Massachusetts, Senator Kennedy, on these very, very important issues. Senator Kennedy, of course—I do not have to tell anyone in this room—is truly a leader in this area and has many wonderful insights into these issues.

While the subcommittee's primary responsibility will be the reauthorization of SAMHSA, I intend for this to be an active subcommittee, and I look forward to holding additional hearings on other issues that are related to substance abuse and to mental health.

I would just say to our audience and to others that we are very open to ideas as far as what hearings we should be holding, and I know my staff cringes when I say that, but this is an energetic group up here, and we are looking forward to having many hearings. This is obviously a wide open field, and a very important field.

As some of you may know, these issues are not new to me. I have been long involved both in this body and my home State of Ohio in efforts aimed to help prevent substance abuse and also in treating mental illness. I authored two significant pieces of legislation in this area in Congress—the reauthorization of the Safe and Drug-Free Schools Act and the Mental Health Courts bill.

During this session of Congress, I have introduced the Mentally Ill Offender Treatment and Crime Reduction Act as well as the Communities Combating College Drinking and Drug Use Act.

In addition to these bills, I look forward to working on the reauthorization of SAMHSA with the other members of this committee and of course with Senator Kennedy.

The Substance Abuse and Mental Health Services Administration serves a vital role in this country's public health system. Established in 1992, SAMHSA is the primary Government agency responsible for substance abuse and mental health prevention and treatment services.

At today's hearing and at future hearings, I look forward to hearing from the experts as to how the programs are working, if there are any problems, and what recommendations they may have for reauthorization. I am pleased to move ahead on these issues and to be working with all the committee members in this endeavor, and I thank all of you for being here.

Senator Reed?

OPENING STATEMENT OF SENATOR REED

Senator REED. Thank you very much, Mr. Chairman.

First, let me congratulate you for being not only instrumental in organizing this new subcommittee but for all of your work on these issues. I know how passionately and how effectively you advocate for so many things but particularly those issues under the jurisdiction of this subcommittee.

Let me also welcome Mr. Curie and commend him for his wisdom, foresight, and brilliance in recommending and appointing Kathryn Power as the new director of the Center for Mental Health Services, a truly remarkable recognition that in Rhode Island, we have the very best director of the Department of Mental Health, Retardation, and Hospitals in the country. Kathryn is someone whom I have had the pleasure of working with for more than a decade. She has served administrations of both parties. She has done it with great professionalism. She has really led the way in integrating mental health and substance abuse services for people with co-occurring disorders, and she is going to be a great leader at the Center for Mental Health Services. And then, when she puts on her Navy uniform and orders you around, Mr. Curie, you will appreciate the full power that she commands.

[Laughter.]

I was pleased to be part of the last SAMHSA reauthorization in 1999, and these are incredibly important issues, and I look forward as the chairman does to your advice as we go forward.

One of the critical issues is really capacity. At the State level, we see a huge surge of people with real problems and real needs, and we do not have the resources, either institutionally or in the neighborhood settings, to deal effectively. And we all recognize and say repeatedly that early intervention, be it a mental health issue or a substance abuse issue, and rapid response is the only way to do it, the most cost-effective way to do it, and yet we still find ourselves telling people to wait, with people juggling different locations and times to get into treatment. That is something that I think we have to deal with seriously.

Again, I look forward to the hearing, and I am just so pleased that Chairman DeWine has called it and will be leading this subcommittee.

Thank you.

Senator DEWINE. Senator Reed, thank you very much.

At this time I submit for the record the prepared statements of Senator Frist and Senator Kennedy.

[The prepared statement of Senator Frist follows:]

PREPARED STATEMENT OF SENATOR FRIST

I would like to recognize Chairman DeWine for calling today's important hearing to examine issues related to mental health and substance abuse. I commend him for his efforts to reauthorize the Substance Abuse Mental Health Services Administration (SAMHSA), and look forward to working with him in this effort.

Earlier this year, President Bush highlighted the importance of drug addiction prevention and treatment as an important priority for the nation. I share this belief, and this committee has worked in a bipartisan manner on these issues in the past.

In the 106th Congress, I had the opportunity to work with Senator Kennedy and other members of this committee to reauthorize SAMHSA as part of the Youth Drug and Mental Health Services Act. The "Youth Drug" Act was a comprehensive attempt to address the tragedy of drug use affecting our children. According to the 2001 National Household Survey on Drug Abuse, almost 5 million youths aged 12 to 17 (21 percent) had used an illicit drug in the past year and about 10.1 million persons aged 12 to 20 used alcohol in the past month. More than 6 million children lived with at least one parent who abused or was dependent on alcohol or an illicit drug.

These challenges are particularly prevalent among minorities. In 2000, Hispanic females aged 12 to 17 were at higher risk for suicide than other youths. Only 32 percent of Hispanic young women and girls at risk for suicide during the past year, however, received mental health treatment during this same time period.

There are many factors for this increase in youth substance abuse. As a father, I am particularly concerned with a decline in the disapproval of drug use and in the perception of the risk of drug use among our youth.

To help address this problem, the "Youth Drug" bill placed a renewed focus on youth and adolescent substance abuse and mental health services, while providing greater flexibility for States and new accountability in the use of funds based on performance. Another important goal of this effort was to allow faith-based addiction treatment and prevention programs to be eligible for Federal funds through "charitable-choice" provisions. These efforts have helped SAMHSA more efficiently carry out its goals of promoting accountability, enhancing capacity, and assuring effectiveness of its substance abuse and mental health treatment and prevention programs.

However, much remains to be done. There are nearly 44 million Americans affected by mental illness and nearly 17 million Americans with substance abuse and addiction problems. Unfortunately, most of these people are not receiving the treatment they need. In

fact, last year less that one-half of Americans suffering from mental illness and less than twenty percent of Americans with substance abuse or addiction problems received treatment.

But these problems are particularly acute for the seven to ten million individuals with co-occurring disorders (who have at least one mental disorder as well as an alcohol or drug use disorder). These individuals experience particular difficulties in diagnostic and treatment services, although these disorders are often treatable when they present as individual chronic illnesses.

These statistics underscore the importance of reauthorizing the Substance Abuse and Mental Health Services Administration. Today's hearing represents the beginning of that important process. I once again commend the Chairman for calling today's hearing and look forward to working with him, with the Members of the Subcommittee and Committee, and with today's witnesses in this important endeavor.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

I commend Senator DeWine for calling this hearing and for his leadership in creating the Subcommittee on Substance Abuse and Mental Health.

I'm pleased that our first hearing on the Reauthorization of SAMHSA—the Substance Abuse and Mental Health Services Administration—focuses on treatment and prevention services for individuals who are mentally ill or suffering from substance abuse.

I join in welcoming Charles Curie, the Administrator of SAMHSA, and I commend him for his long track record of innovation and treating individuals with addictions and mental illness with dignity. I look forward to working closely with him as we review the agency's mission and reauthorize its programs.

Three years ago, Congress passed the Youth Drug and Mental Health Services Act, which reauthorized SAMHSA. The bill was developed with Senator Frist in the aftermath of the Columbine tragedy and directly addressed the problem of violence in children's lives. It created community partnerships in law enforcement, educational support, and mental health and substance abuse programs to provide a comprehensive response to violence. National and regional centers of excellence were established to deal with the psychological problems resulting from suffering or witnessing a traumatic event, such as community violence or school violence. These supports became even more important as the nation struggled with the aftermath of September 11th.

Other initiatives have been less successful. With Senator Domenici, we added programs to address the needs of adults and children who were suffering from a lack of access to needed treatment, such as a program to establish response teams and designate centers to provide emergency mental health treatment for patients. Unfortunately, these programs have not received the resources needed to get them off the ground. A program to coordinate child welfare services and mental health services has not been funded. We know that budgets are tight, but I hope we can work together to redirect resources to these important programs.

We're so proud of SAMHSA's work in reducing discrimination against the mentally ill and those who suffer from addiction. Through research and treatment, we have been able to give them dignity and help them to improve their lives.

Another issue that divides us is the question of whether religious organizations receiving Federal funds can engage in job discrimination. I strongly support the mission of faith-based organizations and their exemplary role in providing services to people in need. But I have worked for many years to end discrimination and promote the separation of church and State, and I oppose the use of Federal funds for job discrimination and proselytizing for religions.

In October we will celebrate the fortieth anniversary of the day the Mental Retardation Facilities and Community Mental Health Centers Construction Act was signed into law by President Kennedy. That legislation brought dignity to the mentally ill by assisting them and enabling them to move out of mental institutions and into their communities. The need today is to strengthen the resources of our communities so that persons living with mental illness can be successful, contributing members of society.

I look forward to working with my colleague to reauthorize SAMHSA in ways that make it stronger and more supportive of these important community investments in children and adults with mental illness.

Senator DEWINE. Charles Curie joins us today as the administrator of SAMHSA. He has over 25 years of professional experience in the mental health and substance abuse field. Prior to his confirmation as the administrator in October of 2001, he was deputy secretary for mental health and substance abuse services for the Department of Public Welfare in Pennsylvania. Before his service in the Ridge administration, he served as president and CEO of the Helen Stevens Community Mental Health Center in Carlisle Pennsylvania and executive director and CEO of the Sandusky Valley Center in Tiffin, OH. He is a native of Indiana, holding an undergraduate degree from Huntington College, a master's degree from the University of Chicago School of Social Service Administration and is certified by the Academy of Certified Social Workers.

We thank you very much for being with us, and we look forward to your testimony, Mr. Curie. You may proceed.

STATEMENT OF CHARLES G. CURIE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CURIE. Thank you, Mr. Chairman, and thank you Senator Reed. It is a privilege to be sharing with you this morning. I want to thank you for the opportunity to present and your invitation to consider the reauthorization of the Substance Abuse and Mental Health Services Administration.

At this time, I would also like to request that my written testimony be submitted for the record.

At the outset, first of all, I did spend 10 years as a Buckeye in Ohio.

Senator DEWINE. I noted that; thank you.

Mr. CURIE. I was a native Hoosier. I always say I grew up professionally in Ohio and grew old in Pennsylvania, and now we will see what happens in the current position.

Senator REED. You could retire to Rhode Island.

Mr. CURIE. Yes—that could be a good plan.

At the outset, I would like to introduce you to three members of SAMHSA's executive leadership team who are with me today. First is Dr. H. Wesley Clark, the director of SAMHSA's Center for Substance Abuse Treatment; also, Ms. Beverly Watts Davis, the director of SAMHSA's Center for Substance Abuse Treatment; and finally, Mr. James Stone, who is SAMHSA's deputy administrator just coming to us in his second week, having been commissioner of mental health in New York until about 2 weeks ago. Ms. Gail Hutchings, who is acting director of SAMHSA's Center for Mental Health Services, is unable to be here today, but she is probably only second to me in terms of being thrilled that Kathryn Power did say yes to becoming director for the Center for Mental Health Services, and I would support everything you said, Senator, about Ms. Power.

I would also like to take a moment to thank the leaders in the substance abuse and mental health services field who are in attendance today and will testify before the subcommittee.

Let me begin with a story the President used when he launched the New Freedom Commission on Mental Health. It illustrates what happens to people all too often in the mental health or substance abuse systems if they get into one of the service systems at all.

A 14-year-old boy started experimenting with drugs to ease his severe depression. This former honor student became a drug addict, dropped out of school, was incarcerated six times in 16 years. Only when he was 30 years old did the doctors finally diagnose his condition as bipolar disorder, and he began a successful long-term treatment program which helped him attain and sustain recovery.

I tell you this story because this tragedy is preventable. This young man needlessly lost 16 years of his life, which at the same time cost the taxpayers countless dollars.

I tell you this story because today, effective prevention, early intervention and treatment for mental and substance abuse disorders are available, and recovery is possible. For example, after a review of almost 800 programs, we identified 50 model substance abuse prevention programs. On the average, these model programs produced a 25 percent reduction in substance use by program participants. We are working to ensure that effective prevention programs are used in communities nationwide through the development of a strategic prevention framework.

We have shown that substance abuse treatment can yield a 50 percent reduction in drug use 1 year after treatment, accompanied by improved job prospects, increased incomes, and better physical and mental health. After treatment, clients are less likely to be homeless or to be involved in criminal activity or risky sexual behaviors.

Our President clearly understands that treatment works and recovery is real. As you know, in his State of the Union Address, he proposed a new substance abuse treatment initiative called Access

to Recovery. This new initiative will provide people seeking drug and alcohol treatment vouchers to pay for a range of appropriate community-based services. As the President said in his speech, our Nation is blessed with recovery programs that do amazing work. Now we must connect people in need with people who provide the services.

We face the same challenge in our mental health programs as SAMHSA. Our Children's Mental Health Program has produced results, including increased functional ability, increasing school attendance and grades, and reducing contacts with the juvenile justice system. And we are embarking on a national project to promote the widespread adoption of six evidence-based practices, treatments that have consistently been proven to generate positive outcomes for adults with serious mental illness.

It is clear that investments in substance abuse and mental illness prevention, early intervention and treatment pay off in big ways—that is, if we can get the services to those who need them.

Much work lies ahead as we continue to bring scientific discoveries to community-based services. To guide our work at SAMHSA, we have reinforced our statutory mission to focus on services. Instead of the old philosophy of "Let a thousand flowers bloom," we are now nurturing a few sturdy redwoods. We have renewed and more sharply focused SAMHSA's mission and vision, aligning them with both HHS goals and the White House.

In keeping with the President's New Freedom Initiative, SAMHSA's vision is to promote a life in the community for everyone. When someone says "You need to get a life," you know what that means; that is what we need to be about with the people we serve. We are working to achieve that vision through our mission, which is building resilience and facilitating recovery.

To accomplish our mission, we have aligned our resources, staff, and dollars with core priority areas identified in our matrix of program priorities and cross-cutting principles. We have also taken steps to expand our partnership with NIH to produce a comprehensive science-to-services agenda that can help reduce the time between discovery of an effective treatment or intervention and its adoption in community-based care.

Today, the Institute of Medicine tells us it can take up to 20 years for that to happen. With the near doubling of the NIH budget driving even more clinical research and development, that gap may grow still greater unless a fundamental change occurs in how scientific advances are incorporated in community care.

I believe our program priority matrix and renewed focus on our services mission and the development of a comprehensive data strategy that helps us measure and manage program performance will help us accomplish and realize our vision. That vision is to help ensure people of all ages with or at risk for mental and addictive disorders have the opportunity for recovery and a fulfilling life in their community, including a job, a home, and meaningful personal relationships.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Curie follows:]

PREPARED STATEMENT OF CHARLES G. CURIE, M.A., A.C.S.W.

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am honored to present to you the vision, mission, and programs of the Substance Abuse and Mental Health Services Administration (SAMHSA or the Agency). Our mission, as envisioned by Congress when SAMHSA was created, is to "fully develop the Federal Government's ability to target effectively substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system."

Over the years, SAMHSA and its three Centers, the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment and the Center for Mental Health Services, have worked with State and local governments, consumers, families, service providers, professional organizations, our colleagues in HHS, the Office of National Drug Control Policy, and Congress to achieve its mission.

The Agency's work has shown prevention, early intervention, and treatment for mental and substance use disorders pay off in terms of reduced HIV/AIDS, crime, violence, suicide, homelessness, injuries, and health care costs, and increased productivity, employment, and community participation. Data confirms that the human and economic cost is much lower when we prevent or intervene early with the best research-based tools available.

During my first year at SAMHSA, I led the Agency through a critical self-assessment of how it has met its statutory mandate during its first 10 years. Based on that assessment, we identified efficiencies, ways to strengthen our overall effectiveness, increase our capacity, and enhance our accountability both to you and to the populations this Agency has a responsibility to serve.

I also found that like many organizations, as SAMHSA continued to grow, "mission creep" had set in. The Agency's initial focus on increasing access to services and using research findings to improve the quality of services available had lost clarity. Increasingly, staff and resources were devoted to the important work of services research what SAMHSA called "knowledge development." And, the operating principle had become let a thousand flowers bloom.

Today, consistent with Health and Human Services (HHS) Secretary Tommy G. Thompson's leadership and vision, we are nurturing a few sturdy redwoods. We have renewed and more sharply focused SAMHSA's mission and vision, aligning them both with HHS goals and President Bush's New Freedom Initiative and management agenda. In keeping with the New Freedom Initiative, SAMHSA's vision is "a life in the community for everyone."

Working together with the States, national and local community-based and faith-based organizations, and public and private sector providers, we are working to ensure that people with or at risk for a mental or addictive disorder have an opportunity for a fulfilling life, a life that is rich and rewarding, that includes a job, a home, and meaningful relationships with family and friends.

We have defined a "rewarding life" not by what it might mean to the people who work at SAMHSA, but through talking to people in recovery. People in recovery do not say that they need a primary care physician or a caseworker to follow them around. They do not say they need a psychiatrist, an addictions counselor, or even a social worker. They say they need a job, a home, and meaningful personal relationships. They want a life, a real life with all of its rewards.

We are working to achieve that vision through a mission that fulfills our mandate from Congress and focuses our attention on the outcomes we are seeking: to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.

To ensure that all SAMHSA programs are science-based, results-oriented, and aligned with the Agency's vision and mission, I initiated a strategic planning process that guides our decision making in planning, policy, communications, budget, and programs. The process is designed around three core objectives—Accountability, Capacity, and Effectiveness or, in short, ACE!

To guide our work and to keep our vision and mission real, we have created a Matrix of agency priorities and principles to guide program development and resource allocation. We have provided you with a copy of the Matrix. The Matrix is a visual depiction of our priorities and principles, among them: co-occurring mental and substance abuse disorders, seclusion and restraint, substance abuse treatment capacity, prevention and early intervention, transforming mental health care, criminal justice, children and families, aging, homelessness, disaster response, and HIV/AIDS. The Matrix was created to be a flexible management tool and it will adjust

with the needs of the field and of the people we serve as time passes and new trends emerge.

With a fiscal year 2003 budget of just under $3.2 billion, SAMHSA's program dollars support formula grant programs, primarily the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant, a portfolio of discretionary grants, and three major national surveys on substance use. In the interest of time, rather than discuss each of our program areas, I want to focus on three most central to our mission and vision.

BUILDING SUBSTANCE ABUSE TREATMENT CAPACITY

The Substance Abuse Prevention and Treatment Block Grant, with its required maintenance of effort, supports and maintains the basic treatment infrastructure that exists in the Nation. Targeted Capacity Expansion (TCE) grants address new and emerging substance abuse trends. By focusing on local needs, these grants provide the flexibility and agility to meet treatment and treatment system needs in the most relevant way. In the current fiscal year, we have developed a new State TCE program that includes a focus on screening and both early and brief interventions. This focus will help expand the continuum of care available in States.

Together, both the Block Grant and TCE programs have made strides in expanding our capacity for substance abuse treatment. They are necessary; they are effective; but alone, they have not yet proven to be sufficient. Our National Household Survey on Drug Abuse found that in 2001, 5 million of the 6.1 million people needing treatment for an illicit drug problem never got help. Of the 5 million, only 377,000 reported that they felt they needed treatment for their drug problem. In fact, 101,000 people who knew that they needed treatment sought help but were unable to find care.

President Bush emphasized this very point in his January 2003 State of the Union Address when he said, "Too many Americans in search of treatment cannot get it." He reaffirmed his commitment to expand the Nation's substance abuse treatment capacity by proposing Access to Recovery, a $600-million program to help an additional 300,000 Americans receive treatment over the next 3 years. The first $200 million installment is included in the President's proposed fiscal year 2004 budget for SAMHSA under current legislative authorities.

The President's substance abuse treatment initiative, Access to Recovery, will use vouchers to purchase substance abuse treatment and support services. It enables us to achieve key objectives identified by substance abuse treatment administrators and providers, legislators and policy makers, and people in recovery and their families as critical to moving the substance abuse treatment field forward.

First, it acknowledges that there are many pathways to recovery. Using vouchers, individuals, for the first time, will be empowered to choose the provider who best meets their needs, whether the setting is nonprofit, proprietary, community-based, or faith-based. The voucher mechanism allows recovery to be pursued in an individualized way, providing consumer choice, the epitome of accountability.

Second, it will reward performance by offering financial incentives for providers who produce results. Outcomes that demonstrate patient success—measures of recovery—such as cessation of drug or alcohol use, no involvement with the criminal justice system, securing employment, social supports, living situations, access to care, and retention in care will determine reimbursement.

Third, it will increase treatment capacity by expanding access to treatment and the array of support services that are critical to recovery. The initial $200 million investment is expected to result in treatment availability for an additional 100,000 people per year.

This initiative, coupled with SAMHSA's ongoing programs to build treatment capacity, can help create profound change in the delivery and accountability of substance abuse treatment services that can help make a difference in the lives of millions of Americans.

The Senate fiscal year 2004 Labor, Health and Human Services, and Education Appropriations Committee bill provides no funding for this initiative. We strongly urge the Senate to appropriate the full $200 million requested for this critical activity and would appreciate any help you can provide.

We are confident that States are prepared to successfully implement this program at the $200 million level. We are working aggressively to prepare States for this initiative and work through implementation issues related to assessments, accreditation, administrative expenses, and other key areas.

PREVENTION/EARLY INTERVENTION

To help achieve the goal of the President's National Drug Control Policy to reduce illegal drug use by young people and adults by 25 present each within 5 years, SAMHSA is reengineering its approach to substance abuse prevention. Over the years, SAMHSA's work has shown that substance abuse prevention can be incredibly effective, if it is done right.

Prevention not only can reduce the numbers of individuals who become dependent on substances of abuse, but also it can deter substance abuse in the first place. It can pay off not only in terms of health care costs, but also in terms of crime and violence, homelessness, and joblessness. It also can help us enhance treatment capacity by simply reducing the absolute numbers of people who are abusing or dependent on illicit drugs.

We have growing evidence that tells us which models of prevention work well, which promising models need further evaluation, and which models lack any strong evidence of effectiveness. We do not need to re-invent that knowledge. We need to apply what we know. We need to ensure that our dollars support known effective prevention programs, programs built on a solid evidence base of ongoing research.

To that end, over the past year, SAMHSA has been working to create a strategic framework for prevention, built on both science-based theory and evidence-based practices. We know from ongoing evaluation of our programs that to succeed, prevention programs must be built at the level of families and communities and must engage individuals, families, and entire communities.

SAMHSA's State Incentive Grants (SIG) for Community-based Action are a stepping-off point to achieve that end. It forms the foundation on which our strategic prevention framework rests. The SIG program provides funds to the Governors' offices of individual States and territories. It also is based on those prevention practices that we know are effective. It enables Governors to develop a coordinated approach to prevention and to determine where and what the greatest needs are. At least 85 percent of funds are then directed by the Governor to community-level prevention programs.

Last year, the SIG program provided resources to over 2,700 community-based and faith-based organizations, community anti-drug partnerships and coalitions, local governments, schools, and school districts. It has promoted the development of thoughtfully crafted, evidence-based State-community partnerships and strategies that enable communities to work on their own greatest challenges in substance abuse prevention.

Most of the community programs have adopted science-based substance abuse prevention strategies, many of which have been evaluated and endorsed by SAMHSA as effective models. These model programs, listed in our National Registry of Effective Prevention Programs, yield on average a 25 percent reduction in substance use by program participants.

Our strategic prevention framework sets into place a step-by-step process that empowers communities to identify risk and protective factors for substance abuse in their communities and to implement the best and most effective prevention efforts for their specific needs. Critically, the framework includes feedback to ensure accountability and effectiveness of our program efforts.

TRANSFORMING MENTAL HEALTH CARE

SAMHSA's vision and mission of a life in the community for everyone is a direct outgrowth of the President's New Freedom Initiative. That same vision and mission guides our efforts to help ensure that people with mental illness have access to effective and appropriate, community-based mental health services that can help them become or remain engaged participants in the life of their communities.

Consistent with other areas of SAMHSA's programming, accountability, capacity, and effectiveness are central to our mental health services discretionary and formula grant programs and activities. Three of those programs are the Projects for Assistance in Transition from Homelessness, the Children's Mental Health Services Program, and the Community Mental Health Services Block Grant.

The Projects for Assistance in Transition from Homelessness (PATH) program continues to generate positive results by bringing an estimated 147,000 homeless people into treatment for mental disorders and substance abuse, as well as providing referrals for housing. PATH gives States flexibility in designing their programs, but helps ensure efficiency by requiring States to match funds with one dollar for every three dollars received in Federal funds. In recent years, State and local support has been more than double the sums required by the match. Over its history, the program has continued to exceed its targets for reaching this often difficult to serve population.

The Children's Mental Health Services Program builds community-based systems of care for children with serious emotional disturbances (SED) and their families. The program supports services for almost 17,000 children and adolescents with SED and their families. It creates a web of services, linking school, family, juvenile justice, and mental health and other health care together to provide an integrated approach to meeting the highly individualized needs of children with SED and their families. Outcome data continue to show that this integration decreases use of inpatient care, increases school attendance and performance, and decreases contacts with the juvenile justice system. Several States have adopted statutes mandating this kind of approach to treatment for children with SED, but the value of a similar approach for other populations of individuals with serious mental illnesses cannot be discounted, either.

The Community Mental Health Services Block Grant program provides funds to the States to provide comprehensive community mental health services to adults with serious mental illness and children with SED. The program's overall goal is to move care for these adults and children from costly and restrictive inpatient hospital care to the community. The Block Grant is funded at $437 million this fiscal year, or about 2.5 percent of State expenditures on mental health services.

As you may know, the President's New Freedom Commission on Mental Health has completed its work, and its final report to the President is expected soon. Once the final report is submitted to the President, the Administration will evaluate the report and its recommendations.

As a result, we expect there may ultimately be some far-reaching implications for SAMHSA's mental health programs. We look forward to working with the Congress to implement the steps needed to improve the mental health service delivery system in America.

NATIONAL SURVEYS

Another area of SAMHSA responsibility is to inform the President, the Congress, the substance abuse prevention and treatment and mental health service fields, and the American public on the status of substance use and treatment services in the Nation. One of those measures is provided by our National Household Survey on Drug Abuse. The National Household Survey provides national and comparable State-level estimates of substance use, abuse, and dependence. It also provides an ongoing source of nationally representative information on mental health and access to mental health services. The analysis of trends over time from the survey, alone and in combination with other data sources, provides an invaluable tool to measure outcomes of the National Drug Control Strategy and to report our progress to Congress.

Two other major national survey's conducted by SAMHSA include the Drug Abuse Warning Network (DAWN) and the Drug and Alcohol Services Information System (DASIS). The DAWN obtains information on drug-related admissions to emergency departments and drug-related deaths identified by medical examiners. The DASIS consists of three data sets developed with State governments. These data collection efforts provide national and State-level information on the substance abuse treatment system.

IMPROVED MANAGEMENT OF SAMHSA RESOURCES

SAMHSA is working to develop an overall data strategy and to shift the block grants to performance partnership grants. With regard to Performance Partnership Grants, or PPGs, SAMHSA has been working on this for sometime, and I am pleased to say our plans for transforming the block grants will be submitted to you very soon as we prepare to send a report to Congress, as requested, on these plans.

Currently, SAMHSA and the States have agreed on performance measures. We have identified the core measures on which all States will report. We are working to revise the fiscal year 2005 block grant applications to include performance data collection. Given that the PPGs comprise almost 80 percent of SAMHSA's budget, we are working to align the PPG performance measures with the Access to Recovery initiative and with potential recommendations of the President's New Freedom Commission on Mental Health.

Through both the Access to Recovery initiative and the PPGs, we have identified seven domains for specific data needed to capture the concept of recovery and determine the effectiveness of our programs. As I mentioned before, these include: drug or alcohol use, involvement with the criminal justice system, securing employment, social supports, living situations, access to care, and retention in care. These domains, when finalized through the PPG performance measures and the work we are doing on Access to Recovery, will likely become the same ones used across all of our

programs. It just makes sense to use consistent measures across programs that have the main goal of building resilience and facilitating recovery.

To make sure we are moving in the right direction when it comes to collecting, analyzing, aggregating, and ultimately turning data into action, I have set up what I call the "Data Strategy Workgroup." I am determined to build a system that uses the health information technology we have today to help us measure and manage performance and in the end benefit the client which is and always should be our overriding goal.

In many ways the "Data Strategy" is starting from a grassroots perspective. The workgroup contains key SAMHSA staff who will be looking at ways to build a collection system that, while protecting confidentiality, will be able to capture a clear picture of the situation and the needs and treatment status of the individual. Such information can then be gleaned to provide a picture at the local/county level.

That information then will be translated to create a State-level picture and combined to create a national-level picture of outcomes. Capturing and using the best data, especially where the PPGs and voucher program are concerned, will allow us, as never before, to clearly recognize outcomes as part of the quality and effectiveness equation. Using a limited number of domains will gather data on a handful of accurate measures, rather than create a sea of minimally useful data, thus trimming and reducing the reporting requirements of the States.

Finally, SAMHSA is actively promoting a Science to Services agenda. After years of discussion about SAMHSA's role in "knowledge development", we are reinforcing our mission in services and in bringing evidence-based, effective products of research to community programs nationwide. We are also reinforcing the clear expectation contained in our authorizing legislation that SAMHSA and the National Institutes of Health (NIH) should collaborate to promote the study, dissemination, and implementation of research findings that improve the delivery and effectiveness of substance abuse and mental health services. As a result, we have recently taken steps to expand our partnership with the NIH to produce a comprehensive "Science to Services" agenda that is responsive to the needs of the field. We have initiated a dialogue with the Directors of NIH's National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, and National Institute of Mental Health, and we have made a common commitment to this agenda. We are working to define and develop a "Science to Services" cycle that reduces the time between the discovery of an effective treatment or intervention and its adoption as part of community-based care, which the Institute of Medicine tells us today can take up to 20 years.

CONCLUSION

Mr. Chairman and Members of the Subcommittee, as the Administrator of SAMHSA, I have taken a hard look and taken steps to clarify SAMHSA's vision and mission. We have set the Agency on a new course being guided by accountability, capacity, and effectiveness. We will continue to manage the Matrix. With the imperative of the President's commitment to grow our substance abuse treatment capacity coupled with the findings of the New Freedom Mental Health Commission, and with your support SAMHSA, we will continue to work toward achieving a vision of a life in the community for everyone.

Thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

Senator DEWINE. Senator Reed?

Senator REED. Thank you very much, Mr. Chairman.

Thank you again, Mr. Curie, for your testimony and for your leadership. I believe you have assembled an extremely good team and look forward to working with you.

You mentioned the President's Access to Recovery Initiative. Part of that is a voucher program, which there are arguments on both sides, but one of the issues is how it addresses the capacity problem. Giving an individual a voucher and then having him or her look in vain for a provider is difficult. And on the other side of the coin, unless you have a rather predictable funding stream as a provider, you are going to get out of the business—if it is, "I have got to attract people, I have got to advertise," in fact you find yourself doing things inefficiently.

Can you please comment?

Mr. CURIE. Yes, I can. I think those are excellent questions. In short, the voucher program indeed will increase capacity because on top of what is already being funded, we are talking about an additional $200 million in the system.

Right now, we have two primary avenues that fund the substance abuse and drug and alcohol treatment system in this country. We have the Substance Abuse Prevention and Treatment Block Grant, which totals about $1.8 billion, and with the State match that is required throughout this country, $3.6 billion pretty much comprises that program. That has been the foundation and backbone, if you will, of public drug and alcohol treatment in this country since Medicaid, Medicare, and other public funders do not fund substance abuse treatment to any great extent.

So we are working to keep that block grant very much intact. Again, we are working at developing performance partnership measures with the States to build some further accountability, but that will still be sustaining the foundation of the drug and alcohol treatment structures.

We also have a second avenue called Targeted Capacity Expansion Grants. That totals about $320 million, and that is what I call our "agility factor"—in other words, as we see new and emerging trends emerge around the country, we are able to fund specific programs to address those trends, and many times, we bring to a larger scale interventions which are purchased originally and funded by Targeted Capacity Expansion Grants.

The Access to Recovery Program, the voucher program, is a third avenue, and it does put in the mix using consumer choice, but I think it needs to be stressed that we are looking at structured choice. In other words, States will be responsible for the voucher program as they are the block grant implementation. And again, we are working with the States to strengthen their role in the Targeted Capacity Expansion Grants so that at the State level, they can work with local communities to identify particular needs. The voucher program needs to be managed at that level, and we are asking States to credential providers, to make sure that there are clear and informed choices being able to be made. And speaking as a former provider myself, I also know that if consumers come and clients come with resources in hand instead of me being contained by perhaps a budget that is grant-funded, and I have only a limited number of slots, I would have every motivation to open up new slots with that additional funding stream.

So we are looking for increased capacity to be one of our overriding goals.

Senator REED. Thank you. That is a very, very appropriate response, and this is a serious proposal, so I think we have to ask serious questions. One factor in considering this proposal is that we are dealing with a population of people who are extremely vulnerable. I must confess that I have difficulties making informed choices about health care providers and different modes and modalities of treatment.

To assume that anyone can make these choices unaided is, I think, unreasonable. And second, if you structure a program so it is a voucher program, but it is essentially a voucher program where a State official says, "You have to go to XYZ facility," that

is not much different than what we have today. The difference is that we are adding another degree of uncertainty, in terms of who is the State official, what programs they are going to direct people to, and what are their criteria—is it what is best for their patient, or is it that we have got to fill a need here, and this is a program we like to see. Can you please explain?

Mr. CURIE. Absolutely. Once the funds are appropriated, we will be issuing a Request for Application to all 50 States. There will be a competitive process in which States need to demonstrate a capacity to be able to implement this voucher program, and in that RFA which we are in the process of developing, being informed by the field currently as well, we are going to be setting out standards by which the States must demonstrate that they will be giving real choice, that they will be structuring the choice, and it is also going to be based on the fact that an assessment has to take place in the first place by a qualified professional who will assess and determine the extent of need being presented to them.

So the choices that the individual will have will be within a range of interventions of qualified providers who can provide that type of services. So clearly, we are going to be expecting States to show us that it is going to be structured, that they have credentialing standards, that they are evaluating on an ongoing basis, that they are looking at not only outcomes in terms of whether people really are attaining recovery and realizing those outcomes around employment, lack of involvement in criminal justice, abstinence, and stabilized living situation. If the State has that ongoing process, we are confident that as the program is implemented, it will become even more refined in terms of informed choices.

So there are going to be standards issued in this RFA; States have to respond to that, but then we are going to give States appropriate latitude in their implementation to make sure that where they are implementing the voucher program, it meets the needs of that State.

Senator REED. Thank you.

There is another issue that will be involved in this approach, and that is the issue of faith-based providers. First, is it accurate to say that there are faith-based providers today in programs that you are administering?

Mr. CURIE. Yes.

Senator REED. And they are operating under guidelines which require them to have a separate corporate identity from their religious identity, and that they follow local laws with respect to civil rights; is that correct?

Mr. CURIE. In many situations, that is the case, and again, it varies from State to State what licensing requirements there are. But what you have just described does exist.

Senator REED. It does exist. It seems to me, though, that obviously, there has been a push to say that religious entities cannot operate with such "restrictions," when in fact it does work every day throughout the country. However, through these efforts we will be into issues with respect to, separation of church and State, whether you have the right to deny employment to professionals because they do not agree with the creed or aspects of the creed

of the particular provider. And it strikes me first that that is an issue you are going to have to wrestle with seriously—we all are—but second, a model works today that is allowing participation by faith-based organizations through these mechanisms, and it is a model that I think is effective, and we might be, for reasons unrelated to serving people, trying to create a different approach.

Mr. CURIE. Well, clearly, there are providers today who have a faith-based orientation who are licensed and are providing services today. We are also recognizing with Access to Recovery that there are many pathways to recovery and that if you have 200 people in recovery in this room, you will have 200 different stories of recovery, of where a person began to achieve it and attain it. And very much with Access to Recovery, we are looking to expand the array of services to assure that not only is there perhaps an initial treatment intervention but also many faith-based organizations that may not be licensed today may be very good a relapse prevention, or as people within recovery have also dealt with the spiritual dimension of their lives, if they are looking at relapse, and they come, and they are struggling with that and are assessed, we want to be able to be assured that there are faith-based options that are appropriate, and we are looking for all providers, whether proprietary, nonprofit, community-based or faith-based, they need to demonstrate functional outcomes in people's lives. And I think that if we hold all providers accountable with that being the common level of accountability, we are not looking at church and State issues in terms of identifying effective religions, but we are looking to identify and purchase effective outcomes.

So we are gearing the standards toward that. We are asking States to credential people appropriately. If they hang out their shingle and say, "I provide this kind of service," that is a public safety and public health issue, and they need to be credentialed and licensed according to that.

We are having discussions now with our current provider base, we are having discussions with faith-based providers who feel they have not had an opportunity necessarily to appropriately participate in the array of services to determine what are the appropriate standards depending on what that provider says they do.

Senator REED. The chairman has been most kind, and my time has expired, but you are getting into one of the thorniest thickets of constitutional, political, and cultural values that we have in this country, and we should go in with our eyes open.

If you are going to insist on credentialing, that raises real questions of whether someone who has a religious vocation and accreditation has to be credentialed as a substance abuse professional to provide services. Many religions would say absolutely not. Then, on the other side of the coin, is someone who has a vocation and a theological degree automatically credentialed as a substance abuse professional? Others would say no—there is a different skill set here.

Let us just know that we are getting into the deep woods here.

Mr. CURIE. Agreed. I think the key right now is to have ongoing dialogue, transparency in what the issues are, and moving ahead in a way which clearly reflects the laws of the land and clearly re-

flects accountability, clearly reflects the fact that we want people to be able to make informed choices.

Senator REED. Thank you, Mr. Curie. You have been very responsive.

Mr. CURIE. Thank you, Senator.

Senator DEWINE. The President's Mental Health Commission will soon make its final recommendation, so first, when is their final report expected, and second, how will this report affect the future direction of the agency?

Mr. CURIE. The final report—very soon—in fact, before the end of this month.

Senator DEWINE. That is soon.

Mr. CURIE. Yes, it is—and I have found that for the Federal Government, that is very, very soon. It will be presented before the end of the month, and we are very excited about this. I know the Secretary and the President are very much looking for this report to inform us as to how to address mental health service delivery in this country. And the goals that are set out in this report are going to parallel the goals that we are seeing reflected as well in overall health care transformation—for example, use of technology for self-care and access will be a focus.

We also have a focus on needing early screening and interventions and how to go about addressing that, and another overall goal that recognizes that mental health is essential to health; it is an overall health care issue.

So again, the interim report described a system that is somewhat fragmented, at this point very fragmented, not necessarily connected, has a nexus with criminal justice, with education. And the attempt in this Commission report and then the action plan that I anticipate will be developed that this report will inform is to address that fragmentation so that we have a clear, coherent policy around how public mental health is delivered in this country, how we do it effectively in partnership with the private sector, and how, bottom line, children with serious emotional disturbance, adults with serious mental illness, and their families have access and a pathway to care so that they are not having to learn how to navigate a system that is difficult to understand, but that the system is one that basically morphs to their needs.

Senator DEWINE. Well, I think we all have an obligation both on the legislative and certainly from the executive side to take those recommendations seriously, and I think we need to be judged in 6 months, a year, or 2 years by how far we have gone in implementing them.

Mr. CURIE. Agreed.

Senator DEWINE. Unfortunately, the history in Washington is that we have reports and reports and reports, and they sit on shelves, and if one percent of a report gets implemented, it is a success. We need to do better than that.

Mr. CURIE. Absolutely.

Senator DEWINE. We have a lot of good people out there with a lot of good ideas, and I think we have a real challenge here to try to implement it.

We all agree that prevention is such an important part of the comprehensive approach to drug and alcohol use and dealing with

this problem, and I must say I am troubled by the fact that the administration for the past 2 years has requested less funding for prevention programs. What is going on here?

Mr. CURIE. That is a very good question. A little bit ago, I introduced Beverly Watts Davis, who is our new director for the Center for Substance Abuse Prevention. She has been on board I believe for 6 weeks at this point.

Senator DEWINE. Welcome.

Ms. WATTS DAVIS. Thank you very much.

Mr. CURIE. The good news with Beverly being aboard is that she understands prevention programs from the ground up. And the one thing that I need confidence in, the Secretary needs confidence in as we move ahead with prevention is that we were setting the stage for CSAP, if it is going to be the lead Federal Agency for substance abuse prevention, to lead by being able to articulate and work with the States, with the State incentive grants, to ensure that we are moving toward what we are calling a "strategic framework for prevention."

We know what works in prevention. We know the risk factors, and we know protective factors that go with the risk factors. And there are a lot of Federal programs that fund a range of prevention types of programs. In HHS, we have ACF, the Administration for Children and Families, we have the Centers for Disease Control, we have HRSA, we also have SAMHSA, obviously, we have Justice, we have Education, and other departments' funding.

We believe it is imperative for CSAP not to just be funding prevention program but to be garnering its efforts around providing the leadership and framework to give States and then communities the confidence that they are bringing their coalition leaders to the table and that those leaders then are helping to develop a plan based on need that is assessed, and CSAP should be facilitating that.

I anticipate, and it should not be read—it does not preclude that we are not looking for increasing resources to CSAP as we move forward, but we also wanted to make sure that as we looked at CSAP and assessed it that we were posturing it to be able to use the dollars in a way that we were confident that we were not just funding programs without that framework.

Senator DEWINE. Well, I am not sure I understand your answer. I do not want to be argumentative, but I think we all agree that—and I am anxious to explore this with First Lady Taft, because I have had the opportunity to read her testimony about CSAP—we all agree that we want best science, and we all agree that we should not fund things that do not work, we all agree that we should fund things that do work, and we all agree that we always need to keep doing more and more research. I think we all agree on that.

But what else are you saying? I mean, we all agree on that.

Mr. CURIE. Yes, yes.

Senator DEWINE. No one wants to fund junk; we want to fund good prevention. I have quite a bit of experience in this in the area of Drug-Free Schools. I served on the National Commission for Drug-Free Schools when I was in the House; I have been through this in both the House and the Senate as a legislator, and we have

seen the bad experiences of funding a lot of junk in the schools, and we hope that we are starting to get away from that, and we are funding better stuff now.

It is the same way in the whole realm of prevention. There is a lot of bad stuff out there to fund, and there is good stuff out there to fund, and we have got to target our money toward stuff that works, and we have got to measure what works.

OK. Now, having said all that, though, it still does not get away from the fact that you have got to fund it, and it still does not get away from the fact that once you identify what is good, you have got to put money into it, and if you do not put money into it, you do not get the job done.

So what am I missing here?

Mr. CURIE. I believe that now we are positioned to have confidence in terms of requesting new funding and sustaining historic funding, that we can say that we are postured to make sure that the money goes to what works.

In the past 2 years as we have looked at the overall budget from SAMHSA, we have prioritized substance abuse treatment looking at the guidelines in terms of resources, of where we are putting our dollars. So I guess I want to go on record that we are not precluding looking at future increases in prevention as we move ahead. It is not a position that we do not support prevention. We agree with you. We want to make sure that the dollars are going in the right place. We need to structure CSAP, and we have been in that process now, to make sure it can clearly show a framework for funding in the future.

Senator DEWINE. OK. First of all, do not misunderstand me. I am not opposed—in fact I support increased funding for treatment. So we are on the same page there.

Mr. CURIE. Right. And these are tough decisions, too.

Senator DEWINE. I know. I understand that, I understand that. But I want to make sure I understand where you think you are with CSAP. I get the impression that you think CSAP was not where it should have been.

Mr. CURIE. Exactly.

Senator DEWINE. OK. CSAP was not where it should have been. Tell me where it was, tell me where it is now, and tell me where it is going to be.

Mr. CURIE. OK. My assessment is——

Senator DEWINE. Because this is what we are doing with this committee, so let us get it.

Mr. CURIE. Oh, absolutely.

Senator DEWINE. Let me make sure I understand where the administration—where was CSAP, how bad was it, and why was it bad; where is it now, and where is it going?

Mr. CURIE. OK. What I want to say is that clearly in CSAP, there has been a staff there of dedicated individuals who are competent in the area of prevention. I think what has been lacking there is a strong, clear strategy and framework of moving the prevention field ahead, giving communities what they need to have confidence that they are funding programs that will work.

In terms of initiatives within CSAP, there were a lot of different initiatives being funded through different divisions within the Cen-

ter, but they were not being tied together over what we are trying to accomplish in terms of outcomes being identified in the field.

Senator DEWINE. Well, were they funding junk?

Mr. CURIE. They were funding some good things, and they were funding some things that did not necessarily demonstrate it was working. So I would say——

Senator DEWINE. They were funding bad things.

Mr. CURIE. They were funding some bad things, yes.

Senator DEWINE. OK. Are they funding bad things now?

Mr. CURIE. I think they are funding less bad things as we go along. As we look at it, we are in the process of assessing that now.

Senator DEWINE. Well, you guys are running the place.

Mr. CURIE. I would say that we have made tremendous progress in putting the dollars into what works. One of the programs I point to in CSAP that I think is excellent is the National Registry of Effective Prevention Programs, and we have identified 50 programs that show excellent outcomes there that can be replicated. Those are the types of programs we want to put more and more of our dollars in as we identify them and emerging promising practices.

And what we are doing now in CSAP in terms of where it is going is assuring that there is a structure in place to assess what is working and what is not working, to be able to jettison what is not working quickly and more quickly, to be able to embrace what is working, to bring it to scale, to give States the information they need to be able to bring it to scale, to give communities what they need to make those decisions. And since we do have a lot of Federal agencies funding a lot of prevention, one of CSAP's primary responsibilities should be providing the leadership to the Nation and the leadership to the field in terms of how to make those wise decisions at the State and community level. That is where a lot of our focus is shifting more and more, and I think making that kind of a hallmark of SAMHSA as we move ahead will be important. I do not think that was clear in the past, and it was very easy for SAMHSA to be one of many Federal programs funding a range of prevention programs. We want to move away from that.

Senator DEWINE. OK.

Senator Reed?

Senator REED. Mr. Chairman I think Senator Murray has some remarks.

Senator DEWINE. Senator Murray has joined us. Thank you. Good morning.

Senator MURRAY. Thank you, Mr. Chairman. Good morning. I appreciate the hearing and I am sorry for being late.

Senator DEWINE. You can make an opening statement or you can go right into questions.

Senator MURRAY. Thank you.

I will submit my statement for the record. I really appreciate your having the hearing. I think it is really important that we focus on mental health, and I know that Senator Wellstone's long work on getting mental health parity is something that all of us still want to see happen some day, or I hope we all do.

Mr. Curie, I do appreciate your coming today, and I am sorry I missed the earlier questions. I just have a few that I want to focus on, because I am concerned that for a long time, we have thought

of mental illness and substance abuse as things that only affect adults, and that adult-only bias has really resulted in significant underfunding for pediatric mental health treatment and juvenile mental health and substance abuse treatment. For too many young people, not treating them means they wind up in prison. That is sort of the way we slant things right now, which is not the way I think we should be focused.

I know that SAMHSA has started to shift some resources to children's services and treatment, but we have a long way to go, and I wonder if you could update us on what you are doing and what you see happening and some of the improved treatments and options for children and young people.

Mr. CURIE. Thank you, Senator. I do agree with you that I think historically, as we look at the public mental health system, because its history and focus came out of treating individuals in State institutions who were primarily adults, children's services have lagged.

I think that is changing. I think we do have more to do. If you look at our Center for Mental Health Services, we have a Systems of Care grant process, and at this point, I think we are funding it at a little more than $50 million. Systems of Care is an approach which brings together all child-caring systems in a community—juvenile justice, education, mental health, substance abuse—to make sure that a child's need is met in a comprehensive plan, because you are right—many times, children fall through different gaps in different systems, and when they fall through those gaps, sometimes, unfortunately and inappropriately, the juvenile justice system ends up treating those adolescents. We want to make sure that that does not happen.

The good news for our Systems of Care approach—it has been reviewed by the parts process in terms of its effectiveness, and it has been deemed moderately effective—I think the score was 75—and we are developing a plan to help improve that score, but I think it gives us a model for both future funding out of SAMHSA as well as informing CMS in terms of appropriate funding of services, and we are in a position to be able to work with State mental health authorities and Medicaid authorities to talk about these programs which really are bringing forth results.

Also, we spoke about the Mental Health Commission a moment ago—there is going to be a strong focus there on children in terms of developing a mental health action plan that address prevention, early intervention, working with schools where the children are in terms of identifying. We know that if we intervene earlier, we can have much more positive results and perhaps avoid a chronic disability around mental illness, and we want to bring those things to scale as well.

So we have many initiatives around children's mental health at this point, and I think we are poised to really work with especially the public financing to assure that incentive are put in the right place.

Senator MURRAY. Do you know what any of the States are doing with their block grant money specifically to improve services for children?

Mr. CURIE. Again, with the block grant—and on the mental health side of things, that typically comprises about one percent of

a State's mental health revenue—many States have used those dollars because they have given them more flexibility to prioritize children. And you find school-based programs being funded in partnership with schools——

Senator MURRAY. To provide personnel at schools, for example?

Mr. CURIE. Yes, there are models like that, and there are many States that use block grant moneys to fund those types of programs. I think the struggle has always been—and speaking as a former commissioner from Pennsylvania—the programs that we fund have typically been on a smaller scale than we would like; we see it working in a lot of areas, and the challenge has always been how we bring to scale some of these school-based interventions.

And again, with the block grant dollars being such a small part of the overall revenue, it is a matter of how can we leverage the block grant when we find these promising practices, also our Targeted Capacity Expansion Grants, and bring them into the mainstream of funding. I think that is going to be one of our biggest challenges coming out of the Mental Health Commission at this point.

Senator MURRAY. I know that SAMHSA does not directly oversee any research, but research is another area that concerns me, that we focus on an adult population, and a lot of new treatments for mental illness do not have pediatric labels or indications. Can you share with us anything that you know about what is being done to do better research for children and mental health?

Mr. CURIE. I do know that the Institutes are looking specifically at children, and research around that area. In fact, I am being briefed within a week in terms of a science-to-services initiative that we initiated out of SAMHSA in collaboration with NIH, and both Dr. Zerhuni and I will be briefed in terms of concrete products that are coming out of that initiative, and children will be a particular part. We are looking at children as well as adults as well as the aging population, needing to focus on those three segments in particular, not only in service delivery, but being informed by services research.

I might add that part of what we need to be doing as well is, once we identify a services research agenda, we have got to think about how we unclog the pipeline, so to speak, of getting the findings to practice, because that lag time is way too long. So that is another aspect we need to be examining.

Senator MURRAY. Thank you very much. I really appreciate it.

Mr. CURIE. Thank you, Senator.

Senator MURRAY. Thank you, Mr. Chairman.

[The prepared statement and questions of Senator Murray follows:]

PREPARED STATEMENT OF SENATOR MURRAY

Mr. Chairman, I want to thank you and the Ranking Member for scheduling this important hearing.

I'm pleased that we have elevated Mental Health and Substance Abuse to a separate subcommittee within HELP. That's appropriate because the need to increase our focus on mental health and substance abuse has never been greater.

As we move to reauthorize the Substance Abuse and Mental Health Services Act, I hope we can continue to work together because a comprehensive reauthorization bill is in all of our best interests.

I think we can all agree that our mental health and substance abuse treatment infrastructure lacks any real coordination. We also know that the demands for services far outweigh the availability of effective treatment options.

I believe this is due—in part—to the lack of Mental Health Parity in the private insurance arena. The inability to treat mental illness the way we treat physical illness has resulted in a fragmented treatment structure. It has also created a shortfall in the availability of services.

Mr. Chairman, we would not accept these types of shortages in any other healthcare field. Can you imagine a 6 month delay in surgery due to a lack of providers or hospitals performing surgery? Can you imagine being told that your child needs sinus or orthopedic surgery but there is a 6 to 9 month waiting period?

It would be unacceptable, but that's what many families face when they need mental health or substance abuse treatment services.

We need to stop thinking about mental health or substance abuse treatment as something separate from physical health, and we need to pass Mental Health Parity. Not only is it the right thing to do, but it would be a fitting tribute to our former colleague Paul Wellstone.

QUESTIONS OF SENATOR MURRAY FOR PANEL I—DR. CHARLES CURIE, ADMINISTRATOR, SAMHSA

Question 1. For too long, we have thought of mental illness and substance abuse as things that only affect adults. This "adult only" bias has resulted in significant under-funding for pediatric mental health treatment and juvenile mental health and substance abuse treatment. Tragically, when young people don't get the help they need, they fall through the cracks.

For too many young people, prison is becoming the provider of last resort for juvenile mental health and substance abuse treatment. Clearly we are failing our children. I know that SAMHSA has begun to shift greater resources to children services and treatment, but we still have a long way to go.

I'm interested in your efforts to continue to improve services and treatment options for children regarding mental health and substance abuse.

I would also be interested in what the states are doing with block grant moneys to improve services for children and adolescents.

Because of the "adult bias" in mental illness and substance abuse, mental health research involving children has also lagged behind, and the gap continues to grow. Many new treatments for mental illness still do not have pediatric labeling or indications. I realize that you are not directly involved in mental health research, but as the Administrator of SAMHSA I know you are aware of research efforts at NIH.

Could you provide an update on pediatric and adolescent mental health research?

QUESTIONS OF SENATOR MURRAY FOR PANEL I AND II

Question 1. What can we do in reauthorizing SAMHSA to improve access to treatment options for children? Is it a matter of money? Or do we need to do more to expand the block grant?

I know that report after report has shown that there is little coordination between providers and systems responsible for providing treatment and services to individuals with mental illness.

These problems are only intensified for children. Too many children are simply falling through the cracks and spending their adult years in prison.

Question 2. We are seeing significant delays in diagnosing and treating mental illness in rural communities. Almost every county in Washington State has been

designated a Mental Health Professions Shortage Area. There are simply not enough mental health providers to diagnosis and treat mental illness. Undiagnosed mental illness often results in greater physical health costs and many other social problems like homelessness, family violence and substance abuse.

Question 3. What can we do to provide greater coverage in rural areas? One of the most promising options appears to be telehealth.

Question 4. Can we use the reauthorization of SAMHSA to expand telehealth opportunities in mental health treatment?

I know in Washington State several demonstrations are ongoing and offer real promise using telehealth as a means to expand access to mental health services.

Question 5. Can you provide any insight into the possibilities of telehealth technology to address the major shortage of mental health providers?

Senator DEWINE. Thank you very much. It is been very good testimony, very, very helpful. You have a very big job, a very important job, and we look forward to working with you as we move forward on the reauthorization.

Mr. CURIE. Thank you, Mr. Chairman, and thanks for your support.

Senator DEWINE. We appreciate it. Thank you. We will be here to support you.

Let me ask the second panel to come up now as I introduce them.

First, Hope Taft is the First Lady of Ohio. She is a tireless advocate of substance abuse prevention services. Mrs. Taft is the cofounder of several anti-drug organizations, including Ohio Parents for Drug-Free Youth and the Ohio Alcohol and Drug Policy Alliance, and is an Ohio Certified Prevention Specialist II. Mrs. Taft was appointed by the President to serve on the President's Council on Service and Civic Participation. She serves on the National Advisory Council of the Center for Substance Abuse Treatment, the National Advisory Council on Alcohol Abuse and Alcoholism, and on the National Conference of State Legislators' Advisory Committee on the Treatment of Alcoholism and Drug Addiction. From 1998 to 2003, Mrs. Taft served as a member of the President's Commission for Drug-Free Communities.

Dr. Lewis Gallant is executive director of the National Association of State Alcohol and Drug Abuse Directors. He has served as executive director since November 2000. Prior to his current position, he served as vice president and president as well. Dr. Gallant came to the National Association of State Alcohol and Drug Abuse Directors from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, where he worked for 8 years and where he was most recently director of the Office of Substance Abuse Services. He also spent 20 years in active military service as human services manager and administrator in the U.S. Army Medical Department.

Martha Knisley joins us from the District of Columbia's Department of Mental Health. Ms. Knisley is the first director of the D.C. Department of Mental Health. She has worked for three decades as a mental health clinician and administrator. She directed two State departments of mental health—Pennsylvania and Ohio. Prior to becoming director in Ohio, as deputy director, she helped build Ohio's Statewide Community Mental Health System. Prior to coming to the District, she was a senior consultant with the Technical Assistance Collaborative created by the Robert Wood Johnson foundation to assist State and local governments manage their public mental health systems.

Ms. Gloria Walker, our final panelist, is joining us from Cincinnati. Ms. Walker is president and owner of GW Consulting and Education Services. She has taught in the Cincinnati public schools and served as a professor at the University of Cincinnati and Southern Ohio College. Ms. Walker is a member of the board of directors of the National Alliance for the Mentally Ill and has also served as board president for NAMI Ohio. Ms. Walker is also a member of the National Association of Mental Health Planning and Advisory Council and the mother of a child diagnosed with schizophrenia and bipolar disorder.

We thank all of you for taking your very valuable time to come here and be with us. We will start with Mrs. Taft.

Thank you very much. We have your prepared testimony. It will be made a part of the record, and if each of you could confine your testimony to 5 minutes and summarize your testimony, we would appreciate it. That will give us the opportunity to ask questions.

Mrs. Taft?

STATEMENTS OF HOPE TAFT, FIRST LADY OF OHIO; LEWIS E. GALLANT, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, INCORPORATED; MARTHA B. KNISLEY, DIRECTOR, DEPARTMENT OF MENTAL HEALTH, DISTRICT OF COLUMBIA, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS AND THE CAMPAIGN FOR MENTAL HEALTH REFORM; AND GLORIA WALKER, MEMBER, BOARD OF DIRECTORS, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mrs. TAFT. Thank you, Chairman DeWine and Members of the Committee, for this opportunity to talk about substance abuse prevention in the context of the SAMHSA reauthorization.

I bring thanks from Ohio's alcohol and drug treatment and prevention field to you, Senator DeWine, for your outstanding commitment, dedication, and leadership in protecting and enhancing the Federal role of alcohol and drug prevention and treatment.

I feel strongly that prevention has been underutilized in both funding and emphasis and has not reached its potential relative to its importance and effectiveness in reducing drug and alcohol use and their related human and societal costs.

In my time before you, I would like to emphasize several point. First, prevention is effective; it is worth the investment. The Center for Substance Abuse Prevention, or CSAP, is vital to local efforts, and it should stay separate from treatment, just as the alcohol and drug prevention and treatment fields should stay separate from the mental health field.

My second point is that Congress can help. It can help the Nation by keeping CSAP a distinct entity. It can help the Nation by keeping CSAP's funding stable and sustained. And Congress can help by encouraging CSAP's current direction of building capacity, effectiveness, and accountability in the field and its movement to environmental community-based approaches.

Finally, Congress can help by making sure that CSAP's success is measured and based on what CSAP funds and can control.

Since the mid-1980's, when I began my career as a certified prevention specialist working in Cincinnati, OH, I have experienced first-hand both the devastation that substance abuse has on families and communities as well as the power of effective prevention strategies in reducing the use of alcohol and illegal drugs.

From 1993 to 2000, there was a 41 percent decrease in marijuana use among 7th to 12th graders living in communities with coalitions associated with the Coalition for a Drug-Free Greater Cincinnati. In the same region over the same time period, where a substance abuse prevention coalition did not exist, there was a 33 percent increase in marijuana use.

As a Nation, we must make a sustained and substantial investment in delaying the age at which American youth start to use alcohol and illegal drugs. Research has found that people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence than those who have their first drink at age 21 or older. And children who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs as adults than those who first use marijuana at age 18.

One of the most important indicators of the number of people who will need treatment is the age of first use of marijuana. Studies show that if we can immediately reduce the number of initiates into drug use by 25 percent, we can reduce the number who need treatment by one million people.

Effective substance abuse prevention efforts can pay major economic dividends. A soon-to-be-released study called "The Cost-Benefit Estimates in Prevention Research," by Dr. John Swisher, finds that the savings per dollar spent on substance abuse prevention can be substantial and range from $2 to $19.64, depending on how the costs were calculated, the outcomes indicated, and differences in methodologies.

Although there is a widely-held view that the use of alcohol and illegal drugs is normal adolescent behavior among American youth, and that not much can really be done to prevent it, the latest statistics from major surveys in both Ohio and nationally tell a different story. Nationally, data show a significant downturn in youth drug use, with students in all grades showing a decline in prevalence. These findings show that drug prevention efforts are working.

With drug use by our Nation's youth dropping after almost a decade of increases, SAMHSA's reauthorization offers an important opportunity to sustain and accelerate this downward trend. There are ways that Congress can help keep the Nation's prevention efforts strong and our children's future bright through the reauthorization of SAMHSA.

The 20 percent set-aside in the Substance Abuse Prevention and Treatment Block Grant is the largest funding source dedicated exclusively to substance abuse prevention in States and communities throughout the Nation. It is imperative that this set-aside be maintained in the SAMHSA reauthorization.

The State Incentive Grants are another important source of funding now in 41 States, with the goal of being in all 50 States. The programs are aimed at filling the gaps in community prevention services, reducing the number of youth using drugs, and imple-

menting prevention approaches that are based on sound scientific research findings.

If these funding sources become more stable and predictable, the field would be better able to build a coordinated approach of effective prevention strategies.

The most effective substance abuse prevention is comprehensive and community-wide and includes environmental strategies that are designed to change and strengthen norms regarding alcohol and drug use. The SAMHSA reauthorization needs to help refocus the emphasis of substance abuse prevention from mostly individual behavioral-based programs to comprehensive community-wide strategies that more effectively address youth drug and alcohol use as current research suggests.

I want to thank Administrator Curie for his leadership in developing a strategic prevention framework within SAMHSA. This framework focuses on a science-to-services and strategy approach which recognizes CSAP's unique role as the lead Federal agency for substance abuse prevention. CSAP's expertise, materials, and services should be utilized by other Federal agencies that deal with substance abuse prevention to avoid duplication of effort and to maximize the utilization of Federal funds in developing, delivering, and evaluating effective substance abuse prevention at the State and local levels.

Effective substance abuse prevention needs to be data-driven, comprehensive, and sustained over time. CSAP should be encouraged to continue to take the lead in developing, funding, and sustaining a bona fide substance abuse prevention system throughout the Nation. This system should define and support the roles, responsibilities, infrastructure, and capacity needed at the Federal, State, and local levels to increase the number of youth who do not use and, of those who do, increase the age of first experimentation.

CSAP's success should be measured on what it funds and can control. Local prevention efforts receive funding from a variety of sources. Many communities have a lot of financial resources while others have very few. Yet it seems like one funding source or another is blamed for the rise in alcohol or other drug use and is never given credit for reductions that happen in a global sense.

It would be wonderful if Congress could encourage the hastening of the time when success was based on efforts over which a funding source had control. This subcommittee's work is vital and will shape the direction of prevention and treatment efforts for many years to come. In fact, your decisions will shape the future of this country.

New research is showing that young people who abuse alcohol may remember 10 percent less than their peers who do not use. Children are the future, and we must do everything we can to invest in keeping them the best and the brightest in the world so they can secure the United States' place as a leader in the global knowledge economy.

I thank you for this opportunity to speak to you, and I welcome questions.

Thank you.

Senator DEWINE. Thank you very much.

[The prepared statement of Mrs. Taft follows:]

PREPARED STATEMENT OF HOPE TAFT

Chairman DeWine, Ranking Member Kennedy, and other distinguished Committee Members, thank you for the opportunity to testify about the importance of substance abuse prevention in the context of SAMHSA reauthorization. Before I begin, I would like to take a moment to formally thank my good friend, Senator Mike DeWine, for his outstanding commitment, dedication and leadership in protecting and enhancing the Federal role in alcohol and drug prevention and treatment.

While I fully understand and support the importance of substance abuse treatment services, I feel strongly that prevention has been under utilized, regarding both funding and emphasis, and thus not reached its potential, relative to its importance and effectiveness in reducing drug and alcohol use and their related human and societal costs.

To that end, today I want to emphasize several points. The first being prevention is effective. It is worth the investment. The Center for Substance Abuse Prevention (CSAP) is vital to local efforts and it should stay separate from treatment, just as the alcohol and drug prevention and treatment field should stay separate from the mental health field.

My second point is that Congress can help. It can help the Nation by keeping CSAP a distinct entity. It can help the Nation by keeping CSAP's funding stable and sustained. Congress can also help by encouraging movement to environmental community-based approaches and by encouraging CSAP's current direction of building capacity, effectiveness and accountability in the field. Finally, Congress can help by making sure that CSAP's success is measured based on what CSAP funds and can control.

Since the mid 1980's, when I began my career as a certified prevention specialist working in Cincinnati, Ohio, I have experienced first hand, both the devastation substance abuse has on families and communities as well as the power of effective prevention strategies to reduce the use of alcohol and illegal drugs. I have also seen the substance abuse prevention field mature from the "treatment model" phase of it's infancy, to the data driven, strategic, multisector efforts, that are achieving outcomes in communities throughout Ohio and across the Nation. For example, there are greater reductions in adolescent substance use in communities with comprehensive substance abuse prevention coalitions, than in communities where these coalitions do not exist. From 1993 to 2000, there was a 41 percent decrease in marijuana use among 7th to 12th graders, living in communities with coalitions associated with the Coalition for a Drug-Free Greater Cincinnati. In the same region, over the same time period, where a substance abuse prevention coalition did not exist, there was a 33 percent increase in marijuana use.

Every new cohort of youth must have the benefit of effective substance abuse prevention. As a Nation, we must make a sustained and substantial investment in delaying the age that American youth start to use alcohol and illegal drugs. Research confirms that early alcohol and drug use can have long-lasting and expensive consequences. Research by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has found that people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence, than those who have their first drink at age 21 or older. According to findings from the National Household Survey, children who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs as adults, than those who first use marijuana at age 18.

In 1999, I came across some information that convinced me we need to focus even more of our efforts on prevention—I read how the treatment of addictions is really a growth industry. By the year 2020, the need for alcohol and other drug treatment will increase by 57 percent.

I also read that one of the most important indicators for the number of people who will need treatment in 2020 is the age of first use of marijuana. Currently, the age of first use of marijuana is about 13. Studies show that if we can immediately reduce the number of initiates into drug use by 25 percent, we can reduce the number who need treatment by one million. There's a real need to think about how we can help our young people grow up in a healthy way.

Effective substance abuse prevention efforts can pay major economic dividends. A soon to be published study in the Journal of Primary Prevention on "Cost-Benefit Estimates in Prevention Research" by John D. Swisher, PhD. and his colleagues, finds that, and I quote "the savings per dollar spent on substance abuse prevention can be substantial and range from $2.00 to $19.64 depending on how costs were calculated, outcomes included and the differences in methodologies."

Although there is a widely held view that the use of alcohol and illegal drugs is normal adolescent behavior among American youth, and that not much can really be done to prevent it, the latest statistics from major surveys both in Ohio and na-

tionally tell a different story. The latest PRIDE survey released in Ohio last year, found that the use of alcohol, tobacco and illegal drugs by youth has declined substantially over the past 3 years. For instance, illicit drug use among Ohio teens decreased 21 percent since 1999, with a 16 percent decrease across the U.S. Alcohol use was down 16 percent, compared to a 12 percent reduction in use nationwide. Ohio's student tobacco use decreased 38 percent compared to 14 percent across the Nation.

Nationally, data from the most recent "Monitoring the Future" survey show a significant downturn in youth drug use, with students in all grades showing declines in prevalence. These findings show that drug prevention efforts are working. With drug use by our Nation's youth dropping after almost a decade of increases, SAMHSA reauthorization offers an important opportunity to sustain and accelerate this downward trend.

As a substance abuse prevention specialist II, a volunteer community leader, and as the First Lady of Ohio, CSAP has been an invaluable source for the materials, tools and resources I have needed. CSAP has the ability to do many things those of us at the local level cannot. It can bring together the best minds in the Nation to develop programs and strategies based on the best research and provide technical assistance. It can do sophisticated evaluation studies of programs and approaches to prevention. It can develop materials and tools that are research based and tested for effectiveness. I firmly believe that CSAP must not only be maintained as a discrete entity within SAMHSA, but that its role needs to be strengthened and enhanced in SAMHSA reauthorization.

There are ways Congress can help keep the Nation's prevention efforts strong and our children's future bright through the reauthorization of SAMHSA.

Maintain CSAP's Funding Streams Including the 20 Percent PreventionSet-Aside in the Block Grants, State Incentive Grants (SIG) and all Other Funding Categories

The 20 percent set-aside in the Substance Abuse Prevention and Treatment Block Grant is the largest funding source dedicated exclusively to substance abuse prevention in States and communities throughout the Nation. It is imperative that this set-aside be maintained in SAMHSA reauthorization. I would suggest, however, that States be encouraged to target more of these resources into building comprehensive, high quality and stable community-based infrastructures, based on the latest research. This will facilitate the consistent application of effective substance abuse prevention strategies, programs and activities in many more communities across the country.

The State Incentive Grants are another important source of funding, now in 41 States, with the goal of being in all 50 States. The programs funded by these grants serve over 5 million people and are aimed at filling the gaps in community prevention services, reducing the number of youth using drugs and implementing prevention approaches that are based on sound, scientific research findings.

If these funding sources become more stable and predictable, the field would be better able to build a coordinated approach of effective prevention strategies.

Emphasize Environmental Strategies

The most effective substance abuse prevention is comprehensive and community-wide and includes environmental strategies that are designed to change or strengthen norms regarding alcohol and drug use. Environmental strategies involve changes in legislation, policy and enforcement throughout an entire community, to directly address youth access to drugs and alcohol as well as the consequences for use. SAMHSA reauthorization needs to help refocus the emphasis of substance abuse prevention from mostly individual, behaviorally based programs to comprehensive community-wide strategies that more effectively address youth drug and alcohol use.

Emphasize Strategic Framework for Prevention

I want to thank Administrator Curie for his leadership in developing a strategic prevention framework within SAMHSA. This framework focuses on a science-to-strategy approach, which recognizes CSAP's unique role as the lead Federal agency for substance abuse prevention. CSAP's expertise, materials, and services should be utilized by other Federal Agencies that deal with substance abuse prevention, such as the Department of Education's Safe and Drug Free Schools and Communities Program. This will avoid duplication of effort and maximize the utilization of Federal funds in developing, delivering and evaluating effective substance abuse prevention at the State and local levels so effective substance abuse prevention is brought to every community.

Emphasize Infrastructure and Capacity Development

CSAP's limited resources need to be focused on building and strengthening State and local infrastructure and capacity for implementing effective substance abuse prevention strategies, programs and activities.

Effective substance abuse prevention needs to be data driven, comprehensive, and sustained over time. CSAP should be encouraged to continue to take the lead in developing, funding and sustaining a bona fide substance abuse prevention system throughout the Nation. This system should define and support the roles, responsibilities, infrastructure and capacity needed at the Federal, State and local levels to increase the number of youth who do not use and of those who do, increase the age of first experimentation.

CSAP's Success Should Be Measured on What it Funds and can Control

Local prevention efforts receive funding from a variety of sources including Drug Free Community grants from the Office of National Drug Control Policy (ONDCP), Safe and Drug Free School Funding from the Department of Education and State and local financial support of which CSAP has no control. Some communities have a lot of financial resources while others have very few. Yet it seems like one funding source or another is blamed for the rise in alcohol or other drug use and is never given credit for reductions that happen in the global sense. It would be wonderful if Congress could encourage the hastening of the time when success was based on efforts over which a funding source had control.

This subcommittee's work is vital and will shape the direction of prevention and treatment efforts for many years to come. In fact your decisions will shape the future of this country. New research is showing that young people who abuse alcohol may remember 10 percent less than their peers who do not use. Children are the future and we must do everything we can to invest in keeping them the best and the brightest in the world so they can secure the United States' place as the leader in the global economy.

Thank you for the opportunity to testify before your subcommittee. I would be happy to answer any questions you may have.

Senator DEWINE. Dr. Gallant?

Mr. GALLANT. Mr. Chairman and Members of the Subcommittee, I am Lewis Gallant, executive director of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD.

Thank you for calling this hearing and for seeking our input. NASADAD members are the lead officials in each State who oversee and manage public substance abuse prevention and treatment systems. We look forward to working with you and the rest of the committee on legislation to reauthorize SAMHSA. Along with this committee and my fellow panelists, I know how other partners, many of whom are here today, stand ready and excited to work together on these issues.

Mr. Chairman, I would like to commend you for your commitment to improve the lives of those who suffer from addiction. I would also like to recognize Senator Kennedy and thank him for his steadfast dedication to these issues as well. Together, you both have been true leaders and true friends of the field.

Another leader is Mr. Charles Curie, administrator of SAMHSA. Mr. Curie is energetic, knowledgeable, and innovative, and he has made outreach to NASADAD a top priority.

This is certainly an exciting time, in large part because President Bush has made substance abuse prevention a national priority. During his State of the Union Address, he told the Nation that recovery is real, and treatment works. With this powerful message, the President has dedicated substantial resources to increasing our Nation's capacity to treat those suffering from addiction. We are grateful for these resources and do not take for granted his personal commitment to this issue.

I have submitted a more detailed written statement to the committee regarding reauthorization. Today I would like to focus on a few key areas.

A top concern for NASADAD is the Substance Abuse Prevention and Treatment Block Grant. A block grant is an efficient and effective program that participates in maintaining a foundation for their respective service delivery systems. As we consider SAMHSA reauthorization, a top priority for NASADAD is the transition from the current block grant to a Performance Partnership Grant, or PPG. The transition is designed to provide States more flexibility in the use of funds while instituting a system of improved accountability based on performance.

While NASADAD supports the goals of this transition, there are key issues requiring attention. First, data infrastructure development and management are the basic ingredients for success in our efforts to plan for and implement the PPG. Substantial resources are needed to help States build systems that will collect, track, refine, manage, analyze and disseminate data in accordance with the anticipated new reporting and other requirements.

In addition to resources, NASADAD is concerned with the timing of the transition to PPG. Some have suggested, for example, that performance measurement should begin as early as fiscal year 2004. NASADAD recommends that any change in the block grant application, and thus the reporting and implementation of performance measures, begin after the following prerequisites move forward: first, the consideration of a report to Congress discussing the transition to PPG, including the flexibility that States need, potential obstacles to PPG, resources required, data to be collected, and any recommended legislative language; second, an assessment by the Secretary of Health and Human Services of the States' readiness to report PPG data as required by the Children's Health Act of 2000; third, the allocation of new and additional resources to assist with data, infrastructure, and other administrative costs, and a process whereby legislation is passed by Congress and signed by the President that reflects an agreement that incorporates the input of the NGA, NASADAD, and others.

As my time is short, I would like to simply list two other issues to highlight. First, as mentioned by Mr. Curie, NASADAD views policies impacting those with co-occurring substance use and mental health disorders as top priorities.

Very quickly, NASADAD would ask that policy recommendations flow from and be consistent with the collaborative work done by NASADAD and the National Association of State Mental Health Program Directors, who are also here today with testimony.

Finally, NASADAD believes that State systems must be directly considered and involved in any SAMHSA grant program to ensure that resources are distributed in coordination with State planning processes. We believe, for example, that States should be eligible to apply for Targeted Expansion Capacity Grants and at the very least, to be signatories to all TEC applications whether or not a State is an applicant.

In sum, we look forward to working with the committee, SAMHSA, and other stakeholders on the reauthorization legisla-

tion. Thank you again for seeking our input. I will be happy to answer any questions that you may have.

Senator DEWINE. Thank you, Dr. Gallant, very much.

[The prepared statement of Mr. Gallant follows:]

PREPARED STATEMENT OF LEWIS E. GALLANT, PH.D.

Mr. Chairman, Ranking Member Kennedy, and Members of the Subcommittee, my name is Dr. Lewis Gallant and I am the Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). First, I would like to recognize you, Mr. Chairman, for your leadership in helping millions of people across the country with addiction problems. The substance abuse field truly appreciates your dedication and commitment to these issues. In turn, thank you for calling this hearing to discuss the reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA)—the Nation's lead Federal agency on addiction and mental health. We sincerely appreciate your outreach to States and look forward to working closely with you and the Subcommittee. I would also like to recognize the Ranking Member, Senator Kennedy, for his tireless efforts to improve our Nation's substance abuse system. Thank you for your work and valuable leadership. Finally, I would like to thank the other members of this Subcommittee. I look forward to working with you.

President Bush: Substance Abuse Services Must Be a National Priority

I would like to commend the President for his personal commitment to substance abuse issues. NASADAD is extremely grateful that President Bush identifies addiction as a top priority and is moving forward to elevate addiction treatment and prevention issues to the forefront of our national agenda.

We do not take for granted, at all, the significance of the President's leadership, and the leadership of Mr. Charles Curie, Administrator of SAMHSA, and Mr. John Walters, Director of the Office of National Drug Control Policy (ONDCP). We do not take for granted the President's action to dedicate substantial resources to close the treatment gap. In particular, the President moved forward to dedicate an additional $1.6 billion over 5 years for substance abuse treatment. This has included significant increases to the Block Grant, his proposed "Access to Recovery Program," and other initiatives. Indeed, this is historic.

Nor do we underestimate the power of the bully pulpit. We are very fortunate that the President is using this bully pulpit—this national stage—to share with the American public a simple yet extremely powerful message: substance abuse prevention and treatment works.

As the President once noted, "In this struggle, we know what works. We must aggressively and unabashedly teach our children the dangers of drugs. We must aggressively treat addiction wherever we find it. And we must aggressively enforce the laws against drugs at our borders and in our communities . . . America cannot pick and choose between these goals. All are necessary if any are to be effective." I could not agree more.

We are also pleased that the President has surrounded himself with leaders in his Administration who truly care about substance abuse and are working to make a difference. We heard today from Mr. Charles Curie, Administrator of SAMHSA. It has been a pleasure to work with Mr. Curie over the past few years. Administrator Curie is an energetic, knowledgeable and innovative leader. As a former State official, Mr. Curie has made outreach to NASADAD a top priority. Mr. Curie has met with NASADAD's Board on a number of occasions, attended our Annual Meetings, held systematic meetings with me as Executive Director, held meetings with our members and much, much more. Mr. Curie and his staff have worked very hard to listen to the concerns of States. We appreciate this outreach and believe this partnership will continue to remain strong.

I would like to acknowledge the excellent work of Tommy Thompson, Secretary of the Department of Health and Human Services (HHS). As a former Governor, he knows first hand the challenges States face in providing services to those with addiction problems. Secretary Thompson has been relentless in his promotion of helpful policies related to substance abuse.

NASADAD would also like to thank ONDCP Director John Walters for his work and leadership. Director Walters has been tireless in laying out a path to meet the President's goals of reducing illegal drug use by 10 percent over 2 years and 25 percent over 5 years. In the process, Mr. Walters has been reminding us all to "push back" against those who promote drug use and experimentation as a normal part of life.

Scope of Addiction in the U.S.

Addiction has a devastating impact on our society. SAMHSA's 2001 National Household Survey on Drug Abuse (NHSDA) found that an estimated 16.6 million persons age 12 or older were classified with substance dependence on or abuse. The survey noted that of these 16.6 million persons, 2.4 million were classified with dependence or abuse of both alcohol and illicit drugs, 3.2 million were dependent or abuse illicit drugs but not alcohol, and 11 million were dependent on or abused alcohol but not drugs. The number of persons with substance dependence or abuse increased from 14.5 million in 2000 to 16.6 million in 2001.

Projections in drug abuse treatment need made by the NHSDA are extremely compelling. Specifically, the study found that if current initiation rates continue at the same levels we are experiencing now, demand for drug treatment will more than double (an increase of 57 percent) by 2020. Even if we managed to cut current initiation rates by 50 percent, demand for treatment would simply remain constant. Needless to say, we must work together to step up our prevention efforts. In addition, efforts must be made to expand access to substance abuse treatment services.

Addiction is an equal opportunity disease that does not discriminate by age, gender or race. For example, the NHSDA found that 10.8 percent of youths ages 12 to 17 were current drug users in 2001. Another study by SAMHSA found that there is an "invisible epidemic" taking place among our senior citizens, where an estimated 17 percent of our seniors have a substance abuse problem.

An acute problem is the link between substance abuse and our child welfare system. Research has found that 70 percent of families with a child in protective care struggle with addiction.

The disease of addiction has a huge economic impact on our country. Studies have shown that alcohol and other drug addiction cost the Nation as much as $400 billion per year. These costs stem from lost job productivity, health care needs, crime, accidents, welfare and child welfare and other factors.

But of course no statistic or gross dollar estimate can ever adequately capture the toll addiction takes on citizens and their families each and every day. We all know a friend, family member, co-worker or even celebrity impacted by substance abuse. As the President said, "Addiction crowds out friendship, ambition, moral conviction, and reduces all the richness of life to a single destructive desire."

Substance Abuse Treatment Works! Substance Abuse Prevention Works!

Although we face incredible challenges, tremendous gains have been made over the years to help address the treatment needs of our Nation. We know, for example, that criminal activity decreases by as much as 80 percent when treatment is administered. We know that infants whose mothers receive substance abuse treatment avoid low birth weight, premature delivery and death at rates better than the national average. We know that welfare recipients who need addiction treatment, and undergo a complete treatment cycle, are more likely to get a job and earn more money than those who receive only minimal treatment services. Simply put—we know treatment works.

We also know that prevention works. For example, we have seen that federally funded substance abuse programs for "high-risk youth" yield reduced rates of alcohol, tobacco and marijuana use. Prevention is also cost-effective. A 2001 study by the Center for Substance Abuse Prevention (CSAP) estimated a savings of up to $20.00 for each dollar invested in prevention services.

There is no doubt that we must constantly strive to improve our substance abuse system. In fact, Governors in States across the country demonstrate this commitment as they implement innovative and exciting initiatives addressing addiction. Legislation reauthorizing SAMHSA provides us with an excellent opportunity to make important improvements. With this in mind, I would like to highlight some key themes as we begin to examine SAMHSA reauthorization.

SAPT Block Grant: The Foundation of Our Addiction System

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is a crucial program that assists States in maintaining a foundation for their respective service delivery systems. In particular, Block Grant funds help vulnerable populations—including youth and pregnant and parenting women—who either have, or at risk of having, a substance abuse problem. Also, the Substance Abuse Block Grant creates and maintains linkages with other public programs to maximize the impact of available resources.

These linkages are vital due to the competing year-to-year pressures impacting State substance abuse systems. For example, States across the country are facing severe budget cuts due to the economy, homeland security costs related to the tragic events of September 11 and other issues. The National Governors' Association

(NGA) and the National Association of State Budget Officers (NASBO) recently announced the results of the latest Fiscal Survey of the States. Specifically, NGA & NASBO found that "37 States were forced to reduce already enacted budgets by nearly $14.5 billion—the largest spending cut in the history of the 27-year-old Fiscal Survey."

Recently, the Senate Appropriations Committee issued a report to accompany the bill funding the Departments of Labor, Health and Human Services (HHS), Education and Related Agencies (Senate Report 108–81). The Report noted:

The Committee wishes to express its strong support for preserving the current block grant and future PPG as the foundation of our publicly funded substance abuse system in every State and territory in the United States. Similarly, the Committee is concerned with any effort that could erode the strength of the current and future block grant. At a time when States are facing fiscal crises, with some cutting substance abuse services, the maintenance of treatment infrastructure and capacity at the local level is extremely important.

We believe this is an important pillar to keep in mind as SAMHSA reauthorization is considered.

Transition from the Current Substance Abuse Prevention and Treatment (SAPT) Block Grant to a Performance Partnership Grant (PPG)

NASADAD views the transition from the current SAPT Block Grant to a Performance Partnership Grant (PPG) as the top priority for SAMHSA reauthorization. In fact, we would recommend a separate hearing on this vital and very complicated issue.

In general, the transition to PPG is designed to provide States more flexibility in the use of funds while instituting a system of improved accountability based on performance. NASADAD has been working with SAMHSA on this transition over the past few years.

As part of the transition, the Children's Health Act of 2000 required the Secretary of Health and Human Services (HHS) to submit a plan to Congress on issues pertaining to this complicated process. In particular, Public Law directed the report to include

(1) a description of the flexibility States need;
(2) performance measures that would be used for accountability;
(3) the definitions for the data elements to be used under the plan;
(4) obstacles to implementation of the plan;
(5) resources needed to implement the performance partnerships; and
(6) an implementation strategy complete with any recommended legislation.

Federal Funding Needed for PPG Implementation—Specific Need for Data Management & Infrastructure Development

While I understand that this panel is not the Appropriations Committee, I must touch on one aspect of the report that is due to Congress—the resources needed for the PPG. Data infrastructure development and management are the basic ingredients to success in our efforts to plan for, and implement, the PPG. Although stakeholders have unanimously agreed that States will require fiscal and technical assistance in order to help significantly adjust, or in some cases, overhaul, their data collection systems, the development and refinement of performance measures has shown how much work needs to be done.

Resources are needed to help States build the systems that will collect, track, refine, manage, analyze and disseminate accurate data in accordance with the anticipated new requirements in the PPG. Funds are needed to help States evaluate current data collection and reporting capabilities against the many new data requirements. Resources are also needed to help address the costs that States are facing in order to reach compliance with certain provisions in the Health Insurance Portability and Accountability Act (HIPAA).

The implementation of the PPG is predicated on the current system of providing adequate and baseline funding levels to each State for substance abuse prevention and treatment services.

Assessment of State Reporting Capabilities—As Called for in Public Law 106–310

Part C, Subpart I, Section 1971 (a) of Public Law 106–310 (SAMHSA Reauthorization) notes that "The Secretary will establish criteria for determining whether a State has a fundamental basis for the collection, analysis, and reporting of data." With this in mind, NASADAD strongly believes that SAMHSA must work to help States determine their own unique data reporting capabilities related to the new and expanded requirements generated by the PPG.

Need for More Localized Data

NASADAD also recommends work to re-establish an initiative consistent with the goals of the State Treatment Needs Assessment Program (STNAP). Similarly, we also support initiatives that will help assess the need for prevention services at the local level. While the NHSDA may provide a useful national overview, we recommend working to identify a mutually acceptable system of measurement that would capture relevant data at the sub-State level. This type of data collection is critical in order to have better access to "real-time" information that describes unmet need in our States and communities. In addition, this data is also needed to accurately and efficiently measure our progress in reaching the President's 2- and 5-year goals to reduce drug use as we seek to close the treatment gap.

A Concern With Timing of PPG Implementation

NASADAD is extremely concerned with the timing of PPG implementation. Every effort should be made to begin to implement a workable system, within a reasonable timeframe, that is clear and efficient for the purposes of helping States with their substance abuse services delivery system and of course, improving the lives of the clients they serve. As a result, many questions will undoubtedly remain regarding performance measures, data elements, methodologies and other details of the PPG.

In the *Federal Register Notice* (FRN) related to the PPG transition, a section on performance measures noted that "all States will begin submitting some of the prevention information for the fiscal year 2005 application, and all States will be able to submit all the data by fiscal year 2006 applications." Further, in its discussion of the treatment performance measures, the FRN says, "[S]ome States will be able to report on the performance data in time for the fiscal year 2005 application. Other States will be asked for a plan of implementation on the collection and reporting on the data." NASADAD remains very concerned with this portion of the FRN.

NASADAD is also concerned with language included in the House Appropriations Committee Report accompanying the bill providing funding for the Departments of Labor, Health and Human Services (HHS), Education and Related Agencies (Report number 108–188). The Report notes:

It is the Committee's expectation that SAMHSA will begin integrating performance measurement into the Substance Abuse Prevention and Treatment Block Grant in Fiscal Year 2004 as States prepare to move to the Performance Partnership Grant. As data become available on the development of performance guidelines and of the actual performance of these programs, the Committee strongly urges SAMHSA to provide Congress periodic updates.

• NASADAD recommends that any changes in the Block Grant application, and thus the reporting and implementation of performance measures, only begin after the following move forward:

• An assessment by the Secretary of HHS of States' readiness to report PPG data,

• The allocation of new and additional resources to assist with data infrastructure and other administrative costs, and

• A process whereby any legislation passed by Congress, and signed by the President, reflects an agreement that incorporates the input of Governors, NASADAD, and other stakeholders.

OTHER ISSUES RELATED TO REAUTHORIZATION

Policies Relating to Co-occurring Mental Health and Substance Use Disorders

A top priority for NASADAD relates to policies that impact the provision of services to those persons with co-occurring substance use and mental health disorders. NASADAD would like to note that any policy recommendations made should flow from, and be consistent with, the collaborative work done by NASADAD and the National Association of State Mental Health Program Directors (NASMHPD). This includes the National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders and subsequent findings by the NASADAD—NASMHPD Joint Task Force on Co-occurring Disorders. This work, made possible in part due to the generous support of SAMHSA, was formally adopted by the Board of Directors of both NASADAD and NASMHPD, and presented to the membership of both organizations during a combined meeting in Reno, Nevada in 2000.

As this Committee considers reauthorization issues, NASADAD would offer the following considerations as discussions move forward:

• **The Promotion of and Use of Common and Consistent Language:** We believe it is vital to work together to promote the use of common and consistent language as policies regarding services to populations with co-occurring mental health and substance use disorders are examined. For example, we recommend that more

work be done to advance a consistent definition and understanding of the term "integrated treatment" by using the NASADAD—NASMHPD Joint Conceptual Framework Documents.

• **More Research and Data Presentation:** We would like to work with SAMHSA to generate better data regarding those with co-occurring mental health and substance use disorders. Policy recommendations should then flow from subsequent findings contained in the research using appropriate and consistent terms and definitions. Policy recommendations, in our view, should not precede the research. In examining the larger picture, we would like to work with SAMHSA to develop a concrete plan and vision for data issues. As the lead Federal Agency for substance abuse and mental health services, for example, SAMHSA could help encourage other Federal agencies that fund addiction services to work with States and others in the development of a coordinated data plan.

• **Workforce:** We can not improve services to those with mental health and substance use disorders without an adequate number of appropriately trained, licensed, experienced and fairly compensated professionals. We recommend the establishment of workforce initiatives and a National Workforce Development Office within SAMHSA.

Synar Provision

Another issue we believe requires attention is the Synar provision. The goal of Synar is to reduce tobacco sales to minors. NASADAD members and Governors are strongly committed to reducing youth smoking and restricting underage access to tobacco. In turn, States have committed substantial resources and time for the enforcement of the Synar provision. The Synar provision required States to enact laws prohibiting tobacco sales to minors and to achieve an 80 percent compliance rate among tobacco vendors. HHS issued regulations for Synar enforcement that established baseline annual target rates for each State. The penalty for noncompliance with Synar is a severe 40 percent cut to the State's Substance Abuse and Prevention Treatment Block Grant.

We agree with the National Governors Association (NGA) in noting that Congress has taken an important first step by inserting language into the fiscal year 2000, 2001, 2002 and 2003 appropriations bills that would save States that commit substantial resources to the goals of Synar from suffering severe penalties to their Block Grant. NASADAD strongly supports NGA in calling for substantial, long-term changes in the administration of the law and the statute itself. These changes are needed in order to ensure that States and the Federal Government work together to meet their common goal of reducing tobacco sales to minors without penalizing populations in need of substance abuse prevention and treatment services. NASADAD also strongly supports NGA's position that calls for the establishment of a Synar enforcement structure that does not threaten, interrupt or eliminate critical substance abuse prevention and treatment services.

Inclusion of States in SAMHSA Grants

As you may know, each State crafts a State-level plan for addiction services. These plans are based on State-level studies that assess targeted prevention and treatment service needs. States are in the best position to determine how to effectively utilize and distribute resources. With this in mind, we would ask that discussions move forward during the reauthorization process that examine SAMHSA funded programs that do not incorporate State systems during the planning and implementation stages. Grants that are developed without examining their impact on State systems can create situations where entities eventually turn to States for resources when the grant expires—without giving the State agencies adequate time to plan to consider the support of such requests. In turn, States often have a difficult time providing funds to these programs because of the lack of communication, coordination and planning.

NASADAD believes that State systems must be directly considered and involved in any SAMHSA grant program to ensure that resources are distributed in coordination with State planning processes. We believe, for example, that States should be eligible to apply for all Targeted Capacity Expansion (TCE) program grants. In sum, we believe State involvement will prevent the creation of programs that become redundant, inefficient, disconnected and at times, discontinued.

Programs Within the Center for Substance Abuse Prevention (CSAP)

The State Incentive Grant (SIG) program has proven to be a successful program. The competitive grants (there have been 41 funded to date) flow directly through the Governors' Offices, through various divisions of State government, and ultimately down to the level of grassroots coalitions. It is an effective mechanism designed to "bridge" formerly disparate government entities (e.g., the State AOD agen-

cy, the criminal justice agency, the child welfare agency, the education agency) who share the common vision of substance abuse prevention.

The Decision Support System—launched 3 years ago—has already proven to be a remarkable, cutting-edge tool that makes use of the World Wide Web platform. This user-friendly interactive system enables the individual to access not only the registry of effective model programs (described below), but also offers general technical assistance, information on State-supported prevention systems (via State "portals"), and assessment tools relevant to the measurement of risk and protective factors within a target population. In an era of increased accountability and performance-based reporting, such an interactive Web-based tool becomes invaluable to the substance abuse prevention community.

The dissemination of model programs is proving to be a useful mechanism in assisting States and communities in replicating and adopting evidence-based practices that are specifically tailored to various demographic target populations. The database created by CSAP, the National Registry of Effective Programs, is the primary national repository for scientifically validated drug, tobacco and alcohol prevention programs.

CSAP and its contractors have developed a programmatic portfolio of valuable prevention-based programs aimed at targeting youth entering life "transitions" (e.g., the beginning of adolescence, entering college). Also, comprehensive work-based programs target the nearly three-fourths of illicit drug users who are in the workforce. States have come to rely on CSAP's identification and dissemination of evidence-based scientifically validated prevention programs. Progress achieved to date through this programmatic portfolio should continue.

Development and training of an effective prevention workforce is particularly vital as the Nation's economy has taken a downturn and many States are under increasingly stricter financial constraints. To date, many States and Territories have relied heavily on the successful CSAP-funded Centers for the Application of Prevention Technology (CAPTs), of which there are six (6) regional centers. Training, technical assistance with workforce development, and access to state-of-the-art model prevention programs comprise the CAPTs' aggregate portfolio.

Conclusion

Thank you very much for listening to my testimony. Again, I look forward to working with the Committee, SAMHSA, NGA and others as we the reauthorization process moves forward. I would be happy to address any questions the committee may have.

Senator DEWINE. Director Knisley?

Ms. KNISLEY. Mr. Chairman, Senator Reed, and Senator Murray, thank you for this opportunity to provide testimony to you this morning about the Substance Abuse and Mental Health Services Administration reauthorization.

I am Martha Knisley, and I am the first director of the Department of Mental Health for the District of Columbia and, more important, I am a southern Ohioan.

Senator DEWINE. Noted; very important.

Ms. KNISLEY. I am speaking today on behalf of the National Association of State Mental Health Program Directors, the association that represents the public mental health authorities in the 50 States, the District of Columbia, and the Territories.

We are particularly pleased to be before you today in this first hearing of the Senate Subcommittee on Substance Abuse and Mental Health Services. The special focus of the subcommittee reflects the critical need for improved access to mental health services at a time when an overwhelming majority of Americans, both adults and children, with mental disorders and emotional problems do not receive appropriate treatment.

We are hopeful that your work, combined with the much-anticipated release of the President's New Freedom Commission on Mental Health's final report, will strengthen our Nation's commitment to ensuring access to treatment and promoting recovery and full

participation. We must recognize that we have a lot of work to do, both to vast improve and to save lives.

I am also very pleased to present this testimony on behalf of the Campaign for Mental Health Reform. As I am sure you understand, the President's Commission, even before its report has been released, has galvanized the mental health community, including consumers, providers, family members, advocates, and administrators. There could not be a more appropriate or exciting time to reauthorize SAMHSA and its programs, since we expect that the President will be looking to SAMHSA to coordinate and move forward an action plan stemming from the Commission's recommendations.

Charles Curie, SAMHSA's administrator, has expressed support for a strong Federal role in shaping mental health. We value his leadership. I have known and worked with him for over 25 years, and we look forward to continuing to work in partnership with Mr. Curie and his team. And we are tremendously excited that Kathryn Power, the director of Rhode Island's Department of Mental Health, will soon be taking the helm at CMHS.

However, SAMHSA will succeed in addressing the priorities and meeting the goals the administrator has laid out only if the have the empowerment of the agency to do so, and it is important that this come from Congress. Too often in the past, SAMHSA has not been granted the authority or the funding to achieve systems reform even when there was consensus in the field about that reform.

We expect the focus of the President's Commission's report will be on the fragmentation found in the mental health system. This system, where consumers and family members are still forced to navigate multiple unconnected service systems, including but not limited to housing, substance abuse, employment, education, criminal justice, Medicaid, child welfare, mental health—and I could go on—SAMHSA must play a vital role, a pivotal role, in assuring that all of these service systems are brought together into a single system of care.

This is particularly acute with respect to children. To address it, we recommend that through legislation, Congress establish an interagency body on children's mental health services across the Department of Health and Human Services and that this body report to Congress on those Federal laws and regulations that impeded full realization of the legislation's objectives.

For example, at Mayor Williams' request, the District, through legislation when it created our new Department of Mental Health, created an interagency body to work on children's issues across all of these systems. We have had positive outcomes in just 2 years by doing this.

For example, sine last November, we have diverted 230 out of 260 children referred for out-of-District institutional care because of our coming to work together under this interagency group.

SAMHSA also needs greater authority to promote cross-system collaboration and integration in a number of other areas, but I will mention just two this morning.

The first is in the tragic over-representation of people with mental illness in the criminal justice system. We applaud you, Senator DeWine, in particular for your leadership on this issue and for in-

troducing legislation to promote collaboration between State and local mental health and criminal justice agencies.

Second, we commend SAMHSA for identifying as a priority the improvement of services to the approximately 10 million Americans with co-occurring mental abuse and substance about disorders. Evidence-based treatments for these conditions are remarkably effective. Such treatments involve having an integrated approach—not a parallel or a sequential approach—to treatment, and if we do it in parallel fashion or sequential fashion, it will be more expensive, and we will have poor outcomes. But even today at the Federal level, mental health block grants are kept separate, so these funding streams must be separated out at the local level.

Here in the District, Mayor Williams, the director of the Department of Health, and myself have just signed a charter agreement where we assure that our policies, funding, program access and all aspects of service delivery are combined into a single, focused approach for persons with dual disorders. Yet we are forced to work around the separateness that still exists at the Federal level. We urge you to modify the legislation to promote the provision of integrated services for persons with co-occurring disorders.

Eliminating barriers to financing integrated treatment will not only improve treatment outcomes but will reduce the most common adverse consequences they face, such as criminal justice involvement, unemployment, and homelessness. We hope that SAMHSA is granted both the authority and the funding also to provide services in permanent supported housing for individuals to end chronic homelessness.

We hope that Congress will give attention to the imminent conversion of the Mental Health Block Grant Program to Performance Partnership Grant. Measuring the performance and effectiveness of mental health programs and services can result in more sophisticated planning at the State level. But our block grant today only comprises 2 percent, and as a matter of fact, in the District, only one percent of our overall funding.

The Performance Grants will be looking at our entire program, and we must be assured that we will have the resources to fully develop the data necessary for this national picture.

Finally, I want to say just one word about the shifting of SAMHSA's research functions to the National Institute of Mental Health. We support SAMHSA's efforts to streamline and eliminate duplication in Federal agencies, but we emphasize that services research must be continued and enhanced, and we will be looking closely to see that this occurs during this shift.

Again, thank you for this opportunity to speak with you this morning. I am happy to answer any questions that you may have.

Senator DEWINE. Thank you very much.

[The prepared statement of Ms. Knisley follows:]

PREPARED STATEMENT OF MARTHA B. KNISLEY

Mr. Chairman, Senator Kennedy, and Members of the Subcommittee, thank you for the opportunity to provide testimony to you this morning about the Substance Abuse and Mental Health Services Administration (SAMHSA). My name is Martha Knisley, and I am the Director of the Department of Mental Health in the District of Columbia. I have worked in public mental health, substance abuse and developmentally disabilities for over 35 years and have served as Director of Mental Health

in Ohio and Deputy Secretary for Mental Health in Pennsylvania. I am speaking today on behalf of the National Association of State Mental Health Program Directors, the association that represents the public mental health authorities in the 50 States, the District of Columbia, and the Territories.

I am particularly pleased to appear before you today in this first hearing of the Senate Subcommittee on Substance Abuse and Mental Health Services. The special focus of this Subcommittee reflects the critical need for improved access to mental health services at a time when an overwhelming majority of Americans with mental disorders do not receive appropriate treatment. This is particularly discouraging given that great strides have been made through medical research demonstrating the effectiveness of a range of such treatments for these serious conditions. We are hopeful that your work, combined with the much-anticipated release of the President's New Freedom Commission on Mental Health's final report, will strengthen our Nation's commitment to ensuring access to treatment and promoting recovery and full community participation. Thank you for understanding the importance of this issue and recognizing the potential to vast improve and save lives.

I am also very pleased to present this testimony on behalf of the Campaign for Mental Health Reform. As I am sure you understand, the President's Commission—even before its report has been released—has galvanized the mental health community, which includes consumers, family members, providers, administrators, and advocates. This community is represented by numerous organizations with diverse interests and different perspectives. Despite these differences, they are joining together to collaborate in an unprecedented fashion to launch the Campaign for Mental Health Reform. Building on the work of the President's Commission, the Campaign will develop and promote Federal policy initiatives based on shared values and principles and will strive to advance mental health as a national priority.

There could not be a more appropriate or exciting time to reauthorize SAMHSA and its programs, since we can expect that the President will be turning to this agency to formulate and coordinate an action plan stemming from the Commission's recommendations. Therefore, nothing could be more important than ensuring that SAMHSA has the authority and resources to get this job done.

Charles Curie, SAMHSA's Administrator, has expressed support for a strong Federal role in shaping mental health policy and in supporting efforts to provide mental health services in appropriate, community-based settings efficiently and effectively. We value the Administrator's leadership and look forward to continuing to work in partnership with Mr. Curie and his team. Indeed, we are indebted to Gail Hutchings who for the past year has served with distinction as the Center for Mental Health Services' Acting Director, and we are tremendously excited that Kathryn Power, the Director of Rhode Island's Department of Mental Health, will soon be taking the helm of CMHS.

However, SAMHSA will succeed in addressing the priorities and meeting the goals the Administrator has laid out only if Congress empowers the agency to do so. Too often in the past, SAMHSA has not been granted the authority or the funding to achieve systems reform, even where there is a consensus in the field about the obstacles and remedies.

We expect that the focus of the President's Commission's report will be on the fragmentation found in the mental health system: that consumers and family members seeking appropriate services are forced to navigate multiple unconnected service systems, including, but not limited to, housing, substance abuse, employment, education, criminal justice, Medicaid, child welfare, and mental health. SAMHSA could and should play a the pivotal role in aligning these programs to more effectively and efficiently serve adults and children with mental health disorders and in leading an initiative for collaboration across various Federal Agencies so as to create greater unity in mission, objectives, and oversight in Federal programs.

This need is particularly acute with respect to children. To address it, we recommend that, through legislation, Congress establish an interagency body on children's mental health across the Departments of Health and Human Services, Education, and Justice that would foster systems coordination, collaboration, and joint financing across all relevant Federal programs. Lead-agency responsibility for this function would be vested in SAMHSA, which would oversee the design and implementation of a comprehensive, interagency approach to children's mental health and report to Congress on those Federal laws and regulations that impede full realization of the legislation's objectives. At Mayor Williams' request, the District through legislation created such an interagency body when we established the new Department of Mental Health 2 years ago; this has led to many positive outcomes. For example, since November of 2002 we have diverted over 230 children and youth from District institutional care as a result of this action. Building a system of care for children, youth and their families is our highest priority. We believe strongly that

prevention, early intervention and community treatment work when we commit resources and work together with families and our partners in education, child welfare, juvenile justice and other systems.

SAMHSA needs greater authority to promote cross-system collaboration and integration in others areas, but two deserve particular attention.

First, we are encouraged that SAMHSA recognizes the tragic over-representation of people with mental illness in the criminal justice system. According to the U.S. Department of Justice, about 16 percent of the Nation's jail and prison population have a mental illness. Incarceration is far costlier than treatment and has significant negative consequences, not only for people with mental illnesses languishing unnecessarily in jail, but for the criminal justice system as well. We applaud Senator DeWine in particular for his leadership on this issue and for introducing legislation to promote collaboration between State and local mental health and criminal justice agencies. As provided in the legislation, the Department of Justice will need to work with the Department of Health and Human Services to administer the program; therefore, we urge that SAMHSA be given the resources necessary to play that role.

Second, we commend SAMHSA for identifying as a priority the improvement of services to the approximately 10 million Americans with co-occurring mental illness and substance abuse disorders. Evidence-based treatments for these conditions are remarkably effective. Such treatments involve integrated approaches that address both the mental illness and the substance abuse problem concurrently. Federal programs that isolate funding streams for mental health and substance abuse into separate "silos" result in "parallel" or "sequential" treatment—expensive approaches with poor outcomes for individuals with co-occurring disorders. Unfortunately, statutory language associated with the substance abuse and mental health block grants sends the message that these funding streams must be kept separate and poses an obstacle to States and localities that want to furnish the treatment that is most effective.

In the District of Columbia, Mayor Williams, Jim Buford, the Director of the Department of Health, where substance abuse programs reside, and I recently signed a Charter Agreement to assure that our policies, funding, program access and all aspects of service delivery are combined to provide a single and focused approach for treating persons with dual disorders. Yet we are forced to work around the separateness that still exists at the Federal level. We urge Congress to modify the legislation and to promote the provision of integrated treatment for individuals with co-occurring disorders.

Eliminating barriers to financing integrated treatment in the two block grants will not only improve the treatment outcomes of individuals with co-occurring disorders, but also reduce the most common adverse consequences they face, such as criminal justice involvement, unemployment, and homelessness. In the District, we estimate that 42 percent of adults who are homeless have a co-occurring disorder. Therefore, we are encouraged that, in addition to improving integrated treatment services, SAMSHA intends to play a key role in the Administration's initiative to end chronic homelessness. At the State and local level, we must work long and hard to help persons who have been streetbound regain control over their lives and maintain a permanent place to reside. We hope that SAMHSA is granted both the authority and the funding to provide services in permanent supported housing for individuals exiting chronic homelessness.

In addition to invigorating SAMHSA's successful programs such as Projects for Assistance in Transition from Homelessness (PATH) and the Comprehensive Community Mental Health Services for Children and their Families Program, we hope that Congress will give attention to the imminent conversion of the mental health block grant to a Performance Partnership Grant. Measuring performance and effectiveness of mental health programs and services results in more sophisticated planning at the State level, enhanced accountability at all levels of government, and, in short, more effective use of scarce resources. But committing to this agenda in a meaningful way, such that performance data can be measured across States and aggregated to present a national picture—a key goal of the Performance Partnership—will also be very expensive to providers, States, and SAMHSA. Most States already collect and analyze significant amounts of data to support their own internal planning and quality improvement activities. Under the Performance Partnership we would be required to meet national goals for measuring performance and effectiveness, but this will require uniform and standardized data collection, analysis, and reporting. Moreover, these new requirements will apply to States' entire mental health systems—not just the block grant that is the focus of the performance partnership—even though the block grant represents, on average, less than 2 percent of State mental health agency operating budgets. In the District, the Block Grant

represents less than 1 percent of our budget. Therefore, to the extent Congress wishes mental health programs to generate standardized data such that policymakers at the Federal level can better assess the effectiveness of these programs—a goal we enthusiastically support—we urge that Congress provide the funding to make this happen.

In addition, we want to express our support for SAMHSA's leadership role in reducing and ultimately eliminating the use of restraints and seclusion among individuals with mental illnesses. SAMHSA has significant expertise and a proven track record in spearheading successful initiatives designed to achieve this goal.

And finally, we want to say a word about the shifting of SAMHSA's research functions to the National Institute for Mental Health (NIMH). We support SAMHSA's efforts to streamline and eliminate duplication in Federal agencies, but emphasize that services research must be continued and enhanced. This research builds on the significant investments that NIMH traditionally has made in understanding the science of mental illness, and ensures the cost-effectiveness of those investments. More importantly, services research is a critical bridge across the chasm between what we know about mental illness and what we do in providing services; the implications of reduced attention to this research are enormous. We are confident that this Subcommittee agrees that it must ensure that critical support for services research is maintained and expanded.

Again, thank you for the opportunity to speak with you this morning. I am happy to respond to any questions you may have.

Senator DEWINE. Ms. Walker.

Ms. WALKER. Chairman DeWine, Senator Reed, and Senator Murray, I am Gloria Walker of Cincinnati, OH. On behalf of NAMI Ohio and NAMI National, I want to thank you and Senators Gregg and Kennedy for establishing the first standing subcommittee in the history of the Congress dedicated to addressing services for individuals with mental illness and addictive disorders.

This subcommittee is an enormous leap forward in addressing the historic stigma and discrimination that has left the public mental health and substance abuse treatment systems fragmented, underfunded, and overburdened.

I am here today not just as a member and director of NAMI National and NAMI Ohio, but also as the mother of a son who has struggled with severe mental illness for nearly 20 years.

I am strongly encouraged by the advances that have been made in treatment for illness over the past decade. This scientific advance is heralding new opportunities for recovery and a full life for my son. He is fortunate to be living in Ohio, where we have perhaps the Nation's best public sector system under the leadership of our mental health commissioner, Dr. Mike Hogan, and Governor Bob Taft.

As you know, we in Ohio have made enormous progress in making sure that services in the community are reflective of the advances that have been made in clinical treatment and service delivery. Unfortunately, Ohio is the exception and not the rule when it comes to mental illness treatment services delivered in public sector programs. In fact there is strong evidence that the public health system in our country is in collapse in many States. This crisis is worsening in many parts of the country as States face a deteriorating budget situation.

The result is that children and adults living with severe mental illness are increasingly over-represented in the chronic homeless population and in local jails and prisons.

The failure of this system is also reflected in our Nation's high suicide rate. This year, NAMI completed its most comprehensive

survey of our consumer and family membership, with 3,400 respondents. The findings are alarming.

Nearly half the consumer respondents reflected in the survey had been hospitalized within the past 12 months, and 40 percent needed emergency services. Fewer than one-third received evidence-based, recovery-oriented services such as assertive community treatment programs, supported employment services, and substance abuse treatment. More troubling is that the lack of appropriate treatment translated into extensive involvement with the criminal justice system. Forty-three percent of the consumers in the NAMI survey had been arrested or detailed by police.

NAMI recognizes that SAMHSA cannot fix every problem confronting State mental health authorities across the country. However, SAMHSA can and should assist State and local mental health authorities to more effectively use their limited resources and to help States ensure that they are making the right investments.

NAMI would like to offer the following recommendations with respect to SAMHSA reauthorization legislation that this subcommittee will soon consider.

SAMHSA needs to provide stronger leadership in bridging the divide between science and practice to ensure wider replication of evidence-based practice.

SAMHSA needs to provide stronger leadership in improving the data infrastructure capacity of the public mental health system.

SAMHSA should be encouraged to continue its mission to make treatment for co-occurring mental illness and substance abuse disorders a priority. SAMHSA is placing a high priority on addressing the needs of the estimated 10 million Americans who have co-occurring mental illness and substance abuse disorders.

SAMHSA should play a stronger role in helping to meet President Bush's goal of ending chronic homelessness over the next decade. NAMI supports President Bush's Samaritan Initiative, and we urge you to build on this effort by creating a new flexible funding stream to finance services in permanent supported housing.

SAMHSA should expand its efforts to address the growing and disturbing trend of criminalization of mental illness experienced by adults in jails and prisons, and adolescents in juvenile justice programs.

Chairman DeWine, NAMI is extremely grateful for the leadership that you have provided in Congress in bringing attention to this enormous and growing problem.

Finally, SAMHSA should continue its efforts to address the absence of a coherent service system for children and adolescents with serious mental illness. This morning, your colleagues on the Governmental Affairs Committee are hearing testimony from families with children with mental illness who have been forced to relinquish custody in order to access services for their children. This is the most glaring, extreme evidence of the near absence of a system of services for children and adolescents in our country. This is a complex issue where accountability is spread across multiple systems including Medicaid, child welfare, foster care, juvenile justice, and mental health. Clearly, something must be done to improve collaboration, systems coordination, and blended funding of services

for children with mental illness across all relevant programs and systems.

SAMHSA has an important role to play in fostering coordination of home and community-based services for children with mental illness and their families.

Mr. Chairman, on behalf of the more than 1,000 NAMI organizations across the country, thank you for this opportunity to offer our views on this important issue.

[The prepared statement of Ms. Walker follows:]

PREPARED STATEMENT OF GLORIA WALKER

Chairman DeWine, Senator Kennedy and Members of the Subcommittee, I am Gloria Walker of Cincinnati, Ohio. Since 2000, I have served on the Board of Directors of the National Alliance for the Mentally Ill (NAMI). I am also a Past President of NAMI Ohio, having served in that capacity from 1998 until 2000. I am also the mother of a son who has struggled with mental illness for nearly 20 years. It is from these perspectives—a leader in the NAMI movement and as a family member—that I offer the following views on the future of SAMHSA and the need to improve the Federal Government's response to the growing crisis in our public mental health system.

Who is NAMI?

NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, and other severe and persistent mental illnesses that affect the brain.

Founded in 1979, NAMI today works to achieve equitable services and treatment for more than 15 million Americans living with severe mental illnesses and their families. Hundreds of thousands of volunteers participate in more than 1,000 local affiliates and 50 State organizations to provide education and support, combat stigma, support increased funding for research, and advocate for adequate health insurance, housing, rehabilitation, and jobs for people with mental illnesses and their families. Local affiliates and State organizations identify and work on issues most important to their community and State. Individual membership and the extraordinary work of hundreds of thousands of volunteer leaders is the lifeblood of NAMI's local affiliates and State organizations.

I am pleased today to submit the following testimony on behalf of the National Alliance for the Mentally Ill (NAMI) on legislation to reauthorize the Substance Abuse and Mental Health Services Administration (SAMHSA).

Public Mental Health System In Crisis

Mr. Chairman, as you know in a matter of days President Bush's Commission on Mental Health (chaired by our own Mike Hogan of Ohio) will be releasing its final report. We expect this report will document what too many NAMI members know from personal experience—that the public mental health treatment and support system in most States is in serious disrepair. In fact, as the Commission noted in its Interim Report last fall, this "system" is in fact not a coherent system, but rather a fragmented and underfunded series of programs crossing multiple layers of government with little accountability and coordination. I can tell you from personal experience that this confusing system overwhelms consumers and families with conflicting eligibility rules and reliance on service models that are inconsistent with the enormous scientific advances that have been made in recent years with respect to recovery-oriented interventions for severe mental illness.

The result of this system in collapse is that children and adults living with severe mental illness are increasingly over-represented in the chronic homeless population and in local jails and prisons. The failure of this system is also reflected in our Nation's alarmingly high suicide rate. This year NAMI completed its most comprehensive survey of our consumer and family membership—3,400 respondents. The findings are alarming.

Nearly half of the consumer respondents reflected in the survey had been hospitalized within the past 12 months and 40 percent needed emergency services. Fewer than one-third received evidence-based, recovery-oriented services such as assertive community treatment programs, supported employment services, and sub-

stance abuse treatment. More troubling is that the lack of appropriate treatment translated into extensive involvement with the criminal justice system—43 percent of the consumers in the NAMI survey have been arrested or detained by police.

SAMHSA's Response to the Growing Crisis in the Public Mental Health System

Given SAMHSA's limited resources ($3.2 billion in a system estimated to consume more than $44 billion), it is unrealistic (and probably unwise) to expect the agency to assume responsibility for complete reform of the complicated and fragmented system that consumers and families must navigate. At the same time, SAMHSA can (and should) play a leadership role in assisting States and localities in modernizing and reforming the way mental illness treatment and supports are delivered. Reauthorization legislation therefore affords an important opportunity for Congress to sharpen the agency's mission to assist State and local mental health authorities in this effort.

NAMI is pleased that the Bush Administration has appointed three leaders with experience in running State mental health authorities to manage SAMHSA and the Center for Mental Health Services (CMHS): Administrator Charles Curie of Pennsylvania, Deputy Administrator James Stone of New York and CMHS Director Kathryn Power of Rhode Island. Each brings vast experience in managing and reforming services and working with NAMI organizations at the State and local level.

NAMI Recommendations for SAMHSA Reauthorization

1. SAMHSA needs to provide stronger leadership in bridging the divide between science and practice to ensure wider replication of evidence-based practice.

Over the past 5 years, SAMHSA has made enormous progress in transforming its programs to create a stronger grounding in science and enhanced emphasis on replication of evidence-based practice. NAMI supports this effort to refine and sharpen SAMHSA's mission to ensure that it is firmly grounded in furthering investment in clinical treatment and that service models are informed by research and recovery-oriented outcomes. This shift is beginning to take place as part of SAMHSA's Programs of Regional and National Significance (PRNS) which funds community action grants and targeted capacity expansion in priority areas such as assertive community treatment, jail diversion, suicide prevention and treatment for co-occurring disorders.

NAMI is also supportive of efforts by SAMHSA to develop a new level of cooperation with colleague agencies at the National Institutes of Health (NIH). It is critically important for SAMHSA and NIH to develop a more workable partnership with respect to services research and services demonstration studies that assess how best to deliver clinical services in real world settings. This is especially the case given the challenges particular to the real world settings in which children and adults are increasingly receiving services: homeless shelters, emergency rooms, jails, juvenile justice facilities, schools and primary care. Both agencies have strengths that need to be effectively coordinated to develop a stronger research base on service delivery and technical assistance capacity for pushing State and local authorities and frontline providers to invest in evidence-based practice.

NAMI therefore recommends that this Subcommittee redirect SAMHSA to its core mission of assisting State and local mental health agencies in bridging the gap between science and practice, with particular focus on replication of evidence-base practices grounded in recovery-oriented services for children and adults living with severe mental illnesses.

2. SAMHSA needs to provide stronger leadership in improving the data infrastructure capacity of the public mental health system.

In 2000, Congress directed SAMHSA to convert its separate substance abuse and mental health block grant programs to "Performance Partnership Grants" (PPGs). The objective was to reform these block grant programs to promote greater emphasis on evidence that measure the performance of States in meeting specific goals, and away from expenditure reports tracking where and how funds are spent. NAMI applauded this effort as part of a larger strategy designed to push States to begin developing better data systems that actually measure progress in meeting outcomes related to treatment, recovery and provider performance.

While SAMHSA has met the goal of converting the block grants to PPGs, NAMI believes that further steps need to be taken to finally put in place effective data collection and dissemination systems. NAMI believes that such a data infrastructure should be able to measure not only performance outcomes achieved with funds allocated through SAMHSA, but all State and local resources as well, whether or not those dollars directly flow through the State mental health authority or other

sources (e.g. Medicaid). As was the case with conversion to the PPG model, such data systems should be able to facilitate assessment of progress toward specific outcome measures and an unduplicated count of who is being served.

NAMI has long been frustrated with the lack of a coherent system of data collection for public mental health spending. The inability to compare and measure the performance of State public mental health systems has been a major impediment to progress in seeking adequate resources to fund public sector programs. After years of frustration, NAMI has acted on its own to establish TRIAD—the Treatment, Recovery, Advocacy and Information Database. This is our own effort to develop a set of measures to assess the performance of States tied to recovery for consumers and their family members. As excited as we are about the data being generated by TRIAD, we are nonetheless discouraged that the inconsistencies of data collection and dissemination systems across the States and SAMHSA still prevents meaningful comparisons across the States.

3. SAMHSA should be encouraged to continue its mission to make treatment for co-occurring mental illness and substance abuse disorders a priority.

NAMI is especially pleased that SAMHSA Administrator Curie has placed such a high priority on addressing the needs of the estimated 10 million Americans who have co-occurring mental illness and substance abuse disorders. SAMHSA's November 2002 report to Congress (mandated by this Committee in 2000) is an important step forward in compiling existing data on the extent of the problem and current research on effective clinical interventions. NAMI agrees that there should be "no wrong door" for entering treatment for individuals with co-occurring disorders.

NAMI also agrees that the existing research literature clearly demonstrates that neither mental illness, nor chemical dependency treatment, can be effective unless both are provided in an integrated fashion through interdisciplinary coordination. However, despite this report we are still seeing too little investment from the separate mental health and substance abuse systems in integrated mental health and substance abuse treatment. NAMI believes that accounting and regulatory burdens are still serving as a barrier to fostering development of integrated treatment by State and local agencies. NAMI would therefore urge this Subcommittee to consider statutory language to make it clear that States may utilize funds from the Mental Health and Substance Abuse PPGs to provide integrated treatment to individuals with co-occurring disorders.

4. SAMHSA should play a stronger role in helping to meet President Bush's goal of ending chronic homelessness over the next decade.

As you know, President Bush (through the leadership of the White House Interagency Council on the Homeless) has put forward his "Samaritan Initiative" to end chronic homelessness over the next decade. In addition, Secretary Thompson has put in place his own plan for all HHS agencies to address chronic homelessness. NAMI supports these efforts, but also believes that SAMHSA can do more to ensure that its programs more effectively address the needs of individuals with severe mental illness and co-occurring disorders experiencing chronic homelessness (i.e., staying homeless for a year or more).

First, as part of the Samaritan Initiative, Congress should authorize and fund a new program to finance services in new and existing permanent supportive housing developed by HUD's McKinney-Vento Homeless Assistance Act. NAMI, along with our colleagues at the National Alliance to End Homelessness and the Corporation for Supportive Housing, have our own proposal on services in permanent supportive housing—ELHSI (Ending Long-Term Homeless Services Initiative). What is key is that existing and future permanent supportive housing have stable funding for services to ensure that individuals are able to make the transition to stable lives in the community.

Finally, NAMI would urge this Subcommittee to examine the current problems with the funding formula associated with the PATH program at CMHS (Projects for Assistance in Transition from Homelessness). This critically important program funds outreach and engagement services for homeless individuals in shelters and on the streets. Since fiscal year 1997, Congress has nearly doubled funding for PATH, up to $50 million requested for fiscal year 2004. Unfortunately, more than 20 rural and frontier States have seen their allocation of PATH funds frozen as a result of artificially low minimum State allocation. Likewise, the current formula resulted in four States (Alabama, Missouri, New York and Ohio) actually losing funds in fiscal year 2003 despite a $3 million increase provided by Congress.

5. SAMHSA should expand its efforts to address the growing and disturbing trend of "criminalization" of mental illness experienced by adults in jails and prisons and adolescents in juvenile justice programs.

Chairman DeWine, NAMI is extremely grateful for the leadership that you have provided in Congress in bringing attention to this enormous and growing problem. NAMI strongly supported your efforts in passing legislation authorizing the Mental Health Courts program at the Justice Department (P.L. 106-515). NAMI is proud to support your legislation (S. 1194) to expand the ability of State and local law enforcement and corrections systems to cope with their growing burden of responding to offenders with a history of untreated severe mental illness—most of them low-level nonviolent offenses.

As you know, effective jail diversion programs, Mental Health Courts, and programs to help adult and juvenile offenders with mental illnesses transition back into the community require close collaboration and cooperation between corrections, courts and mental health systems. Too often, mental health systems have been reluctant to do their part to help these individuals, many of whom would not have ended up in correctional systems had they received timely and appropriate mental health services and supports. At the Federal level, SAMHSA has worked collaboratively with the Department of Justice to provide technical assistance and support for jail diversion and community reentry programs for offenders with mental illnesses.

NAMI strongly urges that the SAMHSA reauthorization legislation be utilized as an opportunity to expand the agency's current jail diversion program and to expand the jurisdiction of this program to include community reentry and transition for juveniles and adults with mental illnesses exiting criminal justice systems. We also urge that SAMHSA be encouraged to work even more closely with the Department of Justice and other relevant Federal Agencies (e.g. the Social Security Administration, the Center for Medicaid and Medicare Services, and the Department of Housing and Urban Development) in carrying out these important activities.

6. SAMHSA should continue its efforts to address the absence of a coherent service system for children and adolescents with serious mental illness.

The impending release of President Bush's New Freedom Commission report on Mental Health will emphasize the wholesale fragmentation and lack of coordination between various systems responsible for providing treatment and services to individuals with mental illnesses across the country. These problems are particularly profound for children and adolescents who suffer from mental illnesses. It is well documented that families of children with mental illnesses frequently have no place to turn to access the services that their children need. As a consequence, children with mental illnesses are even more disproportionately represented in juvenile justice systems than adults with mental illnesses are in adult correctional systems. Moreover, many families are literally forced to give up custody of their children to access care for their loved ones. This is a national tragedy.

As a first step, NAMI recommends that Congress establish, through legislation, an interagency body on children's mental health to improve collaboration, systems coordination, and blended funding of services for children with mental illnesses across all relevant Federal programs. SAMHSA, as the Nation's lead agency for mental health services, should be vested with lead responsibility for this important function.

Additionally, CMHS—through the Children's Mental Health Services Program also funds the Comprehensive Community Mental Health Services for Children and Their Families Program—provides grants to public entities providing comprehensive community-based mental health services for children and adolescents with mental illnesses. NAMI strongly supports the Federal investment in creating home and community based services for children with mental illnesses and their families. We look forward to working with the Subcommittee to ensure that the program is further improved so that children and adolescents with serious mental illnesses receive services that are evidence-based, effective and associated with outcomes that are tracked to ensure accountability.

Conclusion

NAMI is deeply grateful for the opportunity to offer our views on SAMHSA reauthorization legislation. We look forward to working with you and your colleagues on this legislation and other matters that will come before this Subcommittee.

Senator DEWINE. Let me thank our panel. I will start with Mrs. Taft.

I was interested in your comment about the expanded use of CSAP information by other Federal agencies, and I wonder if you could comment about how well you think they are doing now; and also, if you could comment about Director Curie's testimony in re-

gard to where CSAP has been, where CSAP is, and where CSAP is going.

Mrs. TAFT. Thank you, Mr. Chairman, for that question.

I believe that CSAP is finally beginning to grow into its rightful position of being the source in the Federal Government where all agencies and departments should come for accurate research-based information. I do not believe that has been the case in the past. I think that there continue to be some conflicts among the major funding sources for prevention activities at the State and local level in this regard, but I am hopeful that, with continued nudging from Congress, CSAP will become the accepted leader in prevention activities.

Senator DEWINE. So we are moving in the right direction.

Mrs. TAFT. I think we are moving in the right direction.

Senator DEWINE. More agencies need to look toward CSAP, in your opinion.

Mrs. TAFT. Yes. CSAP in my opinion—the research-based information has the ability to turn that into programs and strategies and practice that are effective and should be looked to as the final word in what is effective and what is not.

As you know, the field has developed tremendously since you authored the Drug-Free Schools report. In fact, at that time, it was just Drug-Free Schools report, and since then, it has become the Safe and Drug-Free Schools, and it keeps getting watered down in its approach, and that is why it is really important that CSAP stay strong and can work toward a unified approach.

The whole field has been evolving and changing, and we have continued to learn what is effective and what is not effective, and CSAP has been doing a good job of getting that information out to the field. Now that we have got a good base of knowledge of effectiveness and what works and what does not work, we need to continue to build on that, to get that information out to the field, and to make sure that all children in the United States can benefit from that knowledge.

Senator DEWINE. Thank you.

Dr. Gallant, I wonder if you could tell me about the Synar Amendment which we keep waiving, and if you have any suggestions about changes that we should make in regard to that. We all know the intent of the Synar Amendment, and it is a good intent, but we keep waiving it. And we understand why we waive it—everyone is well-intended here—but what are we doing to do about that?

Mr. GALLANT. Mr. Chairman, as you indicated, we are very supportive of the intent of Synar and see ourselves as really contributing to reducing the effects of tobacco. However, that is now why we exist in most States systems; it is not to reduce youth tobacco use. We believe that Synar would be better-positioned if it were located in one part of Health and Human Services. We believe that the Centers for Disease Control and Prevention has a tobacco control program that has operated for a number of years, and we believe that Synar would be better-positioned there. We also believe that the penalty structure associated with Synar should be eliminated, and that States should be incentivized to reduce youth access to tobacco.

Senator DEWINE. So a carrot instead of a stick.

Mr. GALLANT. That is right, Senator.

Senator DEWINE. Will that work?

Mr. GALLANT. I think it would work far better than to hold a penalty over State systems, particularly for that part of the system that is trying to deliver a service that is already with lack of capacity, so to move it to CDC with their tobacco control efforts. And I think you will also find that most State health departments already have a major role and are accepted by both the executive branch and the legislative branch to have a public health promotion role, including tobacco control. So to put it all in one area I think would increase its impact, would probably make it far more effective, and would probably achieve even better results than we have been able to with our efforts.

Senator DEWINE. Well, it is not working, but just to State my public position, I am not willing to give it up. We have to make it work some way. It is not working now, but we just cannot give it up. We just have too much at stake here from a health point of view, and we have got to all try to figure it out, and you can help us—not just you, but everybody else on the panel, everybody in the room—can help us figure out a way of making this work. In the next few months, we need to work on that.

Mr. GALLANT. We are committed to do that, Senator.

Senator DEWINE. Senator Reed?

Senator REED. Thank you very much, Mr. Chairman, and let me thank the panel for their excellent testimony.

And Mrs. Taft, let me thank you for your testimony and also for your gracious leadership as the First Lady of Ohio. It is a pleasure to see you here today.

You cited several studies in your written testimony of programs that are successful in reducing drug and alcohol use among children. In your estimation, why are these programs effective? Is there something that you have sensed, certain elements that make them successful?

Mrs. TAFT. According to what CSAP tells me, when you can increase the perception of harm and can increase the perception of social disapproval, use among young people will go down. So many, many of the most effective programs now are those that do those two things. And those are usually things that happen in a global sense and are environmentally induced through regulation or through social norms that happen in the community. Then, if you can combine those with programs that give young people life skills that are necessary to refuse alcohol and drug use, you usually come up with success.

Senator REED. Thank you very much. Have you seen any of those programs in action in Ohio, because I am sure you are out and about all through the State.

Mrs. TAFT. Yes. In fact the Pride Survey that happened last year in Ohio showed that Ohio was below the national averages among alcohol, tobacco, and other drug use. So I see a lot of those good programs working.

Senator REED. Thank you very much.

Dr. Gallant, thank you for your testimony also. I want to give you the opportunity, because I notice a trend on the panel—have you ever visited Ohio?

[Laughter.]

You should claim that right away.

Mr. GALLANT. Yes, Senator, I have, and I will be going there this Thursday.

Senator REED. I thought that was happening.

You and your organization play a critical role, and as Administrator Curie suggested, in the Access to Recovery proposal. There is going to be a tremendous role for State substance abuse officials. What role have you had to date in preparing for, commenting on, and participating in the development of the Access to Recovery approach and what role do you anticipate going forward?

Mr. GALLANT. We have had a role. Mr. Curie and his staff have involved us in discussions about the thinking around the Access to Recovery Program. They have involved several of our State directors in helping them think through strategies in terms of how they might implement this program.

We are, as are our State directors, waiting for the final program to be developed so we can see the detail. But overall, we think that this is a good third leg, as long as the block grant remains as the foundation for our system and that the Targeted Capacity Program remains as a way to target special issues and needs, and I think this third leg might allow us to expand in a new and innovative way. But we are waiting to see the details.

Senator REED. Very good. As I suggested, and I think our discussion indicated, there are some very, very difficult issues, technical as well as constitutional, that you and your colleagues will have to deal with.

The only other thing I would say is that there is a real value in having State-level local initiatives, but there also has to be some kind of common baseline nationally, and I think your organization can help guide us in that direction.

And thank you for your testimony, Ms. Knisley. You touched on an issue that is very, very near and dear to me; we all wear multiple hats around here, and I am the ranking member on the Housing Subcommittee. There is a huge crisis in affordable housing for a whole range of Americans, and it is particularly exacerbated if you have a mental health issue or a substance abuse issue. You touched on that, and I wonder what more can we do from your perspective. You must see it every day in Washington, DC.

Ms. KNISLEY. Yes, Senator Reed. As a matter of fact, Washington, DC now has the dubious distinction of growing faster in terms of unaffordability for a person with disabilities. The recent report indicated that it now costs in the District of Columbia 183 percent of your monthly disability income for a one-bedroom market rent apartment. And obviously, this is a huge issue for us.

We now have the technology, and if we apply our resources, our practices have advanced to where we can help people sustain their own living situation, their own home, their own apartment. However, if we do not have affordable housing the work that we are doing would be for naught in our department. And I know it is a major initiative around the country with other States and local

communities, and we have got to have the strong leadership of SAMHSA to see this true with their Federal partners, particularly HUD.

But we have a major affordable housing initiative in our community where I spend a lot of time with the housing finance agency and with our public housing authority trying to make sure that we have access to some of those resources coming into the community, because it is never going to be enough.

So we are very, very concerned, and like I said, we have some newer housing strategies like Housing First, where we help someone get into a place and then be able to stay there. It is a very promising practice, but without the affordability of housing, we are facing a huge uphill struggle.

Senator REED. Sometimes I fear that despite all the improvements and all the resources that we are providing to the mental health and substance abuse community, unless we effectively deal with the housing issues, which are expensive and difficult, you are just treading water, and we are never going to get to the point where we have a system that works, because if you cannot find a place for someone to live, you cannot adequately deal with their other issues, and frankly, if it is a transient placement, you will lose that person. So I just see this as a very critical issue.

Ms. KNISLEY. Absolutely. One thing I should add to that, Senator Reed, is I think we have learned now the value of a person in their own home, the value that that has to their rehabilitation and recovery, because as an individual recovering from mental illness, if you can see the progress you can make, and you can have your own place to live, while we need good treatment facilities, living for a long-term in a congregate setting is just not something that is a natural place for people to be.

So we see this value, and we have seen this value repeatedly. We even have research results that show that for people who can be living in their own place and rebuilding their lives, this has a tremendous influence on their recovery.

Senator REED. In the scope of our reauthorization of SAMHSA, I hope we have the opportunity to develop some of these issues of interagency coordination, of the complementary nature of good, affordable housing, and mental health services and substance abuse treatment, because I think it is an important point, as you do.

Let me ask another question, Ms. Knisley. Administrator Curie talked about the new Performance Partnership Grants and the Access to Recovery initiative. You are engaged in a whole host of programs right now which are time-consuming and difficult. Then there is another level being proposed which requires more parameters, more metrics.

Can you comment about the assistance you need, the technical assistance, the additional administrative resources, to make sure that we do this right and that we actually have performance grants that accurately measure performance rather than just accumulate lots more statistics?

Ms. KNISLEY. Senator Reed, I think it is a very important question, and NASHPD and the mental health commissioners appreciate the opportunity to work with SAMHSA in formulating those grants. I know that in my situation, I have performance goals for

Mayor Williams; that is very important as we are building our new mental health system here in the District. We are trying to come out of a longstanding receivership in mental health, so I have goals for the Federal court, and then the partnership goals and objectives that we need to meet. If we can marry those, and if we can find the least common denominators for reporting data and have that interchanged with SAMHSA to see that we can get there, so the States are not just creating another database, then I think that is a very important piece that we must work on.

The second issue is technical assistance. Public mental health systems have traditionally been underfunded, so therefore our information systems have been traditionally underfunded. And we do not have and have not in the past had the type of technical expertise to do this well, and it ends up costing us more money because we have not been able to put the R and D into it correctly in the first place. So it is very, very important.

It is also very important for us to consider as we talk about this integration, it is so necessary in our case with child welfare, or in the housing world or with criminal justice, that we are not reporting slightly differently to another entity if we are sharing resources. We have got to find a way at the Federal level to bring these different systems together on reporting, and even with our colleagues in substance abuse where they may be reporting—although I think we do a better job with substance abuse because we are married in many ways. But it is still very important that we get a common database, common information, common performance.

Senator REED. Thank you.

Mr. Chairman, my time has expired, but I just want to thank Ms. Walker for her wonderful testimony and for being here today. The chairman might have a question for you, but I just want to thank you for participating, and the whole panel, thank you very much.

Ms. WALKER. Thank you.

Senator DEWINE. Senator Reed, thank you very much.

I have several questions that Senator Kennedy has submitted, and I am going to read these two questions on behalf of Senator Kennedy.

The first is for Mrs. Taft—it is an easy one, really, it is. It is a short one, too. "How effective have we been in this country intervening with children whose mothers are substance abusers?" This is a very important question.

Mrs. TAFT. It is a very important question, because I think the future of prevention and treatment really hinges on how well we do that. The whole issue of fetal alcohol syndrome and fetal alcohol effects and drug-induced deliveries of babies is a big one. It makes those children much more vulnerable to later use on their own and usually puts them in a very dysfunctional family that has all kinds of consequences on their mental health and their ability to learn.

In Ohio, which I can speak the most about, we are doing a lot in this area, and I keep hearing about efforts at the national level to foster more efforts at the local and State level on trying to get mothers to deliver very healthy babies.

Senator DEWINE. I think we have come a long way.

Mrs. TAFT. I think we have, too. I think we have a lot more distance to travel, though.

Senator DEWINE. And we have a long way to go.

Mrs. TAFT. Yes.

Senator DEWINE. Senator Kennedy has a question for Gloria Walker. Ms. Walker, Senator Kennedy says, "I agree with you that treating co-occurring mental illness and substance abuse should be a top priority. In the November 2002 Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, the U.S. Department of Health and Human Services suggests that many States and providers need to change old approaches for new evidence-based treatment practices. How can this reauthorization address this problem?" How can we approach this as we deal with the bill that we are going to be working on for the next many months?

Ms. WALKER. I think the answer has already been given, and that is with integrated treatment, being able to treat substance abuse and mental illness together, which is a problem, fundamentally a problem, because of the financial structure. So I think that is something that definitely has to be addressed, how they will be able to do it and integrate the funding so that a person with mental illness can also be treated for substance abuse as well.

Senator DEWINE. Does anyone else want to add anything to that?

Ms. Knisley, you look like you were ready to add something—that is why I asked. You look like you were ready to go there, and that is why I asked.

[Laughter.]

Ms. KNISLEY. Senator DeWine, I think absolutely the integration. We know today that we have effective interventions for treating both substance abuse and mental illness at the same time. And historically what would happen is that you would treat substance abuse first and then a mental health problem. I can remember as a clinician trying to figure out, well, do I drive this person who is intoxicated around until they sober up so I can get them into a mental health treatment facility, or do I hope that when we go to be assessed for substance abuse treatment, they are not going to say, "He is a mental health problem; take him there." And I can remember driving around in Columbus, OH for hours trying to find someone who would not ask does he have the other illness.

Today we can treat both, and we do. However, we have got to integrate the funding and the policies to make that work in all of our States, and I think that is exactly what Ms. Walker was saying and what we would promote.

And in the report to Congress on co-occurring disorders that was presented last winter, there are many good examples of programs that could do just that.

Senator DEWINE. How does that translate into what we do as far as legislation?

Ms. KNISLEY. I think it translates in several areas. One that is in the SAMHSA reauthorization is to look at the separateness of the block grants. And again, I think we do not want to dilute the block grants—and I am sure that my colleague Dr. Gallant would very strongly say we do not want to see all of a sudden a substance abuse block grant becoming a mental health block grant or vice

versa—so we are not looking at diluting those, but we are looking, I believe, for very strong language about models for integration of programs where we can bring the two funding structures together.

So I think that would be one important area in the reauthorization. And I think second in the reauthorization is to look at this report on co-occurring disorders for other policies that we can effect that you would urge SAMHSA in the reauthorization to work on with us. And I might add again that I think it is very important, Senator DeWine, when we look at the criminal justice population who have mental health disorders, you are going to see a co-occurring disorder almost every time.

Senator DEWINE. Yes, almost every, single time, absolutely.

Ms. KNISLEY. Yes. So as we look at that legislation and the policies there, I think that concurrent treatment is going to be absolutely essential. For example, when we are trying to get someone out of jail today in the District, what we do is try to provide counselors who are going to be treating both disabilities at the same time, and I think it is very important to stress that in the legislation.

Senator DEWINE. Ms. Walker and Director Knisley, in your testimony, you both recommended that Congress should legislate an interagency body on children's mental health to improve this collaboration in providing services for kids. How do you see SAMHSA handling the concerns of children now, and how would this body improve access to services for children? How would this work?

Ms. KNISLEY. I will start it off. I think the first thing about the body is that—well, let me back up and say first of all that SAMHSA is doing a terrific job with the Systems of Care work that they have been doing around the country. The District of Columbia has just been awarded one of the Systems of Care Organizing Grants, and we have had superb technical assistance and support. It is a cooperative agreement with the Federal Government, and they have done an outstanding job.

Ohio was one of the very first grantees of this program in the mid-eighties, and I would have to say that, other than our work on brain disorders that has been supported so very well by Congress, this is the other major area where we have seen the most movement in mental health services. And I know that Mr. Curie, with his background in this area, has continued to push hard to develop these systems of care.

So we think that SAMHSA is doing very well in this area—but there is even more leadership that is needed. And as you know working here with the District, we have got to find as many ways as we can to work with our child welfare system and our juvenile justice system, and sometimes when you do not bring that body together through legislation, the demands of those other programs just take over on a day-to-day basis, for very practical reasons. So we have got to find a way to legislate this. The results will be so much more positive for our children, even though going in, it says, well, an interagency body is additional work and so forth and so on, but the results are there; they are just outstanding. And we have seen many States with these legislative bodies that have worked very, very well, and we trust that the same would happen at the Federal level.

Senator DEWINE. Good. Ms. Walker, do you have anything to add to that?

Ms. WALKER. No, I have nothing to add.

Senator DEWINE. Well, I want to thank the panel. I think we have had a very good first hearing. Dr. Gallant, we do not want to exclude you as the only nonOhioan here. We appreciate your service very much.

Ms. KNISLEY. We will let him in, right?

Senator DEWINE. That is right. And Ms. Knisley, we appreciate your past service to Ohio very much, as past director; and Ms. Walker, we appreciate your continued good work in Cincinnati and around the State and across the country. And of course, Mrs. Taft, we appreciate your good work. You and I have worked together as Ms. Walker and I have, and we just appreciate your good work and your great leadership for the State, and we appreciate the testimony here today.

The reauthorization is an important bill as we move forward with these two very, very important constituencies and important issues, and this committee is going to hold a number of additional hearings, fact-finding hearings. We want to get it right, and I think we have a good bill to build on, a good history to build on, and we want to learn whatever we can learn to make sure that we get it right.

So we appreciate this hearing, and we appreciate your good input. Thank you all very much.

The subcommittee is adjourned.

ADDITIONAL MATERIAL

PREPARED STATEMENT OF MICHAEL FAENZA

The National Mental Health Association (NMHA), the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness, looks forward to working with the Committee as it embarks on the important work associated with reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA).

In partnership with our network of 340 State and local Mental Health Association affiliates nationwide, NMHA works to improve policies, understanding, and services for individuals with mental illness and substance abuse disorders, as well as for all Americans. Established in 1909 by a mental health consumer, NMHA's philosophy has consistently been that the needs of consumers and communities must be at the center of all policy and practice concerns in the mental health and substance use fields.

NMHA's symbol is a bell, a bell cast from shackles and chains widely used in this country by State institutions that warehoused people with mental illnesses. The cruel history of what passed for care of people with mental illnesses is almost unspeakable. Suffice it to say that that history is marked by ignorance, loathing, and fear. Those shackles and chains are gone, but the underlying stigma and ignorance surrounding mental illness and substance use are not.

Thus, we welcome the Subcommittee's dedicated focus on mental health and substance use services, a focus we hope will help erase the long history of stigma surrounding mental illness and substance use and help shape Federal policy to provide greater priority to these important public health problems.

Deliberations on SAMHSA reauthorization arise at a critically important time. First, of course, we anticipate the imminent release of the final report of the President's New Freedom Commission on mental health. The Commission's interim report has already provided a much-needed appraisal of the grave societal problems associated with the failure to make mental health a priority in this country. Indeed its hard-hitting assessment that the public mental health system is "in shambles" is a riveting message that should prompt an equally hard-hitting response. The Commission's final report, recommendations and subcommittee papers will give the Administration, Congress and the mental health community a critical foundation for needed action. Indeed, publication of the Commission's report, this hearing and those that may follow have a distinct urgency because they take place against a backdrop of real crisis.

Last year, in announcing plans to establish a mental health commission, the President stated that "our country must make a commitment: Americans with mental illness deserve our understanding and they deserve excellent care." Yet, he acknowledged, many people now "fall through the cracks of the current [mental health] system."

The cracks in the mental health system are growing wider as States and localities grapple with record budget deficits. Recent estimates place collective State budget deficits for the 2003 fiscal year around $26 billion. In fiscal year 2004, States have reported $68.5 billion in shortfalls, an estimate that is expected to grow substantially in the coming months. In addition, the Federal budget continues to underfund effective, science-based mental health services, thus widening the 15-plus year gap between scientific discovery and community services application.

THE CRISIS IN THE PUBLIC MENTAL HEALTH SYSTEM

As was highlighted in the landmark 1999 report, Mental Health: A Report of the Surgeon General, there are vast disparities in availability and access to mental health services in this country, despite the enormous scientific and medical advances that have been made in the diagnosis and treatment of mental disorders.

The interim report of the President's Commission is bluntly frank in stating that "the mental health service delivery system needs dramatic reform" because "it does not adequately serve millions who need care." In fact, one out of every two people who need mental health treatment don't receive it, and the rate is even lower—and the quality of care poorer—for ethnically and racially diverse communities. The report describes the system as "fragmented and in disarray . . . from underlying structural, financing, and organizational problems." Those failings "lead to unnecessary and costly disability, homelessness, school failure, and incarceration," the Commission reported.

The mental health delivery system in this country has long been underfinanced and overburdened. But economic recession and a rapid transition from budget surpluses to sharp deficits in 44 of the 50 States have placed their mental health sys-

tems in real jeopardy. Nearly two-thirds of States cut funding in 2002 for mental health services, and most States anticipate further cuts for the coming fiscal year. Such cuts mean further strains on the already under-funded public mental health system. States have already instituted such measures as reducing benefits, increasing the cost-sharing burden on low-income Medicaid recipients, requiring prior authorization for certain services (including mental health services); limiting access to needed medications through formularies and other mechanisms, and reducing the rates to providers. These cuts appear to be just the beginning. The situation in 2003 is proving even more challenging as State after State has moved to cut funding for mental health services, reduce Medicaid eligibility levels, and restrict access to medications.

MENTAL HEALTH REFORM

The crisis in public mental health around the country requires more than just fiscal relief. It also requires fundamental reform of the nation's mental health "system." We are proud to join fellow advocates in the mental health community in pressing for such reform, and urge the Committee to make realization of mental health reform a priority in your work on SAMHSA reauthorization.

What is "mental health reform?" The Campaign for Mental Health Reform which NMHA and sister mental health organizations are launching proposes no single "fix." Nor does the President's Commission. But the call for mental health reform seeks to ensure that people of all ages with mental disorders do not fall through the cracks—that lives are not lost, and that recovery becomes a realistic goal. Mental health reform calls for mental illnesses to be treated with the same urgency as all other medical illnesses, and calls for recognition that mental health is fundamental to health. Importantly, real reform requires national leadership and the adoption of specific policies to align now-fragmented systems to deliver needed services rationally and to achieve markedly improved quality.

Certainly, equal access to mental health care is a key goal we hope this committee will adopt, cognizant of the findings of the Commission and the 1999 Surgeon General report that we are far from that goal. The barriers to equal access are formidable: lack of mental health parity in public and private insurance benefits, lack of parity in Federal funding relative to the prevalence of mental disorders and their resultant disability burden, and the enormous barriers stemming from poverty and the widespread failure to adapt service-delivery to unique cultural norms of those with mental health needs.

Eliminating barriers to care—while critical—is itself only a first step. Mental health reform must also concern itself with the organization, financing, and quality of services provided, and with the goals of full community participation for children and adults and recovery from mental illnesses. We must be mindful not only of the vast numbers of people who do not receive needed mental health care, but of how often the services provided are inadequate and inappropriate.

We speak colloquially of the problems affecting the "mental health system." But as the President acknowledged in creating the Mental Health Commission, what we have instead is a fragmented delivery system in which people with mental disorders have contact with multiple, disconnected systems, including primary care providers, mental health service providers, hospitals, schools, child welfare programs, homeless shelters, substance abuse treatment facilities, and—sadly and too often—the justice system. Service provision is frequently based on what a system is willing to pay for, what is available in a particular geographic area, or what a provider is trained or willing to do, rather than on individual need and the application of state-of-the-art treatments and best practices. Not surprisingly, many people fall through the cracks altogether, leading some to refer to our nation's "non-system" of mental health delivery.

THE NEED FOR A STRONG SAMHSA

During this time of unprecedented crisis and opportunity in the mental health field, the importance of a strong Federal role for SAMHSA cannot be overstated. NMHA is a member of the Campaign for Mental Health Reform, which is also submitting testimony today. The Campaign's testimony discusses the need for Congress to provide SAMHSA with the funding and authority to help achieve system reform. In addition, following are some specific concerns that we would encourage the Committee to consider as it reviews SAMHSA's programs and authorities.

• As the President's Commission has noted, mental health is a public health issue. Like other major public health issues, it requires a public health approach. It is critical that we meet the complex needs of those with chronic mental illness. But we must also be concerned with the mental health of the entire community.

Mental health issues touch virtually everyone at some point in their lives. To be truly effective, the mental health system must work in collaboration with other health and human service systems and focus on mental health over the lifespan. We urge support for policies and corresponding appropriations for SAMHSA that emphasize screening, prevention, the promotion of mental health, and access to treatment and services.

• To illustrate the point regarding mental health and public health, one need only consider that the shocking attacks of September 11, 2001 targeted not only major national centers but our national psyche. Many Americans, especially children, bear psychic scars and lingering symptoms from the trauma of that horrific attack and the ongoing terrorist threat we face. The very purpose of terrorism is to create destabilizing psychological trauma. But despite our vulnerability to future terrorism, this country lacks the capacity to provide an effective mental health response to wide-scale disaster. This remarkable lack of preparedness in the face of an ongoing terrorist threat is itself a public health risk that must be faced. We urge the Committee, accordingly, to make the mental health aspects of disaster-preparedness a high priority for SAMHSA in reauthorization legislation.

• As inadequate as the adult mental health system is, the situation is even worse for children. When children's mental health needs are addressed at all, the system for serving them is often treated as an extension of the adult system, and as a result truly child- and family-focused service planning and delivery is in short supply. In many cases, children with mental disorders are not served at all by the mental health system, but end up instead in other systems, such as juvenile justice. Across the country, young people with unmet mental health and substance abuse problems languish in juvenile detention facilities for lack of community resources. The confusion and neglect surrounding the needs of children and adolescents with emotional, behavioral, and learning problems is tragic and unacceptable. We urge the Committee to give particular attention to the needs of children and to support policies that facilitate collaboration among child-serving systems, including mental health, substance abuse, education, child welfare, juvenile justice, and primary care. We also urge you to support approaches that maximize child and family access to mental health services, such as the establishment of school-based mental health services and the "systems of care" approach employed by the Comprehensive Community Mental Health Services for Children and Their Families program.

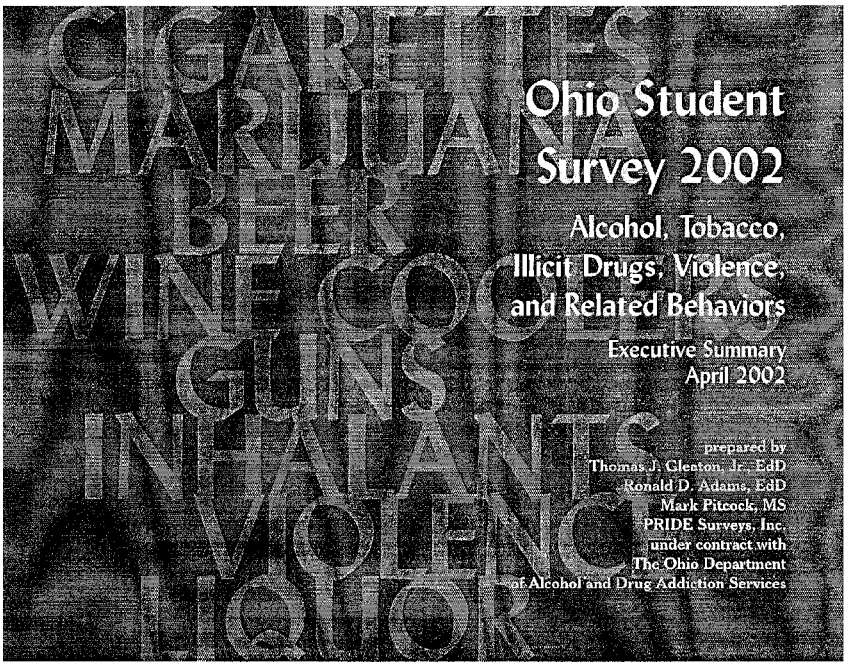
• The Commission's important emphasis on the fragmented nature of mental health service-delivery highlights the need to foster cross-agency systems of care as a means of integrating the provision of needed services. But the Commission also wisely recognizes the role of the mental health consumer in his or her own care, and should be credited with emphasizing the vital role that "consumers" have in their own path to recovery. As the Surgeon General's 1999 report on mental health also recognized, supporting and promoting consumer-run mental health services provides enormous support to people in their recovery from mental illnesses. In that regard, we urge the Committee to examine and give appropriate statutory recognition to the role that consumer self-help and technical assistance (TA) targeted to consumers play in recovery.

• We urge the Committee to take cognizance as well of the role that community-based organizations play in stimulating mental health reform. With the critical need for more, and more effective, community-based mental health and substance-use services and the need to engage multiple governmental agencies to replace service-fragmentation with service-integration, one cannot overemphasize how critical a catalyst community-based organizations can be. The Center for Mental Health Services has long administered a program of community action grants to foster such community-planning toward improved service-delivery. Yet this relatively modest, highly effective grant program (along with consumer TA centers) has fallen prey to ill-advised budget cutting. We urge the Committee to use reauthorization as a means to shore up cost-effective programs like community action grants and consumer and other technical assistance services.

• Finally, with all the problems associated with mental health service-delivery, it is critical to recognize, as the President's Commission did, that both access to mental health services and the quality of those services, are worse for ethnically and racially diverse communities than for the general population. To be effective, service delivery systems must address and respect the diversity among people and cultures. Instead, we have a system in which certain racial and ethnic communities, as well as other underserved populations, face glaring disparities in accessing culturally appropriate mental health services. We urge the Committee to consider proposals to focus Federal and State agencies on the mental health needs of underserved communities as an important component of needed reform.

We look forward to working with the Committee on a mental health reform agenda, one component of which is ensuring a strong Federal role for the Substance Abuse and Mental Health Services Administration. Thank you for this opportunity to share our views and concerns about these critically important issues.

OHIO STUDENT SURVEY 2002



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OVERVIEW

The Ohio Student Survey 2002 is the fourth PRIDE Survey of drug use patterns among 4th, 6th, and 8th grade students throughout the state and the first statewide survey of 10th and 12th graders.* This executive summary provides highlights describing alcohol, tobacco and other drug use and violence by Ohio's elementary, middle, and high school students.

Prevention Successes

Most dramatically, and in all 19 drug categories, Ohio's students report using alcohol, tobacco and other drugs less frequently than their national counterparts. Prevention, intervention, and academic programs are giving Ohio's students a healthy edge for safe development.

Compared to previous year surveys, Ohio's youth are using fewer drugs and the declines are seen across ethnic groups. For white students, use of cigarettes, smokeless tobacco, cigars, beer, wine coolers, liquor, marijuana, cocaine, stimulants, depressants, inhalants, hallucinogens, heroin, and steroids has declined. Black students report decreased usage rates for cigarettes, smokeless tobacco, cigars, beer, wine coolers, liquor, marijuana, inhalants, and steroids. Although showing some potential trouble areas (see page 2), Hispanic students have lowered their rates of use for cigarettes, cigars, beer, wine coolers, liquor, and inhalants.

Ohio's students feel safer both at school and while not at school, compared to previous years.

Risk and protective factors encircle Ohio's students; protective factors have increased in many areas and risk factors have been reduced in other areas.

**Two separate survey questionnaires were used: one designed for 4th graders and another designed for grades 6 through 12. The questionnaires accommodate the different reading and developmental levels of students.*

OVERVIEW

Warning Signs

Hispanic students reported more frequent use of drugs in most categories compared to their white, black, or other counterparts. In many cases, their rates of use also surpassed the national average.

Especially among 6th graders, Hispanic students reported increased use of smokeless tobacco, marijuana, cocaine, stimulants, hallucinogens, and steroids since the 1999 survey year.

A slight increase in the use of cocaine by all 6th graders (0.9% in 2002 vs 0.8% in 1999) may demand further investigation.

While rates of bullying and most violent behaviors are down, more than half of the state's 8th graders have felt threatened at school and a third of the state's 6th graders reported being hurt while at school.

Ensuring the increase of protective factors could mean additional work in encouraging students to participate in school and community activities. Although only a slight decrease was reported among students, programming should be considered to prevent a trend in the decline of participation in future school and community activities.

With students reporting a decrease in family involvement (only 33.1 percent of this year's 6th and 8th graders say their parents talk to them "often" or "a lot" compared to 37.3 percent in the previous survey), parent education and training programs may need to be reinforced to maintain this protective factor around Ohio's youth.

"Thinking about suicide" is another barometer to watch as fewer students reported "never" thinking about suicide. Educators, parents, and community leaders may want to review depression- and suicide-prevention strategies.

How Often Ohio's Students Use Drugs

Overview

For the first time since Ohio has administered the PRIDE statewide survey, 10th and 12th graders participated. On the following pages, comparative data for annual use among 4th, 6th, and 8th graders during the current survey year and the 1999, 1996, and 1993 years demonstrate trends in drug use and violence behaviors. For 10th and 12th graders, comparison to national student rates of drug use and violence behaviors demonstrate how Ohio's youth rank against their counterparts who participated in the most recent national PRIDE survey year (2000-2001).

Monthly usage rates for all categories and all grade levels can be found in the unabridged version of the Ohio Student Survey 2002: Alcohol, Tobacco, Illicit Drugs, Violence, and Related Behaviors. This report is available through the Ohio Department of Alcohol and Drug Addiction Services.

Cigarettes and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
3.5 percent of students said they smoked cigarettes within the past year.

6th Grade
14.6 percent of students said they smoked cigarettes within the past year.

8th Grade
32.8 percent of students said they smoked cigarettes within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
3.3 percent of students said they smoked cigarettes within the past year.

6th Grade
14.8 percent of students said they smoked cigarettes within the past year.

8th Grade
38.7 percent of students said they smoked cigarettes within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
3.2 percent of students said they smoked cigarettes within the past year.

6th Grade
14.3 percent of students said they smoked cigarettes within the past year.

8th Grade
36.4 percent of students said they smoked cigarettes within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
2.2 percent of students said they smoked cigarettes within the past year.

6th Grade
8.1 percent of students said they smoked cigarettes within the past year.

8th Grade
22.7 percent of students said they smoked cigarettes within the past year.

10th Grade
35.9 percent of students said they smoked cigarettes within the past year.

12th Grade
44.2 percent of students said they smoked cigarettes within the past year.

National Student Survey 2001 Annual Use

4th Grade
2.5 percent of students nationwide said they smoked cigarettes within the past year.

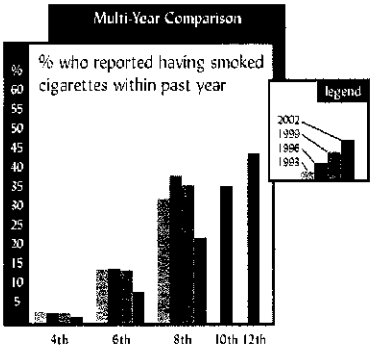
6th Grade
10.3 percent of students nationwide said they smoked cigarettes within the past year.

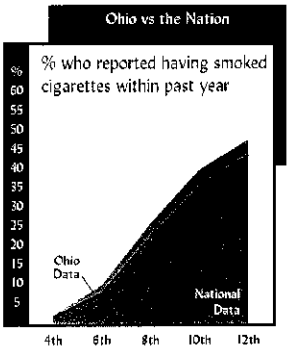
8th Grade
26.8 percent of students nationwide said they smoked cigarettes within the past year.

10th Grade
40.5 percent of students nationwide said they smoked cigarettes within the past year.

12th Grade
48.1 percent of students nationwide said they smoked cigarettes within the past year.

Cigarettes





Implications

Ohio's 6th graders have reported a dramatic decrease in the use of cigarettes since 1993, 1996 and 1999 (14.6%, 14.8%, and 14.3%, respectively vs. 8.1% for 2002). Findings among 8th graders reflect a similar trend, with a 37 percent decrease in cigarette use between the last survey year and 2002. Most important to Ohio's tobacco prevention efforts is the fact that these groups of Ohio's youth, as well as the first-time surveyed 10th and 12th graders, report cigarette use decreasing at a more rapid rate than the rest of the nation.

Ohio Student Survey 2002

Beer and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
9.6 percent of students said they drank beer within the past year.

6th Grade
20.6 percent of students said they drank beer within the past year.

8th Grade
40.6 percent of students said they drank beer within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
7.1 percent of students said they drank beer within the past year.

6th Grade
17.1 percent of students said they drank beer within the past year.

8th Grade
40.4 percent of students said they drank beer within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
6.3 percent of students said they drank beer within the past year.

6th Grade
16.7 percent of students said they drank beer within the past year.

8th Grade
38.1 percent of students said they drank beer within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
5.4 percent of students said they drank beer within the past year.

6th Grade
11.7 percent of students said they drank beer within the past year.

8th Grade
30.0 percent of students said they drank beer within the past year.

10th Grade
52.3 percent of students said they drank beer within the past year.

12th Grade
61.8 percent of students said they drank beer within the past year.

National Student Survey 2001 Annual Use

4th Grade
6.1 percent of students nationwide said they drank beer within the past year.

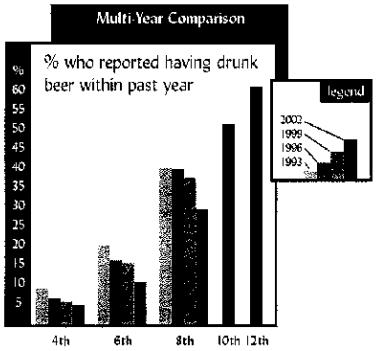
6th Grade
14.5 percent of students nationwide said they drank beer within the past year.

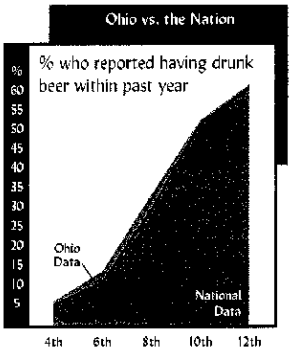
8th Grade
33.9 percent of students nationwide said they drank beer within the past year.

10th Grade
52.9 percent of students nationwide said they drank beer within the past year.

12th Grade
62.4 percent of students nationwide said they drank beer within the past year.

Beer





Implications

Sixth and 8th graders are using beer at decreased rates since the 1999 and previous years' surveys. Approximately one in 10 of the 6th graders surveyed has used beer in the past year compared to one in five 6th graders at the time of the first Ohio survey in 1993. Compared to national trends, students from all four of the Ohio grades that participated in the survey reported consuming beer at lower rates than their counterparts around the nation.

Ohio Student Survey 2002

Wine Coolers and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
8.7 percent of students said they drank wine coolers within the past year.

6th Grade
20.6 percent of students said they drank wine coolers within the past year.

8th Grade
40.6 percent of students said they drank wine coolers within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
5.8 percent of students said they drank wine coolers within the past year.

6th Grade
18.4 percent of students said they drank wine coolers within the past year.

8th Grade
39.7 percent of students said they drank wine coolers within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
5.6 percent of students said they drank wine coolers within the past year.

6th Grade
18.9 percent of students said they drank wine coolers within the past year.

8th Grade
41.0 percent of students said they drank wine coolers within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
5.6 percent of students said they drank wine coolers within the past year.

6th Grade
15.8 percent of students said they drank wine coolers within the past year.

8th Grade
35.4 percent of students said they drank wine coolers within the past year.

10th Grade
49.5 percent of students said they drank wine coolers within the past year.

12th Grade
52.4 percent of students said they drank wine coolers within the past year.

National Student Survey 2001 Annual Use

4th Grade
6.4 percent of students nationwide said they drank wine coolers within the past year.

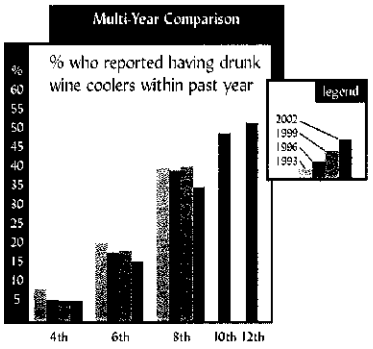
6th Grade
17.5 percent of students nationwide said they drank wine coolers within the past year.

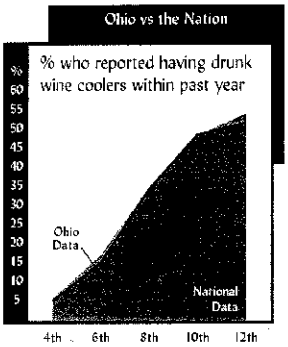
8th Grade
35.9 percent of students nationwide said they drank wine coolers within the past year.

10th Grade
49.0 percent of students nationwide said they drank wine coolers within the past year.

12th Grade
54.4 percent of students nationwide said they drank wine coolers within the past year.

Wine Coolers





Implications

While use of wine coolers by 4th graders remained the same between 1999 and 2002, 6th and 8th graders drank wine coolers less frequently during the past year compared to 1999 reports (6th graders: 15.8% vs 18.9% and 8th graders: 35.4% vs 41.0%). Ohio's 10th graders drink wine coolers at similar rates as their national counterparts, while 12th graders drink wine coolers at rates below the national level (52.4% vs. 54.5%, respectively).

Liquor and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
2.5 percent of students said they drank liquor within the past year.

6th Grade
9.3 percent of students said they drank liquor within the past year.

8th Grade
28.7 percent of students said they drank liquor within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
1.5 percent of students said they drank liquor within the past year.

6th Grade
6.4 percent of students said they drank liquor within the past year.

8th Grade
26.7 percent of students said they drank liquor within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
1.6 percent of students said they drank liquor within the past year.

6th Grade
6.4 percent of students said they drank liquor within the past year.

8th Grade
25.7 percent of students said they drank liquor within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
1.7 percent of students said they drank liquor within the past year.

6th Grade
5.2 percent of students said they drank liquor within the past year.

8th Grade
21.0 percent of students said they drank liquor within the past year.

10th Grade
46.3 percent of students said they drank liquor within the past year.

12th Grade
59.2 percent of students said they drank liquor within the past year.

National Student Survey 2001 Annual Use

4th Grade
2.1 percent of students nationwide said they drank liquor within the past year.

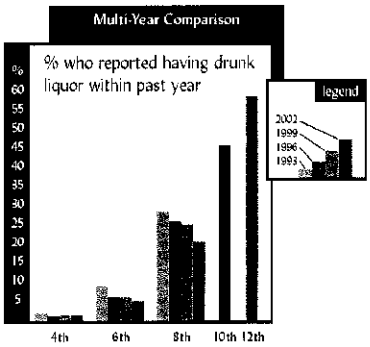
6th Grade
7.5 percent of students nationwide said they drank liquor within the past year.

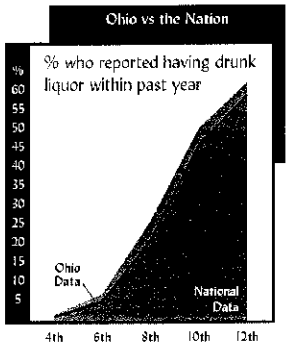
8th Grade
26.7 percent of students nationwide said they drank liquor within the past year.

10th Grade
50.6 percent of students nationwide said they drank liquor within the past year.

12th Grade
62.5 percent of students nationwide said they drank liquor within the past year.

Liquor





Implications

For 4th, 6th, 8th graders, rates for annual use of liquor decreased compared to their counterparts in previous years. Eighth graders reported an 18.0 percent decrease in use, from 25.7 percent of students using liquor in 1999 to 21.0 percent of students reporting liquor use in the most recent survey. Again, at all grade levels, compared to the rest of the nation, Ohio's youth are reporting less annual use of liquor.

Ohio Student Survey 2002

Marijuana and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
0.3 percent of students said they smoked marijuana within the past year.

6th Grade
1.1 percent of students said they smoked marijuana within the past year.

8th Grade
7.4 percent of students said they smoked marijuana within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
0.6 percent of students said they smoked marijuana within the past year.

6th Grade
2.7 percent of students said they smoked marijuana within the past year.

8th Grade
16.2 percent of students said they smoked marijuana within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
0.6 percent of students said they smoked marijuana within the past year.

6th Grade
3.0 percent of students said they smoked marijuana within the past year.

8th Grade
16.2 percent of students said they smoked marijuana within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
0.5 percent of students said they smoked marijuana within the past year.

6th Grade
2.5 percent of students said they smoked marijuana within the past year.

8th Grade
13.4 percent of students said they smoked marijuana within the past year.

10th Grade
30.1 percent of students said they smoked marijuana within the past year.

12th Grade
36.6 percent of students said they smoked marijuana within the past year.

National Student Survey 2001 Annual Use

4th Grade
0.7 percent of students nationwide said they smoked marijuana within the past year.

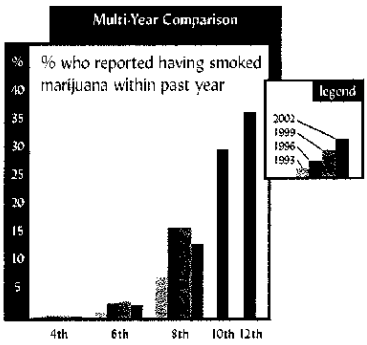
6th Grade
3.6 percent of students nationwide said they smoked marijuana within the past year.

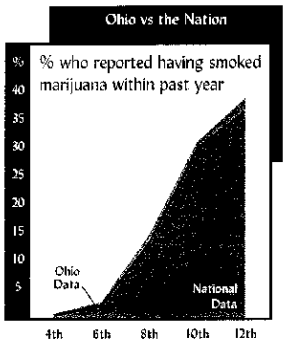
8th Grade
15.0 percent of students nationwide said they smoked marijuana within the past year.

10th Grade
31.5 percent of students nationwide said they smoked marijuana within the past year.

12th Grade
39.0 percent of students nationwide said they smoked marijuana within the past year.

Marijuana





Implications

Marijuana use among Ohio's youth, although decreased from previous years, has experienced the least decline of all the different drug categories for 4th, 6th, and 8th graders. Marijuana use among older students continues at rates that demand attention. During the past year, more than one in 10 of the 8th graders surveyed reported using marijuana; nearly three in 10 of the 10th graders surveyed used marijuana; and more than one in three 12th graders surveyed used marijuana. Despite the continued use, Ohio's youth smoke marijuana less than their counterparts across the nation.

Ohio Student Survey 2002

Inhalants and Ohio's Students

Ohio Student Survey 1993 Annual Use

4th Grade
7.9 percent of students said they used inhalants within the past year.

6th Grade
3.3 percent of students said they used inhalants within the past year.

8th Grade
5.8 percent of students said they used inhalants within the past year.

Ohio Student Survey 1996 Annual Use

4th Grade
6.7 percent of students said they used inhalants within the past year.

6th Grade
4.4 percent of students said they used inhalants within the past year.

8th Grade
10.4 percent of students said they used inhalants within the past year.

Ohio Student Survey 1999 Annual Use

4th Grade
6.7 percent of students said they used inhalants within the past year.

6th Grade
4.5 percent of students said they used inhalants within the past year.

8th Grade
8.1 percent of students said they used inhalants within the past year.

Ohio Student Survey 2002 Annual Use

4th Grade
2.9 percent of students said they used inhalants within the past year.

6th Grade
3.4 percent of students said they used inhalants within the past year.

8th Grade
5.0 percent of students said they used inhalants within the past year.

10th Grade
5.0 percent of students said they used inhalants within the past year.

12th Grade
4.2 percent of students said they used inhalants within the past year.

National Student Survey 2001 Annual Use

4th Grade
4.0 percent of students nationwide said they used inhalants within the past year.

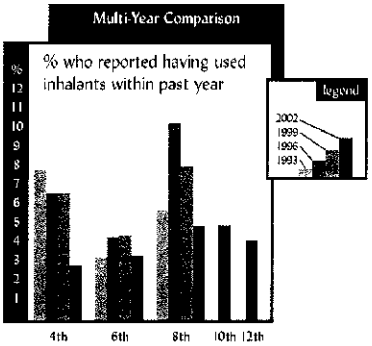
6th Grade
3.8 percent of students nationwide said they used inhalants within the past year.

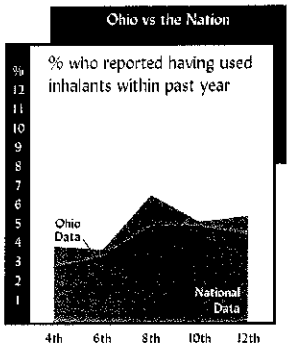
8th Grade
6.7 percent of students nationwide said they used inhalants within the past year.

10th Grade
5.3 percent of students nationwide said they used inhalants within the past year.

12th Grade
5.6 percent of students nationwide said they used inhalants within the past year.

Inhalants



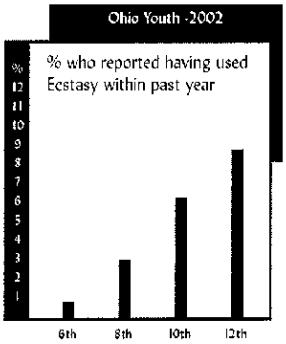


Implications

Inhalant use has been reported most commonly among 8th graders across the nation. From an all-time high with 10.4 percent of Ohio's 8th graders reporting inhalant use in 1996, this year's report shows a 50 percent decline in use among this cohort (5.0% vs 10.4%). Also, Ohio's 4th graders made dramatic progress in reducing inhalant use from 7.9 percent in 1993 to 2.9 percent in the 2002 survey. Compared to national data, Ohio's youth are using inhalants less frequently in all five reporting age groups.

Emerging Trends in Drug Use

Ecstasy



For the first year, Ohio asked its 6th, 8th, 10th, and 12th graders about their use of Ecstasy and OxyContin, two illicit drugs receiving national attention and reported by youth admitted to drug treatment or other services.

Information

MDMA is a synthetic, psychoactive drug with both stimulant (amphetamine-like) and hallucinogenic (LSD-like) properties. Street names for MDMA include Ecstasy, Adam, XTC, hug, beans, "X," and love drug. Its chemical structure (3-4 methylenedioxymethamphetamine, "MDMA") is similar to methamphetamine, methylenedioxyamphetamine (MDA), and mescaline - other synthetic drugs known to cause brain damage.

MDMA is neurotoxic. In high doses, it can cause a sharp increase in body temperature (malignant hyperthermia) leading to muscle breakdown and kidney and cardiovascular system failure.

Implications

Data on the use of Ecstasy is currently being collected for PRIDE's national sample. However, compared to data from the Monitoring the Future (MTF) Study for its most recent year of data (2001), Ohio's youth are using Ecstasy at near-equal rates compared to their national counterparts. Nationally, MTF reports 8th, 10th, and 12th grader use of Ecstasy within the past year was 3.5%, 5.4%, and 9.2%, respectively. In Ohio, the usage rates were 3.1%, 6.4%, and 8.9%, respectively.

Emerging Trends in Drug Use

OxyContin

Information

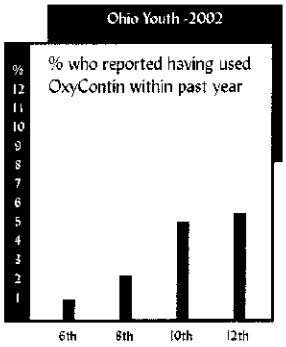
OxyContin contains oxycodone, a strong narcotic pain reliever similar to morphine. It is a prescription drug used to help relieve pain that is moderate to severe in intensity. It may interfere with a person's ability to perform normal tasks that require full attention.

Implications

OxyContin use appears to be affecting Ohio's youth at a rate worth noticing. More than one in twenty 12th graders (5.7%) and 10th graders (5.2%) reported using OxyContin, while 2.4 percent of 8th graders and 1.1 percent of 6th graders said the same.

Since it is suspected that one source of OxyContin for youth is from prescriptions of family members, it might be prudent to distribute patient education materials warning patients of the importance of protecting medications from theft and of not allowing anyone else to use the prescription drug.

In addition, OxyContin has been identified as a gateway to heroin use in Ohio; preventing OxyContin use could lead to keeping Ohio's young away from the harmful effects of heroin addiction.



Population Differences

Ethnic Minority Populations vs the General Population

Ohio's statewide database of self-reported drug use and drug-related behaviors reflects patterns among subpopulations that can help to direct prevention programming. Data from respondents have been analyzed for students self-identifying as white, black, or Hispanic.

Careful consideration should be given to participant responses to determine targeted programming and specific group needs to address a total reduction in drug use and related behaviors.

Hispanic vs Black, White Students

- Most noticeably, in nearly every category, Hispanic students have reported more tobacco, alcohol, and other drug use and many times surpass the usage rates of students nationwide (see figures on this page and facing page).

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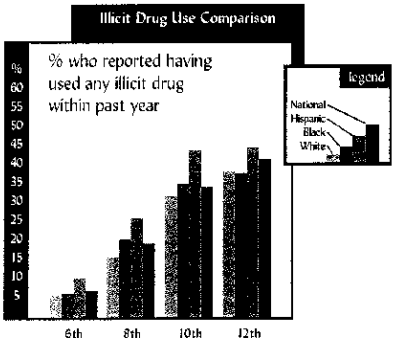
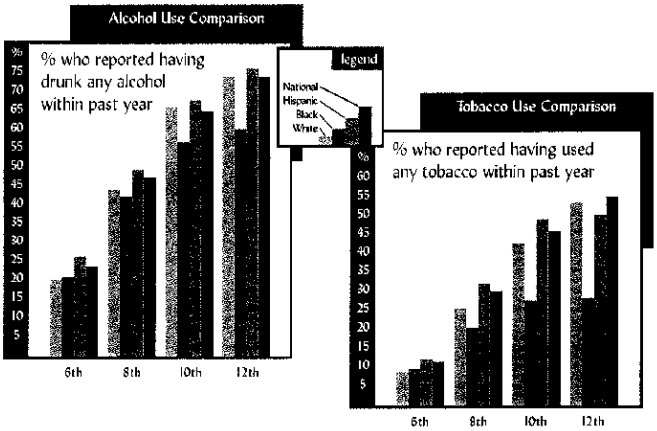


Population Differences



Population Differences

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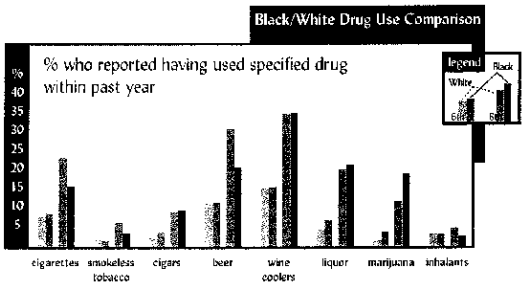
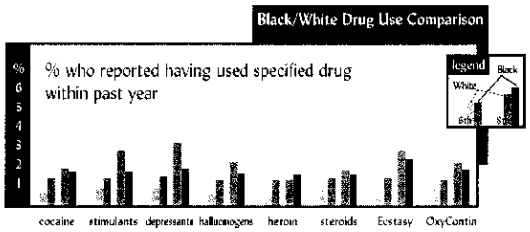
Black vs White Students

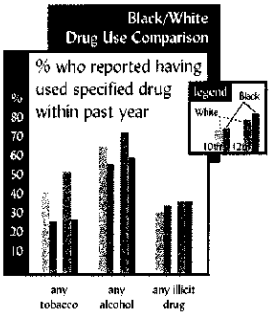


- For 4th and 6th grade blacks, usage rates exceed those for whites in several categories:
  - 4th grade: Use of cigarettes, smokeless tobacco, beer, wine coolers, liquor, marijuana, and the category "other drugs" were found to be higher for blacks compared to whites; however, lower for blacks compared to Hispanics (data not shown).
  - 6th grade: Use of cigarettes, cigars, beer, wine coolers, liquor, marijuana, cocaine, stimulants, depressants, hallucinogens, heroin, steroids, Ecstasy, and OxyContin were found higher for blacks compared to whites. Only smokeless tobacco and inhalants were reported less frequently among blacks compared to whites.
- Of note, as black students advance toward 8th, 10th and 12th grade, usage trends decline and become lower than rates found among the same age white students. For example, black 8th graders reported less use of cigarettes, smokeless tobacco, beer, cocaine, stimulants, depressants, inhalants, hallucinogens, steroids, Ecstasy and OxyContin than white 8th graders.

Population Differences



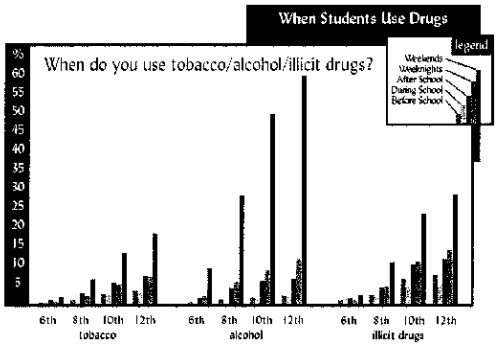
- Conversely to the 4th and 6th grade reports, 10th and 12th grade blacks reported less use of drugs in all areas except marijuana, heroin, and steroids. The figure to the right demonstrates the overall usage rates for any tobacco, alcohol, or illicit drug use.



When and Where Students Use Drugs

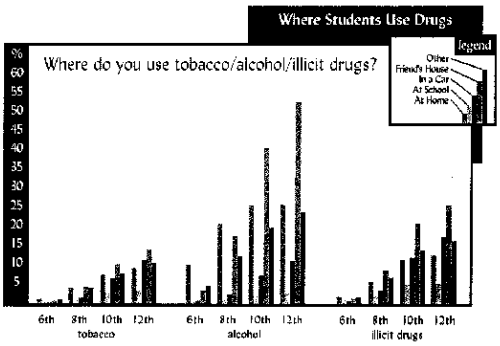
As in past surveys, Ohio's students continue to say that most use of tobacco, alcohol, and drugs occurs in places other than school and at times other than school hours.

For all grade levels, weekends are the most popular time to use tobacco, alcohol, or illicit drugs. After-school hours were the second most popular time for using tobacco, alcohol, or illicit drugs for all age groups, and use of these substances before school was the third most popular time.



When and Where Students Use Drugs

For senior high students (10th and 12th graders), the most popular place for using tobacco, alcohol, and illicit drugs was reported to be a friend's house. Junior high students (6th and 8th graders), on the other hand, reported using tobacco at home at the same rate as using tobacco at a friend's house, yet reported using alcohol at home more frequently than at a friend's house. For this age group, other illicit drug use occurred most frequently at a friend's house.



Safety and Ohio's Youth

In the wake of September 11, the safety of our children has been of top concern for parents, school officials, and community leaders. Nationally, it was hoped students would respond to security threats with reason and assurance that weapons and bullying behaviors were not to be tolerated and overall threats to safety were nonexistent. The survey results bring mixed news.

As in past surveys, Ohio's 4th, 6th, and 8th graders answered 11 questions related to guns, violence, and the fear of being hurt; and, for the first time, 10th and 12th graders also responded to these 11 questions.

4th Graders Respond

In general, 4th graders are feeling safer both at school and while not at school as compared to previous survey years. However, nearly a third (32.4%) of 4th grade students reported being threatened by another student at school during the 2002 year, an increase from 31.6 during the 1999 survey year.

Safety and Ohio's Youth

Will 4th Graders Participate in Violent Acts?

Although the majority of 4th graders said they would not participate in violent acts, even the small percentage of those who think it is OK to carry a gun or to hurt another person is of concern.

Is it OK for kids my age to carry a gun for protection?

Is it OK for kids my age to take what they want, even if it means hurting someone?

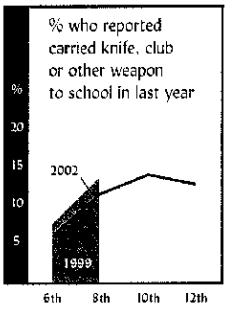
Is it OK for kids my age to beat up another student if it is a fair fight?

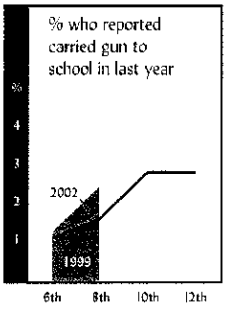
Safety and Ohio's Students

6th, 8th, 10th, and 12th Graders Respond

Weapons

Do Ohio's students carry guns and/or other weapons to school? New data on this violent behavior was collected for 10th and 12th graders and alarmingly found that more than one in ten 10th and 12th grader carried a knife, club, or other weapon (14.3% and 13.3%, respectively).





In addition, among 10th and 12th graders, nearly three in every 100 reported carrying a gun to school during the past year.

If there is good news in this data, it is that fewer 8th graders reported carrying guns to school in 2002 compared to the previous survey year (1.7% vs 2.5%, respectively). Likewise, carrying other weapons to school declined among 6th and 8th graders from the previous survey year (6.7% vs. 7.9% for 6th graders and 11.7% vs. 14.0% for 8th graders).

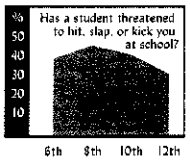
Safety and Ohio's Students

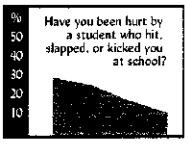
Feeling Safe or Not?

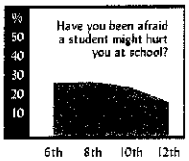
How safe do Ohio's children feel at school? Students responded to questions asking if they were afraid a student might hurt them, if they had been hurt by a student using a gun, knife or club, or by a student, who hit, slapped, or kicked them.

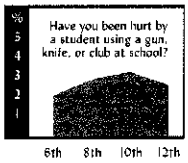
For 6th, 8th, and 10th graders, more than one in four students are afraid they may be hurt by another student, while less than one in five 12th graders feel the same.

Violence (hitting, slapping, or kicking) at school is occurring at rates that warrant additional prevention and intervention activities to reduce harm to the state's youth. Nearly half of all 8th graders surveyed reported being threatened at school. Nearly one third (30.2%) of Ohio's 6th graders report being hurt at school, while 8th , 10th, and 12th graders report being hurt at decreased, but still noticeable, rates (27.3%, 19.4%, and 13.2%, respectively).







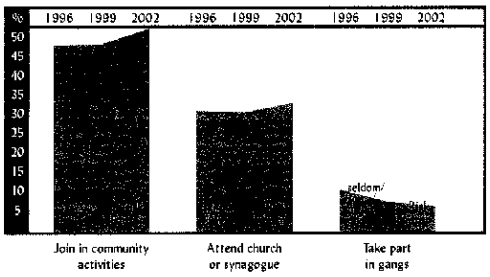


Risk and Protective Factors

How Ohio Works to Protect Its Students

The Ohio Student Survey 2002 asked respondents to answer questions related to protective and risk factors. Researchers have identified several risk factors, which are linked to a higher incidence of drug and violent behaviors, in each of four student environmental circles or domains (school, community, family, and individual). Protective factors in these domains have also been identified and linked to a lower incidence of drug and violent behaviors.

Data from this year can be compared to the previous year surveys to explore ways of improving safe environments for Ohio's youth and to determine what risk factors may jeopardize the safety of its youth. Responses from 6th and 8th graders are highlighted herein; for more complete details, please refer to Table 1, page 34-35 and the unabridged version of the Ohio Student Survey 2002.



In The Community

Community risk factors include: low neighborhood attachment ("never" or "seldom" participating in community activities, church, or synagogue), community disorganization and norms favorable toward drug use and violence (student participation in gangs).

Community protective factors include supportive networks and social bonds (participating in community activities, church or synagogue "often" or "a lot").

During the last three survey years, 6th and 8th graders have reported a decline

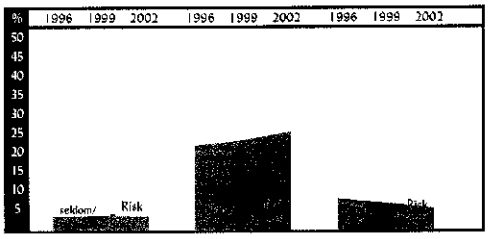
in some protective factors. While more students are reporting that they never participate in gangs during the last year, fewer students are reporting involvement in community activities compared to 1999 and 1996. The lower community involvement rates thus translate to more students considered at-risk, by "never/seldom" participating in community activities.

At School

School risk factors include: academic failure ("never/seldom" making good grades); low commitment to school ("never/seldom") joining in school activities; and early anti-social behavior (getting into trouble at school "often" or "a lot").

School protective factors include: high academic expectations, goal setting, and mastery (making good grades "often" or "a lot"); active involvement in extracurricular activities sponsored by the school (joining in school activities "often" or "a lot"); and pro-social development ("never/seldom" getting into trouble at school).

Students in grades 6 and 8 have reported increased levels of protective factors since the 1999 and 1996 surveys, with more students reporting making good grades and not getting into trouble at school. Involvement in school activities has declined, however, with only 58.2 percent of this year's respondents reporting joining in school activities often/a lot, compared to 59.8 percent and 61.4 percent in the previous survey years. This decline puts 26 percent of 6th and 8th graders at risk, compared to 23.9 percent and 22.6 percent in previous years.



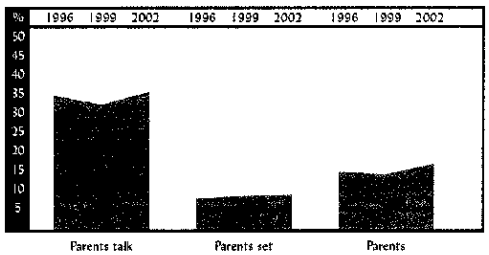
RISK AND PROTECTIVE FACTORS

Within the Family

Family risk factors include: weak parental attitudes toward use (parents "never" or "seldom" talking to their children about the harmful effects of using drugs); and family management problems (parents "never" or "seldom" setting clear rules and "never" or "seldom" enforcing those rules).

Family protective factors include: strong parental attitudes against adolescent drug use (parents talking to their children about the harmful effects of using drugs "often" or "a lot"); parents have clear expectations of their children (parents setting clear rules "often" or "a lot"); and discipline (parents punishing their children "often" or "a lot" when they break the rules).

In general, family involvement was reported at slightly lower levels in the 2002 survey compared to the previous two surveys. Only 33.1 percent of this year's 6th and 8th grade respondents say their parents talk to them "often" or "a lot" about drugs, compared to 37.3 percent and 33.5 percent who said the same in 1999 and 1996, respectively. With fewer parents talking to their children about drugs, more children become at risk as they report their parents "never/seldom" talk to them about drugs (35.4%-1996; 32.8%-1999; and 36.6%-2002). Parents setting and enforcing clear rules "often" or "a lot" also declined since previous years; and parents "never/seldom" setting clear rules increased to 9.7 percent from 9.0 percent in 1999 and 8.5 percent in 1996. Parent education and training programs may need additional reinforcement to maintain this protective factor for Ohio's youth.



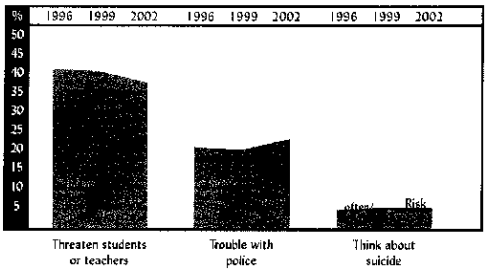
Risk and Protective Factors

Within the Individual

Individual risk factors include: anti-social behavior in early adolescence and rebelliousness (threatening to harm others and getting in trouble with the police); and alienation (thinking about suicide "often" or "a lot").

Individual protective factors include: respect for authority ("never" threatening to harm students or teachers and never getting into trouble with the police); feeling of belonging, higher respect for self (thinking about suicide "never" or "seldom").

In this influential circle, more of Ohio's 6th and 8th graders (61.8%) report "never" threatening students or teachers compared to respondents of the 1999 (58.7%) or 1996 (58.0%) survey. Disheartening, however, fewer respondents in this age group reported "never" getting in trouble with the police and "never" or "seldom" thinking about suicide; thus, more students become at risk as they report getting in trouble with police (21.6%-1996; 21.0%-1999 vs 23.6%-2002), and thinking "often" or "a lot" about suicide (5.2%-1996; 5.3%-1999; 5.3%-2002). Educators, parents, and community leaders may want to review depression- and suicide-prevention strategies.



Ohio Student Survey 2002 Tables

Table 1. Percentage of 6th, 8th, 10th, 12th Graders Who Report Use of Alcohol, Tobacco or Other Drugs

Annual Cigarette Use

	Nat'l* 2000-01	Ohio 2001-02
6th Grade	10.3	8.1
8th Grade	26.8	22.7
10th Grade	40.5	35.9
12th Grade	48.1	44.2
Total	29.6	25.4

Annual Smokeless Tobacco Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	3.1	2.3
8th Grade	7.8	6.1
10th Grade	12.4	12.0
12th Grade	15.0	14.9
Total	9.0	8.0

Annual Cigar Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	4.4	2.9
8th Grade	12.4	9.6
10th Grade	22.9	20.2
12th Grade	32.1	28.5
Total	16.3	13.5

Annual Beer Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	14.5	11.7
8th Grade	33.9	30.0
10th Grade	52.9	52.3
12th Grade	62.4	61.6
Total	38.5	35.6

Annual Wine Cooler Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	17.5	15.8
8th Grade	35.9	35.4
10th Grade	49.0	49.5
12th Grade	54.4	52.4
Total	37.6	36.0

Annual Liquor Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	7.5	5.2
8th Grade	26.7	21.0
10th Grade	50.6	46.3
12th Grade	62.5	59.2
Total	33.8	29.1

Annual Marijuana Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	3.6	2.5
8th Grade	15.0	13.4
10th Grade	31.5	30.1
12th Grade	39.0	36.6
Total	20.3	18.3

Annual Cocaine Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.4	0.9
8th Grade	2.8	2.2
10th Grade	4.7	4.7
12th Grade	7.9	6.4
Total	3.8	3.2

Annual Stimulant Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.7	1.1
8th Grade	4.2	3.0
10th Grade	9.1	6.6
12th Grade	12.3	7.3
Total	6.2	4.1

Annual Depressant Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.6	1.2
8th Grade	3.6	3.3
Jr. High	2.7	2.2
10th Grade	7.5	7.3
12th Grade	9.8	7.6
Total	5.1	4.4

*Most recent PRIDE National data from 2000-2001.

Ohio Student Survey 2002 Tables

Table 1. continued

Annual Inhalant Use

	Nat'l* 2000-01	Ohio 2001-02
6th Grade	3.8	3.4
8th Grade	6.7	5.0
10th Grade	5.3	5.0
12th Grade	5.6	4.2
Total	5.4	4.4

Annual Hallucinogen Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.3	0.9
8th Grade	3.1	2.4
10th Grade	7.1	5.5
12th Grade	11.3	7.8
Total	5.0	3.6

Annual Heroin Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.2	0.8
8th Grade	2.0	1.6
10th Grade	3.0	2.8
12th Grade	4.4	3.2
Total	2.5	1.9

Annual Steroid Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	1.9	1.2
8th Grade	3.1	2.0
10th Grade	3.3	3.1
12th Grade	4.0	3.0
Total	3.0	2.2

Annual Ecstasy Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	na	0.9
8th Grade	na	3.1
10th Grade	na	6.4
12th Grade	na	8.9
Total	na	4.3

Annual OxyContin Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	na	1.1
8th Grade	na	2.4
10th Grade	na	5.2
12th Grade	na	5.7
Total	na	3.3

Annual Any Tobacco Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	12.0	9.4
8th Grade	30.4	25.6
10th Grade	46.2	41.6
12th Grade	55.6	51.5
Total	33.9	29.2

Annual Any Alcohol Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	24.0	20.9
8th Grade	47.7	44.5
10th Grade	65.5	65.3
12th Grade	74.6	73.6
Total	50.6	47.7

Annual Illicit Drug Use

	Nat'l 2000-01	Ohio 2001-02
6th Grade	7.2	6.2
8th Grade	19.8	17.2
10th Grade	34.4	32.9
12th Grade	41.4	38.8
Total	23.9	21.5

*Most recent PRIDE National data from 2000-2001.

Ohio Student Survey 2002 Tables

Table 2. Risk and Protective Factors Ohio 2002, 1999, 1996 Grades 6 and 8

3.7.1 Community - Risk Factors:	W02*	W99	W96	B02	B99	B96	H02	H99	H96	A02	A99	A96
	% AT RISK			% AT RISK			% AT RISK			% AT RISK		
Join in community activities (never/seldom)	52.8	48.5	48.2	55.8	49.5	49.9	63.8	61.9	59.2	53.5	49.1	48.8
Attend church or synagogue (never/seldom)	34.7	32.3	32.0	24.1	20.7	23.3	33	31.6	30.2	33.9	31.3	31.4
Take part in gangs(seldom/some/often/a lot)	6.1	7.3	9.9	12.0	12.6	16.5	14.9	17.0	22.4	7.3	8.3	11.1
3.7.2 Community - Protective Factors:	% PROTECTED			% PROTECTED			% PROTECTED			% PROTECTED		
Join in community activities (often/a lot)	27.4	32.6	33.0	25.8	32.3	32.3	20.3	21.6	25.0	27.0	32.2	32.6
Attend church or synagogue (often/a lot)	46.4	48.8	49.2	52.5	55.5	52.2	46.0	47.6	47.7	46.7	49.3	49.2
Take part in gangs (never)	93.9	92.7	90.1	88.0	87.4	83.5	85.1	83.0	77.6	92.7	91.7	88.9
3.7.3 School - Risk Factors:	% AT RISK			% AT RISK			% AT RISK			% AT RISK		
Make good grades (never/seldom)	3.6	3.6	3.6	5.0	5.7	5.9	8.3	7.6	6.6	4.0	4.0	4.0
Join in school activities (never/seldom)	24.8	22.7	21.5	32.4	29.2	28.9	35.9	38.4	30.7	26.0	23.9	22.6
Trouble at school (often/a lot)	4.8	6.7	7.3	10.8	12.1	13.3	9.9	11.7	12.8	5.7	7.5	8.2
3.7.4 School - Protective Factors:	% PROTECTED			% PROTECTED			% PROTECTED			% PROTECTED		
Make good grades (often/a lot)	70.5	70.0	69.4	54.9	53.1	52.7	54.0	49.9	54.4	68.2	67.5	67.3
Join in school activities (often/a lot)	59.7	61.4	62.7	50.5	53.0	53.1	47.3	43.2	50.6	58.2	59.8	61.4
Trouble at school (never/seldom)	79.8	74.4	72.2	61.2	53.1	52.2	68.0	58.4	58.3	77.1	71.5	69.7

*W - White, B - Black, H - Hispanic, A- All
02 - 2001-02 school year, 99 - 1998-99 school year, 96 - 1995-96 school year

Ohio Student Survey 2002 Tables

Table 2. continued

3.7.5. Family - Risk Factors:	W02*	W99	W96	B02	B99	B96	H02	H99	H96	A02	A99	A96
	% AT RISK			% AT RISK			% AT RISK			% AT RISK		
Parents talk about drugs (never/seldom)	37.1	33.6	36.5	31.4	25.1	24.8	33.8	30.5	31.3	36.6	32.8	35.4
Parents set clear rules (never/seldom)	9.5	8.8	8.3	9.1	8.5	8.0	14.7	13.9	11.3	9.7	9.0	8.5
Parents enforce rules (never/seldom)	17.0	14.3	15.0	19.6	17.3	16.7	24.9	24.4	19.9	17.6	15.0	15.4
3.7.6. Family - Protective Factors:	% PROTECTED			% PROTECTED			% PROTECTED			% PROTECTED		
Parents talk about drugs (often/a lot)	31.3	34.9	31.1	45.3	53.8	53.3	40.1	45.6	41.2	33.1	37.3	33.5
Parents set clear rules (often/a lot)	71.1	75.9	75.8	73.6	79.1	79.2	64.1	68.0	70.9	71.0	75.9	75.9
Parents enforce rules (often/a lot)	56.0	62.1	59.0	51.2	57.8	57.0	47.1	48.3	52.5	55.3	61.2	58.5
3.7.7. Individual - Risk Factors:	% AT RISK			% AT RISK			% AT RISK			% AT RISK		
Threaten students/teachers (seldom/some/often/a lot)	36.5	39.2	40.3	5[illegible]	54.3	53.7	44.9	48.8	51.5	38.4	41.3	42.0
Trouble with police(seldom/some/often/a lot)	22.5	19.9	20.4	28.9	25.4	28.1	31.5	28.0	31.4	23.6	21.0	21.6
Think about suicide (often/a lot)	5	4.8	4.9	5.0	6.3	6.2	8.6	8.9	7.5	5.3	5.3	5.2
3.7.8. Individual - Protective Factors:	% PROTECTED			% PROTECTED			% PROTECTED			% PROTECTED		
Threaten students/teachers (never)	63.5	60.8	59.7	49.0	45.7	46.3	55.1	51.2	48.5	61.6	58.7	56.0
Trouble with police (never)	77.5	80.1	79.6	71.1	74.6	71.9	68.5	72.0	68.6	76.4	79.0	78.4
Think about suicide (never/seldom)	87.6	89.3	88.9	88.4	86.9	86.5	84.2	82.9	84.8	87.3	88.6	88.4

*W - White, B - Black, H - Hispanic, A- All
02 - 2001-02 school year, 99 - 1998-99 school year, 96 - 1995-96 school year

Ohio Student Survey 2002 Information

Survey participants

In fall 2001, 222,155 Ohio students participated in the Ohio Student Survey 2002, administered by PRIDE. Surveys, a national survey organization dedicated to assisting communities define drug and violence behaviors among their young.

Of the 222,155 participating Ohio students, 4th, 6th, 8th, 10th, and 12th graders were represented as follows:

51,631	4th graders
50,369	6th graders
49,083	8th graders
41,512	10th graders
29,560	12th graders

Tenth and 12th graders participated for the first time this survey year, while other grade levels have participated in the three previous surveys occurring in 1993, 1996, and 1999 as shown below.

	1993	1996	1999
4th graders	90,657	69,477	56,250
6th & 8 graders	172,210	112,776	101,530

As in previous years, students in the 2002 survey self-identified individual ethnic groups, with breakdown as follows:*

	2002	1999†	1996†	1993†
Whites	177,224	126,708	150,572	224,314
Blacks	23,299	17,247	20,534	25,976
Hispanics	3,383	2,119	2,258	4,364

Students from 297 public school districts and 2 dioceses participated in the survey. Eighty-four of Ohio's 86 counties were represented and 297 school districts participated. More than 1,000 schools (1,037) administered the survey for grades 6-12 and 917 schools collected data on 4th graders.

*Native Americans, Asian, Mixed Race are not shown.
†Grades 10 and 12 students not included in these survey years.

Ohio Student Survey 2002 Information

Survey funding

Funding for this survey was through the Ohio Departments of Alcohol and Drug Addiction Services (ODADAS) and Education. The information will be used to make policy decisions and to provide families, school districts, and communities with local data. All Ohio school districts were offered the opportunity to participate in the survey.

For additional information

For information on this Executive Summary or the PRIDE Survey, please contact:

Ohio Department of Alcohol and Drug
Addiction Services
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Chief, Division of Prevention Services
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Two Nationwide Plaza
280 North High Street, 12th Floor
Columbus, Ohio 43215-2537
Phone 614-466-3445
Fax 614-752-8645

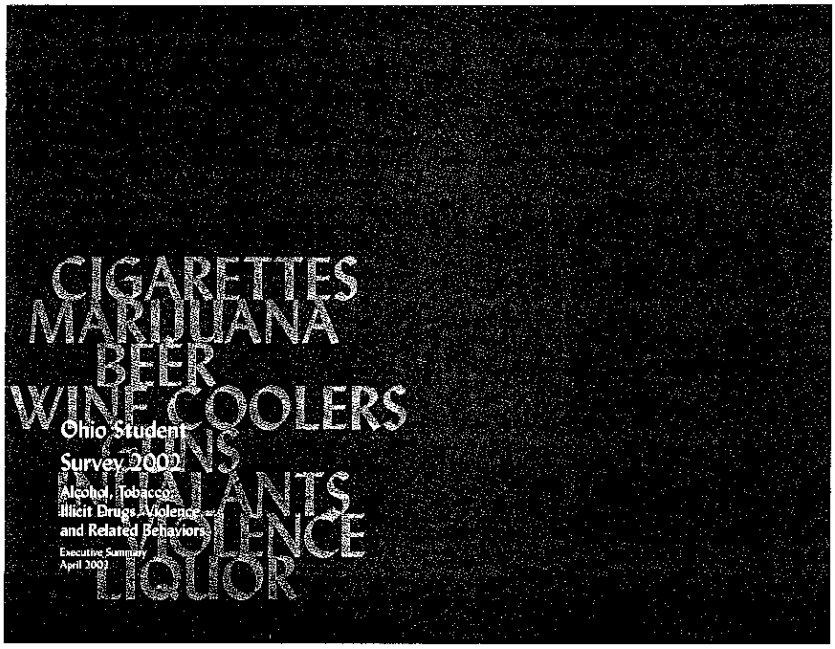
The PRIDE Survey

The information in this Executive Summary represents the major findings of the Ohio Student Survey 2002. Appropriate school personnel may order more detailed reports for each participating school and/or school district through PRIDE Surveys. The reports can provide data and charts specifically for one school or one school district. Other areas of specialized reports available include:

- Accessibility of drugs
- Violence and drugs
- Risk and protective factors by individual, school, community, and family
- Respondent demographic information.

To order additional analysis and reports for your school or school district, please call or write PRIDE Surveys:

166 St. Charles Street
Bowling Green, Kentucky 41210
800-279-6361
or visit www.pridesurveys.com



[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

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