

Providing Substance Abuse Prevention and Treatment Services to Adolescents

Bill Number:

Hearing Date: June 15, 2004, 10:00 am

Location: SD-430

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Curie Testimony

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Charles G. Curie, M.A., A.C.S.W.

Substance Abuse and Mental Health Services Administration, Rockville, Maryland

Administrator

Testimony

Mr. Chairman and Members of the Subcommittee, good morning. I am Charles G. Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS).

Thank you for providing me the opportunity to describe how SAMHSA and our Federal, State, and local community-level partners are working to provide effective substance abuse treatment to people who want and need it, including young Americans.

Drug abuse and mental illness are major public health problems that affect us all. In terms of dollars, substance abuse, including alcohol, illicit drugs, and tobacco use, costs our Nation more than \$484 billion per year. The economic costs of mental illness are also staggering. The President's New Freedom Commission on Mental Health reports the cost in the U.S. from both direct (treatment-related) and indirect (productivity loss) expenses may exceed \$150 billion per year with rapid annual increases, especially in the drug treatment area. Mental illnesses, including depression, account for four of the top six causes of disability among 15-44 year olds in the Western world.

Although not as well known as the deaths due to substance abuse, mental illnesses are a substantial source of mortality. Of the 30,000 Americans who die by suicide each year, 90 percent have a mental illness. The fact that deaths from suicide outnumber deaths from homicide (18,000) is often a surprising finding. Suicide rates are high among several ethnic minority groups, though it remains highest in older white males. Between 1952 and 1992, the incidence of suicide among adolescents and young adults nearly tripled; currently it is the third-leading cause of death in adolescents. We know that substance use increases the probability of a person with mental illness attempting suicide

and increases the person's likelihood of succeeding

Addiction's toll on individuals, their families, and the communities they live in is a cumulative devastation with a ripple effect. This ripple effect leads to costly social and public health problems including HIV/AIDS, domestic violence, child abuse, and crime in general, as well as accidents and teenage pregnancies.

Addiction often begins during childhood and adolescence. Research has shown that substance use dependence, while once thought to be an adult-onset disease, is actually a "developmental disease." It is developmental in terms of having its start during the early stages of adolescence and even childhood, when children use drugs or consume alcohol. The introduction of an illicit drug or of alcohol to the adolescent brain has a dramatic impact because of the changes occurring in the brain during this developmental stage.

The data from SAMHSA's 2002 National Survey on Drug Use and Health provides the scope of the problem. In 2002, there were 2.3 million youths aged 12 to 17 who needed treatment for an alcohol or illicit drug problem. Of this group, only 186,000 received treatment. Without help, it is very likely that these young people, at the very beginning of their lives, will continue on a destructive path of addiction, disability, criminal involvement, and premature death.

Overall, there are an estimated 22 million Americans struggling with a drug or alcohol problem. There is a clear correlation between age of first use of drugs and alcohol and the potential for developing a serious problem. For example, in 2000, 18 percent of people age 26 and older who had begun using marijuana before age 15 met the criteria for either dependence or abuse of alcohol or illicit drugs, compared to 2.1 percent of adults who never used marijuana. Among past year users of marijuana age 26 and older who had first used marijuana before age 15, 40 percent met the criteria for either dependence or abuse of alcohol or illicit drugs.

The story is very similar for alcohol. One-third, 2.3 million, of alcohol-dependent adults age 21 or older in 2002, had first used alcohol before age 14. Over 80 percent, 5.8 million, had first used before they were age 18. And 96 percent, 6.6 million, had first used before age 21. The rate of dependence for those who first drank at age 21 or older was only 1 percent. Conversely, 99% of adults 21 and older who first drank alcohol at age 21 or older do not have a dependence problem.

It is plain to see why improving treatment services for adolescents and bolstering prevention programs targeted to this age group are top priorities for SAMHSA.

## THE SAMHSA ROLE

SAMHSA is working to improve how we approach substance abuse treatment and prevention, not only at the Federal level, but also at the State and community levels. During my tenure, we have restructured our work around the vision of "a life in the community for everyone" and our mission of "building resilience and facilitating recovery."

To focus and to guide our program development and resources, we have developed a Matrix of program priorities and cross cutting principles that pinpoints SAMHSA's leadership and management responsibilities. These responsibilities were developed as a result of discussions with members of Congress, our advisory councils, constituency groups, people working in the field, and people working to attain and sustain recovery.

The Matrix priorities are also aligned with the priorities of President Bush and HHS Secretary Tommy Thompson, whose support for our vision of a life in the community for everyone we appreciate. The Matrix has produced concrete results by focusing SAMHSA staff and the field on planting a few "redwoods" rather than letting "a thousand flowers bloom." I see my responsibility as Administrator to make solid program and management improvements that will last beyond my tenure.

I am proud of our success over the past two and half years since I came to SAMHSA. I believe the SAMHSA Matrix is the underpinning of our success and has helped us to focus on solid investments in the future of mental health and substance abuse prevention and treatment services. In particular, I will highlight the ways we support the prevention and treatment of adolescent substance abuse.

On our matrix you will see the program "Strategic Prevention Framework." Through this Framework we are working to more effectively and efficiently align our prevention resources. The Framework is aligned with the President's and Secretary Thompson's HealthierUS initiative. HealthierUS is a plan to improve overall public health by capitalizing on the power of prevention to help prevent, delay, and/or reduce disability from chronic disease and illnesses, including substance abuse and mental illnesses.

I am pleased to report that the most recent data confirms that the President's two-year goal to reduce illicit drug use among youth by 10 percent in 2 years has been exceeded, with an 11 percent reduction in the past two years. This is a clear indication that our work with our many Federal and State partners, along with schools, parents, teachers, law enforcement, religious leaders, and local community anti-drug coalitions, is paying off. But our work is far from over, and prevention is key.

Fortunately, we know more about what works in prevention, education, and treatment than ever before. Over the years, we have shown prevention programs can and do produce results. Currently, we have 60 model programs listed in our National Registry of Effective Programs. These programs yield, on average, a 25 percent reduction in substance use and affect a broad range of behavioral issues, from violence and delinquency to emotional problems. Primary access to the programs in the Registry is through the SAMHSA Model Programs website, [www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov). The website describes and provides contact information for each of the programs in the Registry.

Unfortunately, as we all know, individuals, communities, or State and Federal agencies do not always translate, or make it easy to translate, into action what is known about

prevention. To help provide a structured approach to substance abuse prevention and mental health promotion that is based on the best that science has to offer, Secretary Thompson launched the Strategic Prevention Framework during the national HealthierUS Prevention Summit in Baltimore on April 29. This new \$45 million competitive grant program will enable States, Territories, and the District of Columbia to bring together multiple funding streams from multiple sources to create and sustain a community-based, science-based approach to substance abuse prevention and mental health promotion.

The Framework is based on the risk and protective factor approach to prevention. For example, family conflict, low school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors.

Clearly, these risk and protective factors exist at several levels – at the individual level, the family level, in schools, the community level, and in the broader environment. People working in communities with young people and adults understand the need to create an approach to prevention that is citizen centered, cuts across existing programs and system levels, and has common outcome measures.

Just as when we are promoting exercise and a healthy diet or advancing vaccination, when we speak about abstinence or rejecting drugs, tobacco, and alcohol and promote mental health, we really are all working towards the same objective – reducing risk factors and promoting protective factors. The challenge is to build a national framework for prevention on that common foundation.

Moving the framework from vision to practice will require the Federal government, States, and communities to work in partnership. Under the new grant program, States will provide leadership, technical support, and monitoring to ensure that participating communities are successful in implementing a five-step public health process that will promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span. The five steps are:

First, communities assess their mental health and substance abuse-related problems including magnitude, location, and associated risk and protective factors. Communities also assess assets and resources, service gaps, and readiness.

Second, communities must engage key stakeholders, build coalitions, and organize, train, and leverage prevention resources.

Third, communities establish plans that include strategies for organizing and implementing prevention resources. They must be based on documented needs, build on identified resources, and set baselines, objectives, and performance measures.

Fourth, communities implement evidence-based prevention efforts specifically designed

to reduce risk and promote protective factors identified.

Finally, communities will monitor and report outcomes to assess program effectiveness and service delivery quality, and to determine if objectives are being attained or if there is a need for correction.

The success of the Strategic Prevention Framework will be measured by specific national outcomes that are true measures of whether our programs are helping young people achieve our vision of a life in the community, for example, whether they are in stable homes, in school, and are not involved with the criminal justice system. We are rapidly moving to implement these national outcomes across all of SAMHSA's programs.

In the area of substance abuse treatment, we are already using national outcomes. This year we commenced the President's Access to Recovery program with a \$100 million investment. The Administration's commitment to expand clinical treatment and recovery support services to reach those in need extends beyond the immediate fiscal year, with its FY 2005 request to double Access to Recovery's appropriation to \$200 million and to increase the Substance Abuse Prevention and Treatment Block Grant by \$53 million for a total of \$1.8 billion.

As you may know, Access to Recovery is based on the knowledge that there are many pathways to recovery. It empowers people with the ability to choose the path best for them - whether it is physical, mental, medical, emotional, or spiritual. In particular, we know that for many Americans, treatment services that build on spiritual resources are critical to recovery. Access to Recovery ensures a full range of clinical treatment and recovery support services are available, including the transforming powers of faith. Critically, Access to Recovery provides States the opportunity to target resources to providing treatment to adolescents.

Over the years, SAMHSA, through its Center for Substance Abuse Treatment (CSAT), has made significant strides in addressing the shortage of adolescent substance abuse treatment. Between 1970 and 1997, there were only 14 published studies of the effectiveness of adolescent substance abuse treatment. In response, SAMHSA funded the Cannabis Youth Treatment (CYT) Study in 1997. Its purpose was to explore whether proven adult models of intervention could be made developmentally appropriate for adolescents and achieve effective outcomes in real-world, community-based treatment settings. The CYT study of over 600 youth randomized to five different treatment interventions resulted in five effective treatment protocols that are now available in manuals that are in use across the country. The five volumes of the CYT Series are based on treatment approaches specifically designed for use with adolescents. The CYT manuals are part of SAMHSA's larger Science to Services Initiative that is working to speed the delivery of effective, evidence-based programs into communities where clinical intervention and treatments are put into practice.

In 1999, a few years after the CYT study began, SAMHSA funded the Adolescent Treatment Models program. The purpose was to identify potentially exemplary programs

that existed in the field and to have them rigorously evaluated to determine their effectiveness. The same core assessment and follow-up instruments, as well as data collection points from CYT, were used, which afforded the opportunity to draw critical comparisons. The outcomes of this study generated 10 treatment program manuals that include effective programs for intensive outpatient, short-term residential and long-term residential programs that are available on-line and are being adopted within the adolescent treatment field as we speak.

Having worked to identify effective treatment interventions, SAMHSA proceeded to develop the Strengthening Communities – Youth (SCY) program in 2001. With a \$39 million investment, twelve sites were funded for five years to develop a continuum of adolescent services and a system of care for youth within their communities.

Although these programs have clearly and undoubtedly strengthened treatment programs for this age group, an identified weakness is the lack of continuing care models for youth after they complete the active phase of treatment. For example, too often when youth complete residential placements and return to their families and communities, they are cut-off from treatment services and quickly resume their substance abuse and other destructive behaviors. In response, SAMHSA awarded grants under its program to Improve the Quality and Availability of Residential Treatment and its Continuing Care Component for Adolescents (ART) during 2002. As a result, numerous residential programs have developed and implemented models of providing continuing care to youth.

Along with improving after-care services for adolescents, SAMHSA launched the Effective Adolescent Treatment (EAT) program in 2003 to assist the field in adopting a previously proven effective approach of the CYT initiative. This approach, Motivational Enhancement Therapy/Cognitive Behavioral Therapy, for adolescents with substance use disorders is now being implemented in 22 sites around the country. In 2004, an additional 16 sites will be funded, which will result in a total of 38 programs implementing a practice for which there is evidence of effectiveness and will directly impact success rates for adolescents who are in a battle for their very lives.

In tandem with improving and extending the continuum of care in residential settings, which often include court-adjudicated youth from the criminal justice system, CSAT also provides for critical treatment services through the Juvenile Justice Drug Treatment Court. Six programs are up and running smoothly, and others will be operational soon through our Youth Offender Re-entry Program, which will support 12-14 new programs in Fiscal Year 2004.

CSAT also supports treatment programs for adolescents through its Targeted Capacity Expansion program (TCE), Targeted Capacity Expansion/HIV (TCE/HIV), and HIV Outreach programs. These grantees are encouraged and supported to adopt only effective treatment practices. They are included in meetings and trainings to further facilitate the evolution and improvement of the field of adolescent substance abuse treatment. Each of these efforts to expand treatment services for adolescents have been well thought

out, and each resulting program has been funded based on the underlying and undeniable fact that all we can do to help our Nation's youth is what must be done – nothing less is acceptable. The treatment services afforded through the opportunities I just mentioned are improving services for adolescents, and we are improving and building upon the services for consumers of all ages -- children, adolescents, young adults, adults, and older adults alike.

I am particularly proud to tell you that improving services for all of these age groups, from this Nation's elderly down through and including our youngest citizens, is the driving force behind achieving our agency goals – goals which are independent yet interconnected and goals which are clearly outlined in our Matrix of agency priorities.

Key to achieving our goals is developing an ability to report on meaningful outcomes. These outcome measures must be concise, purposeful, and useful. They must get at real outcomes for real people. We are changing the emphasis from, “How did you spend the money?” and, “Did you spend the money according to the rules?” to, “How did you put the dollars to work?” and, “How did your consumers benefit?”

Through an internal data strategy workgroup we are conducting a thorough examination of our data collection and analysis systems. The goal is to take steps now to ensure that decisions related to SAMHSA's priorities are based on the most comprehensive and accurate information available.

As I mentioned previously, an essential component of SAMHSA's data strategy is development of “National Outcomes” and related “National Outcome Measures.” Through collaboration with the States we have identified a set of key domains. These domains are:

- (1) abstinence from drug use and alcohol abuse, or decreased symptoms from mental illness;
- (2) increased or retained employment and school enrollment;
- (3) decreased involvement with the criminal justice system;
- (4) increased stability in family and living conditions;
- (5) increased access to services;
- (6) increased retention in services for substance abuse treatment or decreased utilization of psychiatric inpatient beds for mental health treatment; and
- (7) increased social connectedness to family, friends, co-workers, and classmates.

As I mentioned, these national outcomes are already being implemented through the President's Access to Recovery program and the Strategic Prevention Framework.

Ultimately the National Outcomes will be aligned across all of SAMHSA's programs, including the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. The National Outcomes are an attempt to provide greater flexibility and accountability while limiting the number of reporting requirements on the State. Ultimately we are confident this approach will ensure the data collected is relevant and useful and helps to improve services for the people we serve.

Putting the data to work is a responsibility that SAMHSA is happy to shoulder. We can now clearly and definitively demonstrate that Federal investments in prevention and treatment are beneficial. Prevention works. Treatment works -- it helps people triumph over addiction and leads to recovery. The vital treatment and prevention efforts and

programs that I have discussed today are working to improve services for adolescents, and for people of all ages.

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

#### Brown Testimony

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Testimony

#### Introduction

Recent research supported by the National Institutes of Health and other agencies is leading to a common understanding about the critical role of age of onset of addictive disorders in their course, consequences and progression. Researchers are finding that these disorders often begin during adolescence and sometimes even during childhood; therefore early intervention may prevent many of the social, behavioral, health, and economic consequences caused by alcohol and drug abuse as well as provide an opportunity to treat problems before they become full blown and damage in the lives of our youth.

#### Early Onset

NIAAA and NIDA-supported researchers are finding that alcohol and other drug addictions commonly start earlier than previously understood, and the earlier youth start the greater the lifetime risk for dependence. New findings regarding early patterns of abuse and dependence dramatically underscore the importance of reducing underage drinking and drug use. As shown in Figures 1 and 2, the age of most prevalent tobacco dependence onset is 15 and for alcohol dependence age 18 is the most common period of first diagnosis of dependence. It is now clear that most cases of alcohol dependence begin before age 25. After that age, new cases drop off precipitously. The epidemiological research message is obvious: youth is a critical window of opportunity for preventing alcohol, tobacco and other drug disorders. Previous studies have suggested that this is so, but the new research findings, corroborated by independent sources, have confirmed these findings.

Ongoing research may reveal a cause-and-effect relationship between early use and subsequent dependence, or it may reveal that common biological and environmental factors drive the risk for both use and dependence, as well as other addictive and psychiatric disorders. In either case, these new data are a powerful indicator of the need

for more effective preventive interventions for youth.

Given the new epidemiologic findings, the fact that alcohol use is so widespread among children and adolescents is troubling. Alcohol is the primary substance of abuse among American children and adolescents.

- 47 percent of 8th graders, 67 percent of 10th graders, and 78 percent of 12th graders have used alcohol.
- 11 percent of 6th graders have reported binge drinking (5 or more drinks per occasion for males; 4 for females) in the past 2 weeks.
- 30 percent of high-school seniors have reported binge drink at least once a month.
- 44 percent of college students have reported binge drinking in the past 2 weeks.
- 23 percent have reported that they binge drink frequently.
- Youth who drink alcohol before age 14 are 4 times more likely to become alcohol dependent in their lifetime than those who wait until age 21 or older.

#### Neurodevelopmental Studies

A series of recent studies indicate that exposure to drugs of abuse during adolescence may produce more adverse effects than exposure during adulthood in part because of the important changes occurring in the brain during adolescent development. Advances in science have now brought us to a point where researchers can use new animal models, modern brain imaging technology and other neurobehavioral assessment tools to probe the effects of alcohol, tobacco and other drugs on the developing brain and determine immediate as well as its long-term behavioral consequences.

For example, as shown in Figure 3, emerging findings from neuroimaging studies demonstrate that brain structures change during adolescence to become more specialized and efficient in their functioning. Our developmentally focused research indicates important neurocognitive disadvantages among adolescents with alcohol and drug use disorders as compared to teens without substance involvement. For example, even after three weeks of abstinence, alcohol dependent youth display a 10% decrement in delayed memory functions (Figure 4). Neuropsychological testing of these youth followed up to eight years demonstrates that continued heavy drinking during adolescence is associated with diminished memory of verbal and nonverbal material, and poorer performance on tests requiring attention skills. Alcohol and drug withdrawal over the teen years appears to uniquely contribute to deterioration in functioning in visuospatial tasks. Recent brain imaging studies of alcohol and drug using youth compared to youth without such experience have also shown reduced hippocampal volumes, white matter microstructure irregularities, and brain response abnormalities while performing cognitive tasks among those with early alcohol/drug exposure. Additionally, youth who have extensive experience with alcohol have increased brain response when viewing alcohol advertisements compared to other beverage advertisements.

Animal studies are consistent with the findings that alcohol or drug exposure during

adolescence has more adverse consequences than delayed (adult) exposure. In these investigations, adolescent alcohol exposure is associated with more frontal lobe damage and poorer spatial memory. Further research is needed to understand how age of drinking or drug use onset and duration of abstinence at the time of assessment affect cognitive and behavioral findings. Longitudinal studies are needed to clarify neuromaturational changes associated with early alcohol and drug exposure and patterns of resiliency. Although the magnitude of effects observed in adolescents' neurocognition is modest, the implications are major given the prevalence of alcohol involvement, and the important educational, occupational, and social transitions that occur during adolescence.

These new directions in adolescent research will help to inform us on important aspects of cognition, decision-making, motivation, emotional regulation, and risk perception during adolescence, and will help us determine how these factors play a role in the use and consequences of alcohol and drugs. Armed with new knowledge about how adolescents make decisions, control their impulses and desires, and what motivates their behavior, researchers and agencies will be poised to design better preventions and interventions to reduce alcohol, tobacco and other drug experimentation, abuse and dependence, as well as other risky behaviors. Adolescents have in common unique neurobiological and neurocognitive developmental factors that affect risk and resiliency vis-à-vis substance use. Few studies have addressed these developmentally specific neurobiological and neurocognitive mechanisms and consequences of heavy drinking/use in this group despite the importance of these for long-term development.

#### Vulnerability

While early initiation of substance involvement is a powerful predictor of subsequent dependence, not everyone who uses at a young age later develops abuse or dependence. Even among youth with two alcoholic parents, only about one-half become alcohol dependent. The outcome is determined largely by the interplay of environmental and genetic/biological factors.

Environmental factors have the biggest influence on whether a child first uses alcohol, tobacco or other substances. However, genetic factors have an influence on whether a child continues to use. Understanding how these factors result in initiation and continuation of use or make resolution of drinking/drug use more difficult is essential to disrupting the developmental process of addictive behavior. Thus, a focus on genetic/biological aspect of use may clarify how variations in genes result in differences in how our bodies absorb, distribute, and eliminate substances and variability in tolerance.

#### Binge Drinking

Binge drinking, episodes of heavy drinking (5 or more drinks for males; 4 or more drinks for females), is a problem for people in any age group, whether or not the drinker is addicted to alcohol. An alarming number of children and adolescents binge drink and that it is increasing. Drinking too much, too fast in this manner carries additional risks especially for youth. They include car crashes, injury, death, property damage, encounters with the justice system, and family, school, and workplace problems. Each drink

increases the fatal crash risk more for youth than adults. At a blood alcohol level of 0.08% in every age and gender group there is at least a 11-fold increase in single vehicle fatal crash risk. Among males 16-20 at a blood alcohol level of 0.08% there is a 52-fold increase in single vehicle crash risk compared to sober drivers the same age.

Epidemiology studies have shown beyond doubt that genes play a role in risk of alcohol, tobacco and other drug dependence. Research toward discovering which genes are involved, what biochemical pathways they influence in brain cells, and how these pathways translate into specific behaviors is the next step to this line of investigation. Such findings provide information about genetic/molecular events in the brain that influence use, and provide potential targets for pharmacological intervention. For example, new findings about a naturally occurring marijuana-like substance in the brain also provide potential new molecular targets for pharmacological intervention.

#### Prevention of Abuse and Dependence

Prevention of alcohol and substance use problems among youth need to be understood as a continuum of services and consequently research needs to span this continuum. This continuum ranges from universal prevention (those appropriate for all children and adolescents who might use alcohol, tobacco or other drugs) to selective preventative measures for subgroups with risk factors for abuse or dependence, to indicated preventative measures for those individually at high risk for the disorder. Preventive interventions for alcohol, tobacco, and other drug use disorders and related problems can be improved through early detection and diagnosis, and through testing of new behavioral strategies at the individual, family, and community levels. Of particular interest are longitudinal data on children entering the age of risk, adolescents and young adults in high-risk environments (college and the military), youth who resolve use/problems without formal treatment, and women of childbearing age. New interventions to prevent early-onset of use can be gleaned through studies that identify developmental and environmental features as well as biological factors that stimulate or suppress addictive behavior.

It is important to evaluate prevention programs on an ongoing basis as well as disseminate research findings to communities, educators, parents, and health care providers who are the first line of defense against alcohol, drugs and other risky behaviors. Both NIAAA and NIDA offer free educational materials designed to help students learn about the impact of alcohol and drugs on the brain and body. Parents, educators, and community leaders can use these materials to help guide their thinking, planning, selection, and delivery of drug abuse prevention programs at the community level. NIAAA and NIDA also have websites that offer science-based information specifically designed for teens. The Leadership to Keep Children Alcohol-Free has recruited 33 Governors' spouses to spearhead a national prevention campaign which influences both public policy and local practices. The Task Force on College Drinking has brought together university presidents and researchers, and is making headway in efforts to reduce the seemingly intractable problem of drinking by college students.

Clearly, alcohol and substance use disorders are the result of a complex combination of

genetic and environmental interactions that influence how people respond to the substance and their initial propensity for using alcohol and drugs. Longitudinal studies of these genetic and environmental factors are crucial for understanding (1) early initiation of drinking and drug use, (2) transition to harmful use, abuse, and dependence, and (3) remission and abatement of alcohol and drug related problems in untreated populations. This is particularly critical for youth as some resolve problematic use without treatment and research in this area can teach us how to facilitate changes in alcohol and drug involvement in ways that are most developmentally appropriate and acceptable to youth. Developmentally specific research in these areas has potential to help identify mechanisms of vulnerability and protection which can be used in prevention.

#### Improving Effectiveness of Treatment

Findings from the National Household Survey on Drug Abuse indicate that about 10 percent of 12- to 17- year-olds (about 2.3 million) are heavy users of alcohol or drugs, yet only 187,000 (8%) received services. Although estimates of the cost-effectiveness of early intervention are speculative, research suggests that early treatment has the potential to be cost-effective, especially in comparison with incarceration or treatment for a long-term abuse problem. For instance, cost benefit research on drug and alcohol treatment generally (Office of National Drug Control Policy, 2001) suggest that the range of savings is between \$2.50 and \$9.60 for every dollar spent on treatment. Unfortunately, only one person in seven who would qualify for treatment was admitted to treatment in 1999 (National Institute on Drug Abuse Community Epidemiology Work Group, 1999). The proportion of youth who are admitted to treatment is even smaller.

Much progress has been made in developing behavioral/psychosocial interventions for alcohol and other substance use disorders, but much remains to be investigated. Controlled research trials provide evidence that several psychosocial treatment approaches may be effective in reducing alcohol and other drug use while also improving associated behavioral, familial, and psychosocial outcomes. These outcomes are enhanced when a combination of modalities are offered in a comprehensive, integrated treatment plan that addresses alcohol and drug abuse and a broad range of biopsychosocial problems, skills deficits, and comorbid psychiatric problems. For example, having families involved in the treatment program increases the likelihood of success in youth. Brief Strategic Family Therapy (BSFT) and Cognitive Behavioral Interventions are examples of promising youth specific treatment already in the field. The evaluation and dissemination of more evidence-based interventions in a variety of community venues, including schools, healthcare settings, and prisons, should be a high priority. Developing, evaluating, and improving efficacy and cost-effectiveness of treatments is a central goal in alcohol, tobacco and drug research. Adolescent focused treatment research lags behind adult treatment research. Studies are needed to develop and test new behavioral therapies; conduct clinical trials in existing treatment settings, examine cost-effectiveness of behavioral and pharmaceutical therapies; clarify mechanisms of action that make effective treatments successful; and conduct trials of dissemination strategies, to test how effective they are at introducing behavioral and pharmacological treatments into real-world clinical practice.

Alcohol, tobacco and other drugs affect genders and subpopulations differently, and some groups suffer more adverse effects of alcohol, tobacco and drugs than other groups. For treatment of these youth problems to be optimally effective, research to study the role of gender, ethnicity, socioeconomic status, and other variables in determining the effects of various substance abuse interventions is sorely needed. For example, we need to support studies on specific facilitators and barriers to alcohol and drug treatment in minority and rural populations.

Clearly multifaceted longitudinal research is sorely needed to fully understand the development and resolution of alcohol and drug use disorders in the context of child and adolescent development. Through such focused process research (e.g., changes in brain structure and recovery of functioning, decision making process, social and family dynamics) can improved prevention and intervention policies emerge.

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Weissberg

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Testimony

Good morning, Chairman DeWine, Senator Kennedy, and members of the Subcommittee. Thank you for inviting me here today to comment from my 30-year perspective as a psychologist, prevention researcher, and practitioner addressing the challenges facing school and other community-based prevention programs as they work to prevent youth substance abuse.

I am Roger Weissberg, Professor of Psychology and Education at the University of Illinois at Chicago, where I direct a Prevention Research Training Program in Urban Children's Mental Health and AIDS Prevention funded by the National Institute of Mental Health. I also serve as President of the Collaborative for Academic, Social, and Emotional Learning (CASEL), an organization dedicated to the development of children's social-emotional competencies and the capacity of schools, parents, and communities to support that development. CASEL's mission is to establish integrated, evidence-based social and emotional learning (SEL) as an essential part of preschool through high school education (see [www.CASEL.org](http://www.CASEL.org) for information on advances research and practice in this area).

Recently, I co-edited a Special Issue of the American Psychologist on "Prevention that Works for Children and Youth" (Weissberg & Kumpfer, 2003). The articles in the Special Issue are an outgrowth of an American Psychological Association Presidential Task Force on "Prevention: Promoting Strength, Resilience, and Health in Young People" that I co-chaired. The task force members concluded that prevention research has matured substantially in recent decades, synthesizing new knowledge and offering important findings to guide prevention practice and policy. Part of my testimony will highlight some common features of effective prevention programming identified by scholars representing diverse perspectives. I am pleased to emphasize that there is great overlap between our views and the principles emphasized in the new Strategic Prevention Framework to advance community-based programs for substance abuse prevention and mental health promotion announced by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In Part I of this testimony, I briefly introduce findings about trends in adolescent substance use and other risky behaviors and comment on the implications of these findings for coordinated prevention and youth-development programming. In Part II, I review results from recent large-scale studies and reviews on effective school-based prevention programs. Part III presents some of the challenges and difficulties that schools

face in administering school-based prevention programs. In Part IV, I share with you some of the work CASEL is doing to reduce the gap between research and practice. In the last part, I comment on SAMHSA's "Strategic Prevention Framework" as a powerful tool towards collaboration and coordination among multiple prevention programs.

## I. Trends in Adolescent Substance Use and Other Risky Health Behaviors

The news regarding recent national trends in adolescent substance use is mixed. Perhaps the simplest set of headlines is "During the past 12 years, tobacco and alcohol use has declined; marijuana, cocaine, and illegal steroid use has increased; and, overall, too many students engage in all forms of substance use." To support this summary, I highlight some findings recently reported by the Centers for Disease Control and Prevention (CDC) from the 2003 Youth Risk Behavior Surveillance System ([www.cdc.gov/yrbss](http://www.cdc.gov/yrbss)). The National Youth Risk Behavior Survey is conducted every two years during the spring semester and provides data gathered from students in grades 9-12 in public and private schools throughout the United States. The chart below summarizes changes in percentages of self-reported substance use between 1991 and 2003.

Behavior 1991 2003

Lifetime cigarette use 70.1 58.4  
Current cigarette use (last 30 days) 27.5 21.9

Lifetime alcohol use 81.6 74.9  
Current alcohol use (last 30 days) 50.8 44.9  
Episodic heavy drinking (last 30 days) 31.3 28.3

Lifetime marijuana use 31.3 40.2  
Lifetime cocaine use 5.9 8.7  
Lifetime illegal steroid use 2.7 6.1

Defying some commonly held stereotypes, substance use crosses geographic and economic boundaries. For example, studies comparing substance use between adolescents from affluent suburban versus low-income urban families show that high rates of teens from affluent families use substances (Luthar & Becker, 2002; Levine & Coupey, 2003). Such findings speak to the importance of universal (i.e., targeting all children) rather than selective approaches to prevention. Targeting only selective groups of children and youth in our prevention efforts may result in ignoring substantial numbers of children and youth who are in urgent need of prevention programs. Some may argue that broadly targeted prevention programming may not be appropriate for at-risk groups. However, research findings suggest that as long as we provide programs with fidelity, that is, implement them in a way that is faithful to the original program design, most programs are equally beneficial for all students (Griffin, Botvin, Nichols, & Doyle, 2002). Furthermore, Caulkins and his colleagues (2002) recently examined whether the benefits of a model school-based prevention program exceed its costs. According to their

best estimates, they concluded that society would currently realize quantifiable benefits of \$840 from a student's participation compared with a program cost of \$150 per participating student, a saving of almost \$6 for every \$1 invested.

It may sound as though I am making an argument that early and effective substance abuse prevention for young people should be our highest priority. But, actually, I will argue that a broader perspective is needed. Preventing substance abuse is a worthy endeavor, but it is a limited goal. It is indisputable that young people who are not drug abusers may still lack the resources to become healthy adults, caring family members, responsible neighbors, productive workers, and contributing citizens (Pittman, Irby, Tolman, Yohalem, & Ferber, 2001). In addition to having drug-free sons and daughters, parents across the United States want children who:

1. are intellectually reflective and committed to lifelong learning;
2. interact with others in socially skilled and respectful ways;
3. practice positive, safe, and healthy behaviors;
4. contribute ethically and responsibly to their peer group, family, school, and community; and
5. possess basic competencies, work habits, and values as a foundation for meaningful employment and engaged citizenship.

Although the prevalence of substance use calls for action, there is also reason for concern about high rates of related adolescent risk behaviors in domains such as violence, sexual behavior, depression, and suicide. Consider the following percentages of student involvement in problem behaviors from the 2003 CDC Youth Risk Behavior Surveillance System:

#### Behavior 2003

Threatened or injured with a weapon on school property (last 12 months) 9.2

Engaged in a physical fight on school property (last 12 months) 12.8

Currently sexually active (last 3 months) 34.3

Had 4 or more sex partners (lifetime) 14.4

Felt so hopeless almost every day two weeks or more in a row that they stopped doing some usual activities (last 12 months) 28.6

Made a suicide plan (last 12 months) 16.5

Attempted suicide (last 12 months) 8.5

When we look at the broader picture of adolescent functioning, it is clear that, beyond substance use, significant percentages of young people experience mental health problems, engage in other risky behaviors, and lack social-emotional competencies. The 1999 Surgeon General's report on mental health indicated that 20% of children and adolescents experience the symptoms of a mental disorder during the course of a year, and that 75-80% of these children do not receive appropriate services (U.S. Department

of Health and Human Services, 1999). Dryfoos (1997) estimated that 30% of 14 to 17 year-olds engage in multiple high-risk behaviors, and that another 35%, considered to be at medium risk, are involved with one or two problem behaviors. Approximately 35% have little or no involvement with problem behaviors, but even these young people require strong and consistent support to avoid becoming involved.

Such a constellation of multiple high-risk behaviors points to the importance of moving beyond the problem-focused approach and especially beyond targeting only one problem behavior at a time. Ripple and Zigler (2003) argued that such approaches fail to take into consideration the complicated etiology of individual target problems and the significant overlap of multiple problems. The design of prevention programs should be guided by the theoretical knowledge on risk and protective factors commonly underlying multiple problem behaviors. Furthermore, programs should not merely aim at reducing risk conditions; they also should explicitly promote personal and environmental assets that will decrease problem behaviors and, more important, serve as foundations for healthy development (Greenberg et al., 2003; Kumpfer & Alvarado, 2003; Wandersman & Florin, 2003).

In assessing the functioning of young people and families, I draw three major conclusions that have relevance for prevention policy and practice. First, a significant proportion of children will fail to grow into contributing, successful adults unless there are major changes in the ways they are taught and nurtured. Second, families and schools must work together more systematically and effectively to enhance the social-emotional competence, character, health, and academic learning of all children. Finally, new kinds of community resources and arrangements are needed to support the positive development of young people into responsible, healthy, productive workers and citizens.

## II. Principles of Effectiveness Based on Meta-Analyses and Large-Scale Reviews of Prevention Programs

The No Child Left Behind Act has prompted heightened awareness of educational accountability as well as the need for evidence-based programs to improve student performance. Federal and state government agencies are mandating that only programs proven to be effective should receive public funds. Due to significant advances in prevention science, there have been increasing efforts to identify effective prevention programs and the characteristics that underlie such programs (Nation et al., 2003).

A number of institutions, both public and private, including the Centers for Disease Control and Prevention, the Center for Substance Abuse Prevention, the Office of Juvenile Justice and Delinquency Prevention, the U.S. Department of Education, and CASEL have put forth lists of model programs. However, there have been growing concerns about the gap between scientific knowledge about prevention programs and actual practice (Wandersman & Florin, 2003). Therefore, with the intention to inform practitioners about the availability and characteristics of effective programs, several researchers have conducted reviews and meta-analyses of prevention programs. These studies have yielded noteworthy principles of successful prevention programming

(Catalano et al., 2002; Durlak, 1998; Eccles & Appleton, 2002; Greenberg, Domitrovich & Bumbarger, 2001; Kumpfer & Alvarado, 2003; Nation et al., 2003; Tobler, 2000; Wilson, Gottfredson, & Najaka, 2001).

In their meta-analysis of 207 universal prevention programs published between 1978 and 1998, Tobler et al. (2000) found that programs that only emphasized information and lacked an interactive approach were minimally effective. Among three types of programs categorized under interactive approaches—interpersonal skills training programs, comprehensive life skills training programs, and school-wide restructuring programs—system-wide restructuring showed the strongest impact. As researchers have consistently pointed out, thoughtful school-based prevention and youth development interventions should enhance students' personal and social assets and at the same time improve the quality of the environments in which students are educated (Catalano et al., 2002; Eccles & Appleton, 2002; Greenberg et al., 2003). Given that peer social influences are the most salient determinant of substance use, no one will doubt the crucial role that refusal skills (the ability to “say no” and mean it) play in preventing teens from using tobacco, alcohol, and other substances. However, skills training alone is not sufficient. Considering that many youth involved in substance use lack a sense of connectedness to school and family, instruction of skills and knowledge should take place in tandem with changes in school-wide culture that help children feel more engaged, safe, and supported.

Weissberg, Kumpfer, and Seligman (2003) highlighted six characteristics of effective prevention programming across school, family, and community levels for young people:

1. Uses a research-based risk and protective factor framework that involves families, peers, schools, and communities as partners in coordinated programming that targets multiple outcomes;
2. Is long-term, age-specific, and culturally appropriate;
3. Fosters development of individuals who are healthy and fully engaged by teaching them to apply social-emotional skills and ethical values in daily life;
4. Aims to establish policies, institutional practices, and environmental supports that nurture optimal development;
5. Selects, trains, and supports interpersonally skilled staff to implement programming effectively; and
6. Incorporates and adapts evidence-based programming to meet local community needs through strategic planning, ongoing evaluation, and continuous improvement.

Despite advances in scientific knowledge about ways to make prevention programs effective, there still is wide gap between research and practice—what we know and what we do. In the case of school-based prevention programs, many schools still do not use programs of proven effectiveness (Gottfredson & Gottfredson, 2001). Even when schools select research-based programs, the majority of them report that they do not implement those programs with fidelity. Bolstering the quality of schools so that they work effectively with families to foster both the social-emotional development and academic performance of all students must be the top priority of any comprehensive prevention strategy for young people (Osher, Dwyer, & Jackson, 2002).

### III. Barriers to Successful Implementation of School-Based Prevention Programs

Several observations can help to explain the disparity between research and practice. Taken together, they represent a set of barriers to the successful implementation of beneficial school-based prevention programs.

First, there is widespread fragmentation and lack of coordination among prevention programs. In most cases, schools are flooded with programs covering such topics as character education, substance abuse prevention, and HIV/AIDS awareness, with no effort to coordinate what are in fact closely interrelated realms. No matter how many prevention programs schools have, those programs are not likely to achieve their intended effects as long as they are introduced in a piece-meal and uncoordinated manner.

A second challenge is the lack of administrator-teacher support and professional development opportunities. Bombarding principals and teachers who are already overburdened by academic duties with a succession of new programs with minimum support and guidance is likely to raise educators' resistance and ultimately result in ineffective program results. As seen in the work of Osher et al. (2002) and Adelman and Taylor (2000), for a prevention program to achieve maximum impact, the entire school community should embrace the program's mission and goals, thereby changing whole school culture. However, without the ownership of the school community, active leadership of administrators, and high-quality implementation by teachers and student-support staff, the program is not likely to be successful.

A third challenge is the lack of an accountability system. I have already noted that the majority of the programs are not implemented with fidelity. The problem is exacerbated by the absence of accountability systems through which both the implementation and the impact of a prevention program is assessed and shared publicly in an ongoing fashion. Therefore, to achieve faithful and successful implementation of prevention programs, we should adopt accountability systems for children's social-emotional development and health with the same vigor as we do for their academic performance.

### IV. The Social and Emotional Learning Framework: Bridging the Gap Between Science and Practice

In 1994 a group of educators, school-based prevention researchers, and child advocates came together to address the ineffective nature of so many prevention and health promotion efforts. The result was the formation of the Collaborative for Academic, Social, and Emotional Learning (CASEL). Since its inception, CASEL has been working toward the goal of establishing social and emotional learning (SEL) as an essential element of education from preschool through high school. SEL is the process of acquiring the skills to recognize and manage emotions, demonstrate caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. SEL is fundamental to children's social and emotional development, health and mental well-being, ethical development, citizenship, motivation

to achieve, and academic learning.

Developmentally and culturally appropriate SEL-focused classroom instruction in the context of a safe, caring, well-managed, and participatory school environment enables young people to learn, practice, and apply SEL skills. It also enhances students' connection to school through caring, engaging classroom and school practices. Learning social and emotional skills is similar to learning other academic skills in that the effect of initial learning is enhanced over time to address the increasingly complex situations children face. SEL outcomes are best accomplished through effective classroom instruction; student engagement in positive activities in and out of the classroom; and broad student, parent, and community involvement in program planning, implementation, and evaluation. Ideally, planned, systematic SEL instruction should begin in preschool and continue through high school. We at CASEL believe that the rationale for SEL can serve as a powerful framework to facilitate coordination and integration of multiple fragmented prevention efforts (Greenberg et al., 2003) and thus address more effectively some of the most pressing problems facing prevention and health promotion programs today.

There is growing evidence that school-based SEL programming can successfully enhance students' academic performance as well as reduce substance use and address other problem behaviors (Greenberg et al., 2003; Zins, Weissberg, Wang, & Walberg, 2004). In spite of the fact that most schools' mission statements embrace the notion of the whole child, most schools do not make systematic efforts to institutionalize promotion of social and emotional competencies and creation of environments supporting their development.

CASEL believes that schools should explicitly address children's social and emotional development as an educational priority. We are conducting a variety of activities to help educators and prevention professionals create and sustain more effective approaches to prevention programming. These activities include:

- Disseminating scientific knowledge about the conceptual framework for SEL and evidence-based SEL programs through CASEL's publications, web site, and monthly electronic newsletters;
- Providing support and technical assistance for the pre-service and in-service training of teachers and administrators to ensure fidelity and sustainability of school-based SEL prevention programs;
- Promoting school-family-community partnerships; and
- Developing and facilitating local, state, and national networks of educational leaders who are concerned about effective prevention and positive youth development programming

At the state level in Illinois, our Governor recently signed the Children's Mental Health Act of 2003 (Public Act 93-0495). Section 15 (Mental Health and School) requires the following:

1. The Illinois State Board of Education shall develop and implement a plan to

incorporate social and emotional development standards as part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.

2. Every Illinois school district shall develop a policy for incorporating social and emotional development into the district's educational program. The policy shall address teaching and assessing social and emotional skills and protocols for responding to children with social, emotional, or mental health problems, or a combination of such problems, that impact learning ability.

CASEL is currently working with the Illinois State Board of Education and the Illinois Children's Mental Health Partnership to implement this legislation. The Illinois effort can serve as a national model for fostering educational systems that focus on student competencies that serve as foundations for successful academic performance, health, character, and citizenship.

At the national level, CASEL trains school building-level and school district-wide coordinators who support the implementation, evaluation, and continuous improvement of evidence-based school safety and substance use prevention programs. Specifically, we, as a team with three other groups (the American Institutes for Research, the Education Development Center, and the National Association of School Psychologists) provide training and technical assistance to the National and Middle School Prevention Coordinators under the Office of Safe and Drug-Free Schools in the U.S. Department of Education. The coordinators play a critically important role in their schools and districts by ensuring successful implementation of evidence-based programs. Their roles include: (1) integrating and coordinating multiple programs, (2) conducting needs assessments and establishing baseline data related to prevention and youth-development programming, (3) conducting implementation and outcome assessments, and (4) overseeing and facilitating prevention-related school staff development.

We applaud the Office of Safe and Drug-Free Schools for its effective leadership in conceptualizing and advancing efforts to train and support Safe and Drug-Free School Coordinators. Given the crucial role that they play in successful implementation of programs and the host of tasks for which the coordinators are responsible, more funding should be provided for training the coordinators and selecting and hiring more individuals to join in this important endeavor. For school-based prevention to succeed, it is crucial that districts and schools have staff members who are explicitly responsible for assuring the selection, effective implementation, coordination, evaluation, and continuous improvement of evidence-based programming.

Another important avenue for informing and supporting educators to implement research-based SEL programming is through the Regional Education Laboratories. CASEL is effectively collaborating with the Mid-Atlantic Regional Educational Laboratory for Student Success at Temple University to disseminate information and provide supports to thousands of educators who implement school-family prevention programming (CASEL, 2003; Zins et al., 2004).

## V. Toward Further Collaboration and Coordination: The SAMHSA Strategic Prevention Framework

In recent years, SAMHSA has provided groundbreaking and high-quality national leadership in translating rigorous science into effective practice. For example, through its Model Programs initiative, Training and Technical Assistance Centers, and informative publications, SAMHSA has focused on making sure that the highest quality, evidence-based programs are provided effectively and broadly to American children and families. Given the common risk and protective factors for substance abuse and mental health problems, it is good to see increased coordination between CSAP and CMHS so that their science-based interventions focus simultaneously on the fundamental and common factors that influence both types of outcomes. The best payoff from these efforts will come from programming that begins in early and middle childhood and works with schools, families, and communities to create integrated systems of prevention and treatment in which prevention is seen as the front line of defense to reduce the number of new cases as well as an important offensive strategy to enhance the competence of all young people.

SAMHSA has recently announced that it will provide \$45 million to support states in implementing the new “Strategic Prevention Framework (SPF)” to prevent substance abuse and promote mental health. The Framework is based on the belief that effective prevention programs must (1) involve individuals, families, and entire communities, (2) acknowledge the importance of health promotion as well as problem prevention, (3) emphasize common risk and protective factors among multiple problems, and (4) have accountability systems through which program implementation and impact are monitored in an ongoing fashion.

The SPF recognizes the lack of collaboration and coordination among multiple prevention efforts and the absence in too many cases of a comprehensive theoretical framework. I applaud SAMHSA for creating this comprehensive framework. It has tremendous potential to, in SAMHSA’s own words, “bring together multiple funding streams from multiple sources to create the true cross-program and cross-system approach that health promotion and disease prevention demand.”

The newly proposed SAMHSA Framework will facilitate collaboration among different prevention programs in multiple settings that include schools, families, and communities, a crucial component for effective prevention strategies. SAMHSA’s strategic planning represents an exciting set of directions, but their prevention initiatives require new and substantial funds if we are to reduce significantly the number of young people who develop substance abuse and mental health problems. I urge you to provide more funding for SAMHSA’s prevention efforts. In addition, I hope that you will encourage stronger interagency linkages between federal agencies - such as the U. S. Department of Education, SAMHSHA, and the National Institutes of Health - both to improve practice and to understand factors that influence high quality dissemination and utilization of effective prevention programs and policies.

Once again, thank you, Mr. Chairman and Senator Kennedy for the opportunity to present this testimony and for holding this timely hearing. I would be glad to answer any questions the subcommittee may have.

Ramsey-Molina

Providing Substance Abuse Prevention and Treatment Services to Adolescents

Bill Number:

Hearing Date: June 15, 2004, 10:00 am

Location: SD-430

Witness:

Rhonda Ramsey-Molina

Coalition for a Drug-Free Greater Cincinnati, Cincinnati, Ohio

President/CEO

Testimony

Good Morning Chairman DeWine and other distinguished members of the subcommittee. My name is Rhonda Ramsey Molina and I serve as the President of the Coalition for a Drug Free Greater Cincinnati.

The Coalition for a Drug Free Greater Cincinnati was founded in 1996 by Congressman Rob Portman as an effort to mobilize all sectors of the community to address adolescent substance abuse and the effects on neighborhoods throughout Greater Cincinnati. Our mission – promoting drug free environments for youth and mobilizing and supporting local anti-drug coalitions – is served through implementation of multiple strategies through multiple sectors aimed at changing community norms, attitudes and standards of conduct. Hailed as a national model for coalitions with its innovative approach to adolescent substance abuse, the Coalition has grown dramatically since its inception to include 31 local coalitions in neighborhoods throughout Greater Cincinnati.

I begin my testimony by sharing a brief story of why I am committed to coalitions as an integral part of adolescent substance abuse prevention and treatment.

Several years ago, prior to joining the coalition field, I provided direct services to children of chemically dependent parents within the city of Cincinnati. One day with a group of five fourth grade little girls who were all daughters of single, crack addicted mothers, I realized the importance of coalitions. One of the girls in the group stated, “When I grow up I am not going to use drugs.” She said, “When I grow up I am going to have a baby, then get married and my boyfriend is going to sell drugs so I can be rich.” Astonished by her thought pattern, I took a deep breath and step back and shared with her that it is against the law to sell drugs. I asked her what happens to people who sell drugs. She stated, “They go to jail for thirty or ninety days then they get out and you have a party.” Again, astonished by her thought process, I said that that may be what your boyfriend does to make money, but what do you want to do. Come to find out, she wanted to be a heart surgeon. Recently, her grandfather, the only constant, positive male influence in her life, had died of a heart attack and she wanted to help people like her grandfather who had sick hearts.

The reality is that any program, provided only once a week for fifty minutes over a ten-week period, while valuable, is not able to address the larger community issues that adolescents face the other 23 hours a day they are not participating in the program. Direct service programs focus on individuals, not the community at large. The messages adolescents receive in their community are not necessarily the same messages they receive in the program.

- Coalitions address the community at large. In an effort to support every child and enhance the effectiveness of individual programs, coalitions build a community consensus of non-use so that youth receive a consistent message regardless of what system they interact with in the community.

- Coalitions develop a broad base of support and collaboration. They convene the energy and resources of multiple sectors to enhance the effectiveness of individual approaches. Congressman Rob Portman initiated the Coalition in Cincinnati because he realized that he could not simply legislate away the drug problem from Washington. He needed to partner with the community at large so that together we could attack the issue from all sides. We could collaboratively legislate, educate, recreate, arrest, intervene, treat, etc. We mobilize more talents, resources and approaches to influence an issue than any single organization could achieve alone.

- Coalitions implement data driven planning processes to define the issue within their community and then program accordingly.

In 1996 the Coalition For a Drug Free Greater Cincinnati implemented the Student Drug Use Survey in an effort to provide the region the most current and reliable source of validated information on youth substance abuse. In 2004, this survey gathered drug use data from nearly 70,000 seventh through twelfth grade students in Greater Cincinnati.

- Data from this survey and other surveys were used to identify key risk and protective factors present in Greater Cincinnati and to develop a comprehensive community plan to address the issues using strategies that enhance protective factors and reduce risk factors.

The community plan is implemented through partnerships and collaboratives with the many partners who make up the coalition

Example - Linda Verst, a prevention specialist, partnered with the Coalition to sponsor community roundtables to assess community needs regarding adolescent substance abuse treatment. In a large, rural geographic area of Northern Kentucky, treatment services were scarce and needs were going unmet. The roundtables promoted the spirit of collaboration among providers who in turn shared resources and planned cooperatively. This resulted in increased access to adolescent substance abuse treatment throughout Northern Kentucky.

- Given their collaborative approach, coalitions are uniquely positioned to plan and implement a diverse set of strategies to change community norms, attitudes and standards of conduct.

Example - Tamie Sullivan, a parent in the community, chaired our Parent Task Force and facilitated the implementation of the "Strong Voices, Smart Choices" parent education campaign. This campaign partnered with businesses, doctors, pharmacies, the local media, and the Ohio National Guard to put parenting tips into the hands of over

750,000 parents in Greater Cincinnati. The campaign changed community attitudes and norms. Middle school parents often pull away from the issue at this critical time, this campaign under Tamie's leadership, changed the standard so that the expectation is that parents become increasingly involved during the middle school years. The result, a 57% decrease in drug and alcohol use among youth who report that parents talk to them and set clear rules regarding substance abuse.

- The coalition focuses on increasing protective factors and decreasing risk factors. And we are moving the needle.

Examples of measurable impact♣ (see attached table)

Rob Matteucci, a Vice President at Procter♣ & Gamble volunteers to oversee the implementation of the anti-drug media campaign in our market. The result, a 12% decrease in drug use among youth who have seen or heard anti-drug advertisements.

Mike Hall, Principal at a local high♣ school, partners with businesses, a local hospital and professional athletes in Greater Cincinnati to implement the "Coaches, Kids and Chemicals" program. Over 1200 coaches, principals and athletic directors have been trained to incorporate substance abuse prevention into their athletic programs. The result, a 34% decrease in drug and alcohol use among youth involved in school sports.

♣ Pastor Wilkins, Chair of the Faith Community Alliance, partners with local service providers and other faith leaders to implement the "Reviving the Human Spirit", a faith-based initiative aimed at increasing the effectiveness of faith based programs in our region. The result, a 55% reduction in drug and alcohol use among youth involved in these programs.

Marty Herf, with the Ohio♣ Bureau of Workers Compensation worked with the Drug Free Workplace Task Force to convene local businesses, EAP (Employee Assistance Program) providers and state representatives to implement the "Say Yes To A Drug Free Workplace" program. This program initiated the creation of a statewide incentive for businesses who implement a qualified drug free workplace program. The result, southwest Ohio has the highest percentage of drug free workplaces in the state.

By working through multiple systems within the community to address adolescent substance use and abuse the Coalition for a Drug Free Greater Cincinnati has positively impacted the issue. All of the strategies that have been implemented to enhance protective factors, that the Coalition has organized the community around, have become increasingly more effective for the last six years. And, for the first time in over a decade, drug use is declining in Greater Cincinnati. In fact, for the first time since the 80's, data indicate that less than 20% of the combined seventh through twelfth population are 30-day users of alcohol, tobacco and marijuana.

I am a firm believer in the power of communities to reduce the use and abuse of illicit drugs and alcohol among adolescents. Communities that attack their drug problems in a comprehensive way, involve as many individuals, groups and institutions as possible have the greatest likelihood of success. With such strong coalitions working to convene the community to work collaboratively, Southwest Ohio boasts adolescent use rates that are significantly lower than state and national averages, which are also declining. Additionally, we see much greater reductions, by as much as 41%, in adolescent drug and

alcohol use in communities where strong coalitions exist than in control communities where there are no coalitions.

**REDUCTION IN MONTHLY USAGE OF CIGARETTES, BEER AND MARIJUANA  
SEVENTH THROUGH TWELFTH GRADE COMBINED**

	2000	2004	% Reduction
Tobacco	21	15	29%
Marijuana	15	13	13%
Alcohol	30	19	37%

\*Self-reported by Students in Grades 7-12 in CDFGC/Pride Survey

## REDUCTION IN MONTHLY USAGE OF CIGARETTES, BEER AND MARIJUANA AS A FUNCTION OF KEY PROTECTIVE FACTORS

### PROTECTIVE FACTOR\* AVERAGE REDUCTION IN USAGE\*\*

Attending Church or Synagogue 55%  
Participating in Sports 34%  
Viewing Anti-Drug Commercials 12%  
Parents Talking and Setting Rules 57%

\*Self-reported by Students in Grades 7-12 in CDFGC/Pride Survey

\*\* Average reduction for Cigarettes, Beer and Marijuana Monthly Usage. Reduction is the percent change in monthly usage among those who participated in protective factor "A Lot" or "Often" as compared to "Rarely" or "Never".

Anton

Providing Substance Abuse Prevention and Treatment Services to Adolescents

Bill Number:

Hearing Date: June 15, 2004, 10:00 am

Location: SD-430

Witness:

Ronald P. Anton, LCPC, MAC

Day One, Cape Elizabeth, Maine

Director of Juvenile Justice and Community Programs

Testimony

Introduction

Chairman DeWine and members of the Subcommittee, thank you for the opportunity to present testimony on behalf of Day One, the Maine Association of Substance Abuse Programs, and the State Associations of Addiction Services, a national organization of state alcohol and drug abuse treatment and prevention provider associations whose mission is to ensure the availability and accessibility of quality drug and alcohol treatment, prevention, education, and related services. Day One has been making a difference in the lives of youth for over 30 years. Our spectrum of Care provides prevention, intervention, treatment and aftercare services for youth and their families throughout Maine. Today, we are Maine's premier agency dealing with adolescent substance abuse and we are respected as a resource and authority in the field. Our innovative programs and collaborative ethos provided adolescents, parents, schools and communities the training, treatment, and support needed to bring hope, healing and recovery to Maine youth and their families. Our mission is to dramatically reduce substance abuse among Maine youth to help them live productive, healthy, and rewarding lives.

Overview

We would like to present you with information about adolescent treatment in Maine and to share with you highlights of Day One's Juvenile Treatment Network, our "voucher system" for adolescent services. But first, here is some information about our state.

Maine is a frontier state with a population of approximately 1.2 million and geographically the size of all of the rest of New England combined. Maine has the largest county east of the Mississippi River (equal to the size of Connecticut and Rhode Island combined), and this county is in the most northern and rural part of the state. Maine's Office of Substance Abuse (the state's Single State Authority) has stated that it maintains a viable treatment continuum of services in the State that includes: shelters, extended shelters, detoxification, extended care, residential rehabilitation, halfway houses, non-residential rehabilitation, outpatient care, as well as facilities for treating adolescents. This range of services is designed to help clients receive the level of care they need.

Maine's publicly supported substance abuse service system is complex and community based, providing education, prevention, early intervention, and treatment services. Currently, OSA has 45 contracts for services with 33 substance abuse treatment agencies. Our Juvenile Treatment Network has reached beyond these contracted treatment agencies in an attempt to reduce barriers, and provide access and choice to adolescent substance abuse treatment services.

In State Fiscal Year (SFY) 2003, 14,747 clients and 19,784 admissions were reported through OSA's Treatment Data System. This was a 12.4 percent increase in clients served since the previous fiscal year. Of those clients admitted for services in SFY 2003, 66.3 percent were males and 33.7 percent were females, continuing a similar pattern from past years. Eighty-five percent were adults and 15 percent were youth, continuing a growing pattern in serving youth.

### Day One's Adolescent Treatment is Research-Based

As an agency dedicated to providing services to adolescents and families affected by adolescent substance abuse, we constantly have been aware of the uniqueness of adolescents, and the special needs that they present. Adolescents are not just young adults. They present with varying and different issues than do adults, and need to have an ability to look at their specific risk and protective factors as they address their substance use and other life issues in treatment. Consequently, the challenges in providing services are to find and utilize effective prevention and treatment strategies. Day One supports the ongoing professional development of our staff in the various programs that we operate.

Treatment through Day One is available across the full continuum, from outpatient services and intensive outpatient, to long-term residential and transitional housing for youth in need. In the last six years, as more and more research has become available, we have (through both our Day One programming and through training sponsored or

provided by our Juvenile Treatment Network) introduced and reinforced the use of evidence-based and other “best-practices” in prevention and treatment services to youth. We have worked collaboratively with the Office of Substance Abuse in all of these endeavors. In the prevention area, Day One currently provides a number of science-based and model prevention programs, including “Guiding Good Choices” and “Reconnecting Youth.”

In addition, in the assessment and treatment area, for the past number of years we have worked with Dr. Norman Hoffmann, on the faculty of Brown University, and an international expert on screening and assessment instruments, in the use of the “Practical Adolescent Dual Diagnosis Interview” (PADDI) as part of a co-occurring assessment in most of our Day One treatment services. Our studies of the results of the use of the PADDI have been published in a number of professional journals, including *Addiction Professional* and *Offender Substance Abuse Report*. Other publications are pending and our use of the PADDI continues. Also, our outpatient treatment services here at Day One are recent participants as a “Center of Excellence” in a private foundation grant award that will bring strong collaborations and additional skills development in the area of services to youth presenting with co-occurring substance abuse and mental health issues. This grant initiative will allow Day One the opportunity to work closely with Dr. Ken Minkoff, a psychiatrist and specialist in the development of service systems for people with both substance abuse and mental health issues. Day One will also participate as a founding member in the Maine Institute for Quality Behavioral Health Care.

Day One’s juvenile corrections programs utilize the evidence-based treatment modalities found to be most effective with adolescents in the juvenile justice system. Consequently our substance abuse treatment programs in the two state juvenile correctional facilities and in our statewide Juvenile Drug Treatment Courts system make use of these approaches. Research conducted with our Juvenile Drug Treatment Courts demonstrate that adolescents in that program are less likely to return to the justice system with new offenses, and more likely to address their substance use and abuse issues in a positive manner than adolescents in the juvenile justice system that do not participate in this program.

#### Development of the Juvenile Treatment Network or “Voucher Program”

Our most innovative approach to treatment has been through the creation of a systems approach to accessing and providing services for youth. The initial collaborations that ultimately resulted in the formation of the Juvenile Treatment Network began in 1996 with the receipt of a small state grant. Then, thanks to the impetus provided by a CSAT Treatment Capacity Expansion Grant that Maine received in 1998, Day One worked to formally develop what is called the Juvenile Treatment Network. The Juvenile Treatment Network is a coordinated statewide initiative whose goal is to identify, screen and refer adolescents with substance abuse issues to state approved treatment providers of their choice and to increase access to substance abuse treatment services by providing a system to coordinate a last resort funding for these services. The Network is a collaboration of the Office of Substance Abuse (OSA), substance abuse treatment providers, Maine

Juvenile Drug Treatment Courts and Judiciary, the Department of Corrections, schools, police and other community agencies. Day One is contracted by the Office of Substance Abuse to staff and manage the Network.

Prior to the Juvenile Treatment Network substance abuse treatment services to adolescents in Maine were provided by only a handful of agencies across the state. Resources were scarce, and so our approach to treatment capacity expansion was to develop a system of services for adolescents that could be accessed across the state. Screening, assessment and treatment services are now available through more than 50 provider agencies at more than 80 locations across Maine.

The Juvenile Treatment Network utilizes the “Juvenile Automated Substance Abuse Evaluation” (JASAE), a standardized tool to screen adolescents and to provide information to determine if and to what extent further substance abuse assessment and treatment services are needed. These screening services are available throughout Maine and are conducted by a cadre of individuals who are trained by the Network to administer this screening instrument. If it is determined that further services are needed the adolescent is referred to one or more of over fifty participating treatment providers statewide. In addition, the Network coordinates and distributes last resort payment funds for adolescents referred to Network member substance abuse treatment providers and who meet funding eligibility criteria.

The JASAE screening and referral process was implemented in January 1998 as part of the Juvenile Treatment Network. Results to date include:

- Close to 10,000 JASAE surveys have been administered which translates to just under 10,000 adolescents being identified in the state of Maine as being at risk for developing a substance abuse problem
- Of those, about 57% of the screenings recommended a further substance abuse evaluation to determine to what extent services are needed. Through this process, Maine reaches 18% of kids in need of treatment, exceeding the national average of 8% by more than double.
- Adolescents identified as needing treatment were given the choice to select one of the 50 participating treatment providers for services in over 80 locations throughout the state. Maine is the only state to have a statewide coordinated system of care for adolescent substance abuse screening, assessment and treatment services.
- Through a combination of federal Targeted Capacity Expansion Grant funds (SAMHSA/CSAT funds) and state funds, over \$750,000 was distributed through the Juvenile Treatment Network to pay for screening and treatment services.
- Provided five treatment capacity expansion loans to treatment providers in 1999 as incentives to begin additional treatment services in underserved areas of the state.
- Provided five treatment capacity expansion start-up grants in 2002 for new and/or innovative substance abuse treatment programs totaling over \$70,000.
- Additional data from the JASAE administrations is included at the end of this testimony.

The Juvenile Treatment Network has demonstrated success in implementing an effective centralized identification, screening, referral and last resort funding system to increase access to substance abuse treatment services for adolescents. This model is an effective “Voucher program” and shares common goals and objectives for implementation. In a

January 2004 report, prepared by the Office of Substance Abuse, and presented to the Maine Legislature Joint Standing Committee on Health and Human Services regarding “An Act to Obtain Substance Abuse Services for Minors,” it was stated that “Capacity to treat adolescent substance abuse has expanded dramatically over the past few years, particularly at the outpatient level because of the creation of the Juvenile Treatment Network.”

The benefits that this “voucher program” model has demonstrated include:

- Providing a structure that has helped to increase access to substance abuse treatment services and recovery services for adolescents;
- Providing client choice and informed selection of treatment providers throughout the state of Maine;
- Providing an effective infrastructure through which to distribute last resort funds for substance abuse treatment services;
- Maintaining professional integrity of licensing and certification standards;
- Providing for performance accountability of treatment providers;
- Offering funding for a limited range of recovery support services that can readily be expanded when appropriate; and
- Providing assessment and treatment services at an average cost of \$1,597 per adolescent admitted to treatment.

#### The Programs

There are two programs the Network manages: the Juvenile Corrections Substance Abuse Treatment Network (JCSATN) and the more recently created (2002) Substance Abuse Treatment Network for Adolescents (SATNA).

The Juvenile Corrections Substance Abuse Treatment Network was created in response to the increasing number of juvenile offenders who have substance abuse issues and who need and cannot obtain substance abuse treatment. In January of 1998, substance abuse treatment providers throughout the state formally applied for membership in the Network and a standardized screening tool, the Juvenile Automated Substance Abuse Evaluation (JASAE), was chosen for the purpose of screening and referring juvenile offenders in the state of Maine.

Because of the success of the Juvenile Corrections Substance Abuse Treatment Network, and to implement recommendations from the Third Year Evaluation Report (conducted by the University of Southern Maine, Department of Social and Behavioral Research) of the Juvenile Treatment Network and Juvenile Drug Treatment Courts, the Substance Abuse Treatment Network for Adolescents was created to address the needs of adolescents with substance abuse issues before they became involved with the juvenile justice system. This program began on July 1, 2002, and identifies adolescents who may have a substance abuse problem through participating schools and other community-based organizations statewide. The Substance Abuse Treatment Network for Adolescents also uses the Juvenile Automated Substance Abuse Evaluation for screening and assessment purposes.

In addition to screening and referral services, the Network also has a last-resort payment source for adolescents in both programs who meet certain eligibility guidelines and are accessing further evaluation/substance abuse treatment as a result of their JASAE recommendations.

#### The Treatment Providers

Network member treatment providers are selected based on the following criteria:

- Agency must be licensed by the state Office of Substance Abuse
- Agency must be Medicaid Eligible
- Agency must provide outpatient and/or intensive outpatient substance abuse services in one or more services locations
- Agency must adhere to Network policies

Participating treatment providers commit to the following:

- Participation in Network-sponsored training and attendance at a minimum of three Network meetings per year
- Incorporation of best practices into treatment programs for adolescents, with best practices defined by the Network in collaboration with the state Office of Substance Abuse and demonstrated by research;
- Use of Network-developed protocols and forms for communication between the Juvenile Treatment Network, Network Member Treatment Providers, Department of Corrections, schools and other community organizations;
- Collaboration with other Network members and participants to identify gaps in treatment services and work cooperatively to fill those gaps;
- Participation in a Network screening and referral system designed to match client needs with provider strengths;
- Development of program admission and discharge criteria consistent with best practices for adolescents; and
- Participation in Network development of policy, procedures and training designed to implement Network goals and encourage provider compliance; and
- Timely completion of required state Office of Substance Abuse Admission and Discharge forms with the appropriate Network Code.

Members of the Juvenile Treatment Network receive the following benefits:

- Last resort outpatient treatment reimbursement eligibility for providers;
- Free registration for Network-sponsored trainings;
- Participation in the Network screening and referral system;
- Input into the development of Network policy and a system of comprehensive continuum of care for adolescents;
- Participation in a data collection system that will assist in identifying barriers to substance abuse treatment services throughout the state; and
- Improved communication between referral sources and treatment providers through attendance at quarterly Network meetings.

Last Resort Funding Distribution

Network funds are available to pay for substance abuse treatment for adolescents that have no other means of payment. Adolescents must meet identified criteria to be considered eligible for last resort payment funds.

The goal of the Network is to reduce barriers to treatment services and partial funding is available if a hardship or barrier that would prevent the adolescent from accessing treatment services has been identified by the treatment provider.

Eligible adolescents must not have private insurance that will cover substance abuse treatment services. If an adolescent's coverage does not include substance abuse treatment services, or the juvenile has exceeded the allowable benefits, Network funds may be an option. If an adolescent and his/her parents do have insurance but paying their co-pay would be a financial hardship, the Network funds may be an option. This is also true if the family has a deductible that must be met before the insurance will cover services.

Any adolescent who is eligible for Medicaid is not eligible for Network funds until Medicaid resources are exhausted or if a particular service is not covered by Medicaid (e.g. assessment and other transitional services from institutional care to community-based services).

If a client can pay a certain amount per session, Network funds may be able to fund part of the session providing that the total amount does not exceed the maximum allowance listed on the Substance Abuse Treatment Network for Adolescents billing form.

By accepting Network funds for treatment services the provider agrees not to bill the adolescent/family for any fees over and above the maximum reimbursement paid by the Substance Abuse Treatment Network for Adolescents

The Network funds will cover transportation costs for adolescents to get to and from treatment appointments. This option is available regardless of payment source. If, in the provider's judgment, transportation is a barrier to treatment, the Network funds will cover bus or cab fare, or pay mileage to the adolescent or friend/family member that drives the adolescent to and from treatment.

As with transportation costs, the Network funds will cover childcare regardless of the funding source for treatment.

### Additional Services

In addition to the centralized identification, screening, referral and payment system in place, the Network also functions to facilitate collaboration between the Department of Corrections, Office of Substance Abuse, Maine Department of Behavioral and Developmental Services, Maine Juvenile Drug Treatment Courts, substance abuse treatment providers, schools, police and other community agencies. To facilitate this collaboration the Network annually hosts 28 meetings throughout the state. Representation from all of the above mentioned agencies are typically present. These meetings are a place where individuals and agencies can and do discuss barriers to treatment services and how to address these issues. The meetings also serve to provide a forum to disseminate information as it relates to the Network or the field. In addition, the Network will provide training in response to provider and other partners' needs.

The Network has a comprehensive database in which data is recorded from the JASAE

assessment tool, information related to the referral for the JASAE and further evaluation as well as data relating to the last resort payment source. To date the Network has information pertaining to close to 10,000 JASAEs. This information is used in a number of ways by various agencies. This information has been used to identify trends and barriers, gauge service capacity needs and support grant proposals.

In addition, the Network has developed Policy and Procedure Manuals for all of the Network operations and has shared these manuals with other states and agencies looking to implement a similar structure to address substance abuse treatment.

### Closing

Day one continues to strive for quality and comprehensiveness in all of its prevention and treatment services. Equally as important, we work diligently to address barriers to treatment and systems issues that negatively affect the ability of Maine's youth and families to access these needed treatment and recovery support services. We believe that our model, one of the first statewide models in the nation to build a system for adolescents that identifies youth in need of services, expands access to and improves treatment statewide, and engages all collaborative partners, has produced positive results in a relatively short period of time. Surveys from our members support this direction and approach. We hope that the Subcommittee will continue to study this model and encourage and support the expansion of adolescent prevention and treatment services nationwide. Thank you for listening to this testimony today. I would be happy to answer any questions.

### Additional JASAE Screening Data

Percentage of those referred for further evaluation: 57%

(Percentages below based on total number of JASAE's screened)

Male/Female ratio: 65% Males, 35% Females

Percentages regarding living status:

Living at home with both parents: 41%

Living at home with mom: 26%

Living at home with dad: 8%

Living with relatives: 3%

Living with sister/brother: <1%

Living with non-family: 3%

Living in foster home: <1%

Other: 6%

Unknown (pre-data collection for this variable): 12%

Percentages regarding educational status:

In school full time: 66%  
In school part time: 5%  
Suspended: 2%  
Quit school: 9%  
Kicked out of school: 4%  
Finished school: 2%  
Unknown (pre-data collection for this variable): 12%

Most frequently used drug:

Alcohol: 48.5%  
Marijuana: 34.8%  
None: 10.7%  
Sedatives/Hypnotics: 1.2%  
Barbiturates, Amphetamine, Cocaine, Crack,  
Hallucinogens, Heroin, Inhalants, Tranquilizers, Other: Each <1%

ShIPLEY

Hazard Communication in the Workplace

Bill Number:

Hearing Date: March 25, 2004, 10:00 am

Location: SD-430

Witness:

Michele Sullivan, Ph.D.

MRS Associates

Testimony

STATEMENT OF MICHELE R. SULLIVAN, Ph.D.

BEFORE THE SUBCOMMITTEE ON EMPLOYMENT, SAFETY, AND TRAINING

UNITED STATES SENATE

March 25, 2004

Mr. Chairman, Members of the Subcommittee:

My name is Michele Sullivan. I am a hazard communication professional with over 20 years experience in industry, trade associations and consulting for companies, government agencies, and international organizations. I was a member of the National Advisory Committee on Occupational Safety & Health (NACOSH) Hazard Communication Work Group (1995-96). I participated on the Organization for Economic Cooperation & Development (OECD), the International Labor Organization (ILO) and international groups that developed the new Globally Harmonized System (GHS) of

Classification and Labeling of Chemicals. I have been a member of the Society for Chemical Hazard Communication (SCHC) for over 20 years and I'm the Chairman of the SCHC Board of Directors.

I appreciate this opportunity to appear before the Subcommittee on Employment, Safety, and Training this morning as it considers hazard communication.

#### SCHC

SCHC is a professional society of individuals who are engaged in the business of hazard communication. The members' jobs are diverse. Many prepare labels and material safety data sheets (MSDSs) for their employers' products. Others train users of hazardous chemicals, act as expert witnesses or implement government regulations. They work in industry, government and academia. SCHC membership has grown from 40 people in 1979 to approximately 700 today.

SCHC's purpose is to promote effective communication about chemical hazards. The Society is committed to sharing knowledge and resources and educating its members and the public about communicating chemical hazards on product labels, MSDS and other literature.

SCHC strives to keep its members aware of the latest developments concerning hazard communication. The Society holds meetings to provide up-to-date information on current developments and education and networking opportunities for its members. Recently the development, content and implementation of the new Globally Harmonized System (GHS) of Classification and Labeling of Chemicals have been covered. Training workers about hazard communication is frequently a topic at meetings.

The Society's purpose has always been to educate and provide information on hazard communication. Today the society offerings have grown to over 25 professional development courses. These courses mainly focus on information and guidance needed to prepare a global 16-section MSDS. The students in these courses are generally people involved in writing or developing MSDSs. The courses range from introductory MSDS workshops, to courses on first aid statements and advanced courses on assessing and communicating toxicological results. SCHC also offers several courses on the diverse hazard communication labeling requirements for the USA and other countries. SCHC students have a broad range of occupations – for example chemistry, industrial hygiene, and toxicology. There are no degrees in MSDS and label writing.

SCHC is one of the organizations canvassed for the American National Standards Institute (ANSI) Z129.1 Labeling Standard and the ANSI Z400.1 MSDS Standard. The society compiles comments on the draft standards from its members and provides the comments to the ANSI committees for consideration.

#### Outreach/Alliance

The Society has a history of collaboration and outreach. Shortly after the OSHA Hazard Communication Standard, 29 CFR 1910.1200, (HCS) was published, SCHC and OSHA

collaborated to educate stakeholders by jointly sponsoring seminars on a regional basis with both OSHA and SCHC participating.

Recently, SCHC and OSHA have signed an Alliance to provide information and training on hazard communication, MSDSs and the new Globally Harmonized System (GHS) of Classification and Labeling of Chemicals. Through the Alliance, SCHC and OSHA will work collaboratively to promote effective hazard communication.

Some Alliance activities that SCHC is pursuing include:

- Creating an Alliance page on the SCHC website that highlights hazard communication and GHS resources and links
- Having OSHA speakers participate at SCHC meetings
- Serving on the editorial board for OSHA's Hazard Communication Safety and Health Topics page
- Promoting awareness of the GHS by:
- Participating in the MSDS Round Table at American Industrial Hygiene Association (AIHA) 2004 spring conference
- Sponsoring GHS sessions at the 2004 National Safety Council's Annual Congress and 2005 World Safety Congress
- Including GHS topics on SCHC programs.

Alliance activities under discussion include the development of MSDS training and checklists to be used by OSHA, and more GHS forums.

## GHS

As an internationally recognized hazard communication expert, I had the opportunity to participate in developing the GHS. Representatives from governments, industry, workers and international organizations all participated. These representatives were all experts in areas of hazard communication. These specialists worked not only to create a globally harmonized hazard communication system but to incorporate enhancements based on their knowledge, experience, and past learnings. The GHS could be viewed as the next step on the hazard communication journey of continuous improvement.

Traditionally, hazard communication has had a three-prong approach: labels, MSDSs and training for workers. These hazard communication elements are all interrelated. While recognizing the importance of training, the GHS focuses mainly on hazard definition, labels and MSDSs.

It is instructive to examine the hazard communication elements and how the GHS could enhance them.

## Hazard Definitions

The starting point for all hazard communication is the definition of what is hazardous. This forms the foundation for understanding a product's characteristics and how to safely handle and use the product. It triggers label warnings, hazard and precautionary

information on MSDSs, and packaging, transport and storage requirements.

The definition of what constitutes a hazardous chemical product varies today among USA government agencies that regulate consumer products, pesticides, transport, workplace, etc. Generally, the same is true for most other industrialized countries that have a mature chemical industry. What this means is that the same chemical product can be hazardous and non-hazardous for different end uses in the USA, requiring different labels. In the workplace workers can see labels with different warnings for the same product and different MSDSs.

The GHS has criteria-based hazard definitions. The GHS would harmonize hazard definitions among domestic regulatory agencies as well as globally. Since hazard definitions are the starting point for hazard communication, global adoption of the GHS elements could promote consistency and comprehensibility.

### MSDSs

In 1983 the OSHA Hazard Communication Standard's performance oriented approach for MSDS seemed appropriate. Twenty years later, the benefits of a standardized MSDS format have been recognized.

The Chemical Manufacturers Association (CMA) and the American National Standards Institute (ANSI) developed the first 16-section MSDS (ANSI Z400.1). The format was not selected randomly. Information needed in an emergency appears first and useful non-emergency information on what regulations apply and toxicological/ecological data, etc., appear later in the MSDS. The 16-section MSDS sequence is based on 4 questions:

1. What is the material & what do I need to know in an emergency?
2. What should I do if a hazardous situation occurs?
3. How can I prevent hazardous situations from occurring?
4. Is there any other useful information about this material?

This MSDS format prioritizes the placement of different types of information.

The International Standards Organization (ISO), the International Labor Organization (ILO) and the European Union all adopted similar 16-section MSDS formats during the 1990's. The 16-section MSDS format is common today for companies doing international business.

The audience for MSDSs has expanded from health and safety professionals, workers, employers and customers to include fire departments, emergency responders, state and local emergency planning groups and members of the community. In recognizing that MSDS are complex technical documents, the ANSI Z400 MSDS Standard currently lists target audiences for each MSDS section so that the MSDS writer can determine the appropriate language level. It recommends using non-technical lay language for the worker MSDS sections. Such an approach to writing MSDSs could help readability.

Near the beginning of the MSDS, the ANSI MSDS format includes an emergency

overview that provides health, physical and environmental hazards in straightforward language. This corresponds in the new GHS MSDS to requiring hazard and label information in MSDS section 2. Providing hazard information on MSDSs in a way that can be easily identified and understood by non-technical people is in agreement with the NACOSH Hazard Communication Work Group (1995-96) recommendations.

The GHS requires a defined sequence for the 16 MSDS sections. It specifies minimum information requirements for each section. Adoption of the GHS would promote consistency and the quality of MSDS.

### Labels

Guidance for labeling industrial chemicals has existed for many years. Initially there was a Labels and Precautionary Information (LAPI) Manual (1945-1975) developed by CMA. This evolved to the ANSI Z129.1 Labeling Standard which is a voluntary industry standard often used to decide what is an appropriate hazard warning for performance-oriented regulations. However, not all companies use the ANSI hazard statements on labels and workers see different statements for the same hazards.

In other countries many workplace hazard communications systems require hazard symbols or pictograms as well as hazard statements. USA workers currently see these different symbols on imported products. The GHS will standardize hazard statements and hazard symbols. To reinforce understanding, the GHS conveys information in more than one way - using symbols with colored frames, signal words and hazard statements. Under the GHS, words used in hazard statements would have a precise meaning that would not change from company to company. Although training would be necessary, particularly on the use of symbols, this standardization should help with worker comprehensibility.

The GHS also includes an option for “supplemental information”. This is label information that is not standardized. Considering the liability situation and the duty to warn requirement in the USA, “Supplemental Information” could be a key GHS label element for companies.

### Support/Guidance/Assistance

Hazard communication and MSDSs are complex technical topics. It requires expertise in many different areas to develop a quality MSDS. It requires resources that are scarce in major corporations and often lacking in small businesses. The necessary tools/assistance/guidance should be available for small businesses to enable them to handle this complex subject in-house, if so desired.

There is more information available today than ever before. However, this can make the task more difficult. It is helpful for small and medium enterprises to know what are good sources of information for hazard communication. Information is needed on chemical hazards. But information on related topics is also needed: personal protective equipment, controls, decomposition products, process hazards, first aid, fire-fighting measures, spill and leak control, disposal, etc.

Some excellent information is available on the Internet. OSHA has recently updated its hazard communication page so that it is easier to access and has new links. Some organizations (e.g., NIOSH) have published CDs with hazard related information and made them available for free or at nominal costs. Many types of guidance and assistance could be valuable in promoting effective hazard communication: e-tools, local training, distance learning, mentoring, etc. Guidance and assistance would be particularly helpful in relation to the GHS.

Assistance with obtaining quality information and how to use that information in hazard communication is an area that could be looked into. There are opportunities for government agencies, trade associations, professional associations, alliances/consortiums and companies to contribute. There could be value in exploring partnerships to promote effective hazard communication.

It is hard to imagine that any company would intentionally develop poor quality MSDSs. With that in mind, one approach would be that whenever inadequate or poor quality MSDSs are found, assistance could be offered the company to improve its hazard communication program.

#### Summary

The GHS would:

- standardize hazard definitions
- standardize hazard warnings and hazard symbols on labels
- standardize MSDS format and information.

The GHS can improve hazard communication by allowing information to be more easily compared and by utilizing symbols & standard phrasing to improve awareness and understanding. Consistent information will be communicated on labels and MSDSs. Therefore, workers should have improved comprehensibility. By providing detailed and standardized physical and health hazard criteria, the GHS can lead to better quality information. By providing an infrastructure for the establishment of national chemical safety programs, the GHS can promote the sound management of chemicals globally. Facilitation of international trade in chemicals is also expected to be a GHS benefit.

Implementation of the GHS offers challenges for both industry and government. The hazard definitions for all chemical products would have to be reviewed and their MSDSs and labels potentially revised. OSHA has estimated that there are over 650,000 chemical products.

The USA has some unique issues that affect hazard communication. Liability and the duty to provide an adequate warning have always been considered in developing USA labels. These considerations are now also being applied to MSDSs. In considering the GHS as a means to improve hazard communication, these issues should be kept in mind.

The GHS does NOT require hazard or other testing of chemical products. Some of the

differences in hazard communication, particularly for topics like personal protective equipment, controls, decomposition products, process hazards, first aid, fire-fighting measures, etc., can be related to lack of knowledge, testing and standardization in these areas. The GHS does not address these issues.

Implementation of effective hazard communication provides benefits for governments, companies, workers, and members of the public. The interests of workers, users of chemicals, the public, regulators and the chemical industry could be well served by pursuing the GHS. A major benefit would be improved safety for workers through consistent and simplified communications on chemical hazards and practices to follow for safe handling and use.

If the USA adopts the GHS, there will be some discretion in implementation. However, modifications could cause loss of global harmonization.

Again, I appreciate the opportunity to appear here today and to provide input on the issue of hazard communication, MSDSs and the GHS. Mr. Chairman, I would be pleased to answer any questions the committee may have.