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What is SAMHSA Doing to Help Communities Make Good Decisions About the Allocation of Scarce Treatment Resources?

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**Testimony Before the House Government Reform and Oversight Committee
Subcommittee on Criminal Justice, Drug Policy, and Human Resources**

Thursday, February 17, 2000

**What is SAMHSA Doing to Help Communities Make Good Decisions About the Allocation
of Scarce Treatment Resources?***

Martin Y. Iguchi**

Thank you for the opportunity to testify. I ask that my written statement be entered into the record. [1]

As a member of CSAT's National Advisory Council, as a NIDA treatment researcher, as a psychologist and former drug treatment program administrator, and as Co-Director of the Drug Policy Research Center at RAND, I have spent considerable time thinking about the Substance Abuse and Mental Health Services Administration's (SAMHSA) role as it relates to the provision of drug treatment in America.

I am going to focus on one question: Is SAMHSA helping state and local communities to make best use of their scarce drug and alcohol treatment resources? [2] My discussion of this question involves three areas of SAMHSA activity in support of community decisionmaking: 1) helping communities to identify treatment costs, utilization, and outcomes; 2) helping communities to determine where treatment is most needed; and 3) helping communities to identify "best" treatment practices. SAMHSA clearly plays a vital role in these areas, but significant challenges are identified and will be discussed.

Helping communities to identify treatment costs, treatment utilization, and treatment outcomes.

Communities need information to assess what treatment resources are in place, the cost of those resources, and how those resources are performing. This is a very complicated process as a single individual may utilize services from a variety of systems. For example, a single person may be enrolled in drug treatment, may be getting treatment for depression at a community mental health center, may be on Medicaid, and could be involved with a criminal justice diversion program. Each system contacted by that individual keeps its own records in its own separate database. To understand the coordinated cost of services utilized by a given individual

requires a single database integrating information from multiple systems. Recently, in partnership with the states of Oklahoma, Washington, and Delaware, SAMHSA developed a database system capable of merging cost and utilization information from Medicaid, mental health, and substance abuse systems [3]. This integrated database system represents an important step forward in that it overcomes significant technical obstacles and recognizes the multitude of agencies and resources that must be coordinated to evaluate service delivery.

Although it would be ideal for all health delivery programs to monitor outcomes as a matter of routine, doing so can be an expensive and complicated proposition. This is particularly true for substance abuse treatment because follow-up is complicated by a distinct lack of resources in existing agencies to collect this information, by the illegal nature of the problem, by the low socio-economic status of many in treatment, and by the multiple life dimensions positively influenced by treatment that need to be measured to appreciate the full impact of treatment. For example, treatment may reduce substance use, it may diminish criminal activity, it may diminish violent behavior, it may improve mental health, it may increase the likelihood of employment, or it may prevent the birth of a drug-exposed child.

Recognizing the complications and expense of ongoing outcomes monitoring in community settings, SAMHSA has commissioned a working group specifically to address this issue [4] and it has entered into numerous partnerships with states to develop performance measures for a variety of treatment interventions [5]. Quite appropriately, these groups have focused to date on a number of during-treatment process measures that may be used by communities as predictors of outcome. These intermediate measures might include, for example, the amount of substance use reduction, treatment retention, treatment engagement, patient satisfaction, or quality of life improvement.

While significant progress has been made in the development of tools for assessing cost and performance, much work remains to be done in integrating cost and effectiveness measures. While this is not an issue for SAMHSA alone, the lack of consensus among economists regarding the best means for conducting economic evaluations of drug treatment programs means that comparisons across different evaluations are compromised by a lack of reporting standards. This leads to decisionmaking guided by cost considerations alone – without adequate attention to effectiveness.

Support for identifying treatment gaps.

In 1998, the US GAO reported serious deficiencies in states' abilities to develop estimates of treatment need [6]. This problem continues. States still do not have capacity for assessing treatment need. SAMHSA's recent expansion of the National Household Survey on Drug Abuse (NHSDA) to allow for state-level analyses represents a potential improvement in the availability of epidemiological data for communities. However, in order for this information to be useful to states, several problems must also be addressed. First, SAMHSA needs to place considerably more emphasis on releasing the data as quickly as possible to state analysts in a form that allows for analysis of regional need [7]. Second, states require more technical assistance to develop systems for monitoring treatment need [8]. SAMHSA needs to provide leadership in the development of analytic models that will allow states to make use of their own data.

Identifying and promoting "best treatment" practices.

SAMHSA has done an excellent job in the promotion of evidence-based practices. The Addiction Technology Transfer Centers (ATTCs) and the Treatment Improvement Protocols (TIPs) all play an important role in the dissemination of best practice guidelines.

Another mechanism for promoting treatment quality is through accreditation. In the treatment of chronic opiate abusers, SAMHSA's new role in accrediting Methadone Treatment Providers (formerly an FDA function) represents a tremendous move forward for the field and holds significant promise for the promotion of evidence-based practice.

In addition to dissemination, SAMHSA appears to recognize that many community treatment programs already provide excellent care. SAMHSA has several projects that document and evaluate these "model" programs. SAMHSA also has a number of treatment projects that take empirically validated treatments and apply them in multiple community settings. These studies are important because they help to identify barriers to implementation, they demonstrate the real world utility of interventions known only to researchers, they provide important information regarding cross-cultural relevance, and they serve as models for policy makers and other treatment providers to consider.

Conclusion.

In summary, SAMHSA has clearly played a vital role in helping communities to make good decisions about their allocation of scarce treatment resources. However, and as might be

surmised from my brief review, SAMHSA has several challenges ahead. In particular, SAMHSA has a great deal more work to do in helping communities to identify treatment gaps. In order for the expanded National Household Survey on Drug Abuse to be useful, a system must be put into place that will get the data to states in a form that they can use. Further, there is a tremendous need to upgrade the analytic capability of states and to provide them with technical assistance to make use of the data. This challenge must be met if communities are to make optimal use of their resources, and if we are to have full participation as a nation in achieving the goals established in Healthy People 2010.

ENDNOTES

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[1] In the interest of time, this paper skirts the block grant allocation formula entirely. For a thorough review of the Block Grant Funding Allocation Formula, please see Burnam, et al., *Review and Evaluation of the Substance Abuse and Mental Health Services Block Grant Allotment Formula*. Santa Monica: RAND, 1997.

[2] I use the term communities to broadly refer to state and local governments, as well as other self-defined interest groups, neighborhoods, and coalitions.

[3] See CSAT/CMHS Contract #270-96-007, Contract deliverable for task 24 #: Report on the system requirements for the integrated database for mental health and substance abuse treatment service project, August 29, 1997.

[4] See the CSAT document: Garnick (1999) "Improving performance measurement by managed care plans for substance abuse: Year 1 report of the Washington Circle Group."

[5] States involved in the state performance and outcome measurement partnership include Arizona, Arkansas, Connecticut, Kansas, Maryland, Massachusetts, Minnesota, Missouri, North Carolina, North Dakota, Oklahoma, Rhode Island, Utah, and Washington.

[6] USGAO, *Drug Abuse Treatment: Data Limitations Affect the Accuracy of National and State Estimates of Need*. Washington, DC: United States General Accounting Office, 1998.

[7] Although not within SAMHSA's area of responsibility, data from NIDA's Monitoring the Future study, with regional identifiers, should also be made available to communities as expeditiously as possible.

[8] There is a substantial need for the development of models to usefully integrate the NHSDA data with other data sources to derive useful regional estimates of drug use and drug use trends over time. For an example of just how complicated this can be, see, Ebener, Saner, & Anglin,

Building a Data & Analysis Infrastructure to Support Substance Abuse Policy Decisionmaking: A Strategic Plan. Santa Monica: RAND, 1995.