

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DRUG ABUSE TREATMENT WAITING
LIST REDUCTION GRANT PROGRAM**



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INSPECTOR GENERAL**

OEI-02-90-00420

EXECUTIVE SUMMARY

PURPOSE

This inspection assesses the extent to which the Drug Abuse Treatment Waiting List Reduction Grant Program reduced waiting lists for drug treatment by expanding the capacity of existing programs.

BACKGROUND

The Drug Abuse Treatment Waiting List Reduction Grant Program, established under Section 509(E) of the Public Health Service Act, was created to reduce treatment waiting lists by expanding existing drug treatment programs. Congress authorized \$100 million for grants under the program, \$75 million of which was to be used in Fiscal Year (FY) 1989 and the remaining \$25 million in FY 1990. Sixty-nine grants covering 361 local programs were awarded. An additional \$40 million for program grants was reauthorized for FY 1991.

Both public and non-profit private entities were awarded grants, either independently or through a "State Umbrella Application." These grantees had to fulfill four requirements: (1) have experience in delivery of treatment services for drug abuse; (2) demonstrate, as of the date the application was submitted, success in carrying out a program approved by the State; (3) be unable to admit any individual into treatment earlier than one month after the individual requests care; and (4) provide assurances that the program would have access to financial resources sufficient to continue its expanded capacity after the grant is terminated. The grant was originally awarded for a period of 12 months. It was later amended to allow for a three or six month extension in response to problems that prevented programs from being able to spend their money within the allotted time.

METHODOLOGY

Telephone interviews were held with 98 grantees from a random sample of 100, 22 of the 23 State Agencies relating to our sample grantees, and 14 agencies which routinely refer clients to grantee programs. For purposes of this study, the State grantees are called the State and all other grantees and umbrella subgrantees are called grantees, unless otherwise defined.

FINDINGS

ALMOST ALL GRANTEES HAVE INCREASED CAPACITY AND MOST HAVE REDUCED THEIR WAITING LISTS

Almost all grantees (94 percent) have already achieved their expansion goals or anticipate doing so by the end of their extension periods. Most have increased their capacity. Eighty-six percent have added to their number of treatment slots and 78 percent serve more individuals now than before. Additionally, 75 percent report reducing their waiting lists and 72 percent also report reducing their waiting periods.

Even with the grant, almost all grantee and State respondents believe there is a continued shortage in the number of publicly funded drug treatment slots in their State.

RESPONDENTS' VIEWS OF PROGRAM'S SUCCESS ARE TEMPERED BY CONCERNS OVER CONTINUED FUNDING

While 60 percent of the grantees rate the waiting list reduction grant program successful, 40 percent of these feel it can be truly successful only if continued funding is available. Two-thirds of the grantees who do not rate the grant program successful cite difficulties with continued funding; more than half the States rate it unsuccessful for the same reason.

Many grantees and States consider the grant a temporary solution. While over half the grantees are certain of obtaining continued funding, more than half of these believe it will only be for a limited time. States express similar concerns.

RESPONDENTS EXPERIENCED SEVERAL ADMINISTRATIVE PROBLEMS

Almost two-thirds of grantees experienced some delay in receiving their funds, with most blaming the bureaucratic process. Similarly, over half the States report delays in receiving their money from the Federal government.

Respondents believe the grant period should be longer, such as a three-year funding cycle, in light of the lengthy State legislative process and the kinds of problems experienced in expanding services.

WAITING LISTS ALONE ARE NOT VIEWED AS A GOOD INDICATOR OF NEED

Most respondents believe treatment need is greater than waiting lists reflect. While most could not offer a better measure of treatment need, some suggest alternatives, such as conducting prevalence studies, looking at program utilization rates, recording data on calls to treatment hotlines, querying referral sources and performing outreach. Some respondents believe measuring waiting periods would be more accurate.

RECOMMENDATIONS

The Alcohol, Drug and Mental Health Administration (ADMAHA) should:

- ▶ Assure that waiting lists are not used as the sole basis for awarding a grant, but are considered in conjunction with other indicators of need such as utilization rates and prevalence studies.
- ▶ Support a longer grant period in future legislation of this type. Respondents recommend at least a three-year funding period to correspond with the States' legislative cycles and to allow them time to start up and to get clients into treatment. At a minimum, some respondents recommend a longer time to draw down the funds.
- ▶ Require any future grants to have a maintenance of effort clause to enable programs to increase capacity without experiencing a concurrent cutback in State funds.
- ▶ Develop a uniform definition of a waiting list and a systematic way of maintaining a waiting list for use by all States. This will help both in planning future legislation and in providing more meaningful data on a current basis.

COMMENTS

Comments on the draft report received from PHS, ASPE and the Office of National Drug Control Policy (ONDCP) concur with the recommendations of this report. Suggestions for changes in the wording and clarifications in the text have for the most part been incorporated into the final report. The actual comments can be found in Appendix II.

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INTRODUCTION

PURPOSE

This inspection assesses the extent to which the Drug Abuse Treatment Waiting List Reduction Grant Program reduced waiting lists for drug treatment by expanding the capacity of existing programs.

BACKGROUND

Drug abuse in the United States commands much public concern and attention. It is generally believed that there are not enough drug treatment programs available for all individuals seeking treatment. This is particularly true in areas of high heroin and cocaine/crack abuse and in low-income communities. Experts agree that if more treatment programs were available in areas where the demand for treatment exceeds the capacity, many more would attend them.

Legislative History

Drug and alcohol treatment programs have always been primarily funded by State governments with a percentage provided by the Federal government through the Alcohol, Drug Abuse, and Mental Health Services (ADMS) and the Alcohol and Drug Abuse Treatment and Rehabilitation (ADTR) block grants. To supplement these grants the Drug Abuse Treatment Waiting List Reduction Grant Program was established. Its purpose was to help existing drug abuse treatment programs rapidly expand their capacity to serve drug abusers who are waiting for treatment in an effort to provide "treatment on demand" for all. The authorization authority is found in section 509(E) of the Public Health Service Act, as amended by Public Law 100-690, the Anti-Drug Abuse Act of 1988. The Waiting List Reduction Grant Program is administered by the Office of Treatment Improvement (OTI) in the Alcohol, Drug and Mental Health Administration (ADAMHA).

Drug Abuse Treatment Waiting List Reduction Grants

To receive a waiting list reduction grant, applicants had to fulfill four requirements: (1) have experience in delivery of treatment services for drug abuse; (2) demonstrate, as of the date the application was submitted, success in carrying out a program approved by the State; (3) be unable to admit any individual into treatment earlier than one month after the individual requests care; and (4) provide assurances that the program will have access to financial resources sufficient to continue its expanded capacity after the grant is terminated. In addition, the State was required to provide letters of assurance giving applicants top priority for continued funding once the Federal grant terminated.

Programs could apply either independently or in a "State Umbrella Application." In an "umbrella" the State submitted one application on behalf of the programs and in some cases provided technical assistance and support to the individual programs. A State was able to use up to two percent of the grant funds to cover the administrative costs of managing the grant. The amount of the grant was based on the number of new treatment slots scheduled to be created by the program multiplied by the annual cost of each specific type of slot created. The grant was originally awarded for a period of 12 months. It was later amended to allow a three- or six-month extension in response to problems that prevented programs from being able to spend their money within the allotted time.

The OTI has given these grants to both public and non-profit private entities. Funds were usually awarded quickly, with priority going to those treatment programs judged to have the greatest need to expand their capacity. The programs chosen were those that proposed to create the most new treatment slots, were part of a State-wide plan to expand treatment capacity, provided State verification of their waiting lists and submitted the strongest assurances that funding for their expanded program would continue after the grant's termination.

Congress authorized \$100 million for grants under the program, \$75 million of which was to be appropriated in Fiscal Year (FY) 1989 and the remaining \$25 million in FY 1990. Twenty-nine grants, totalling \$74.5 million, were awarded by September 30, 1989, and an additional 40 grants, totalling \$25 million, were given out by April 1, 1990. These 69 grants covered 361 local programs in 34 States, the District of Columbia and Puerto Rico. Twenty-one programs received funding directly and the remainder received funds through umbrella applications submitted by States. When the funds were awarded, the 361 grantees had an existing capacity of 76,772 slots; the Waiting List Reduction Grant Program resulted in the funding of 20,073 new slots, a 26-percent increase.

Re-authorization

The Senate re-authorized an additional \$40 million for program grants in FY 1991. The re-authorization legislation includes the following provisions: the term "waiting list" is called "waiting period"; priority is given to programs serving pregnant and postpartum women; programs are encouraged to use up to 50 percent of their grant to provide aftercare in order to prevent relapse; and current and previous grantees can re-apply for funds. Also, the \$40 million had to be obligated by December 31, 1990, and OTI was required to prepare a report to Congress on the efficacy of the program.

METHODOLOGY

The first phase included selection of a random sample of 100 grantees and subgrantees out of a universe of 201 who received money during the first round of funding (see Appendix I). The team interviewed 98 of these grantees who were from 23 States and represented a mix of treatment modalities. The funding ranged from

\$8,568 for two slots to \$3,152,500 for 845 slots. The grantees were asked by phone to (1) provide statistical data relating to the size and duration of their waiting lists, the number of persons served and the number of treatment slots; (2) indicate the extent to which their program has been able to secure continued funding; and (3) give their views of waiting lists and this type of one-time funding. Annual reports and supporting documentation relating to waiting list data and continued funding was requested which, when received, verified verbal responses.

Second, 22 of the 23 State Agencies relating to our sample grantees were queried by telephone. Nineteen received umbrella grants; the remaining three did not but had independent grantees in their State. All were asked about the effectiveness of a one-time grant, the success of grantees in obtaining permanent funding, and the validity of waiting lists as a measure of treatment need.

For purposes of this study, the State grantees and those States that did not receive grants are called the State and all other grantees and umbrella subgrantees are called grantees, unless otherwise defined.

Third, a subsample of 14 agencies who routinely refer clients to grantee programs were asked by telephone whether it was now easier to get clients into the grantee's program. These referring agencies include probation departments, courts, hospitals, and local drug and alcohol agencies in various parts of the country.

FINDINGS

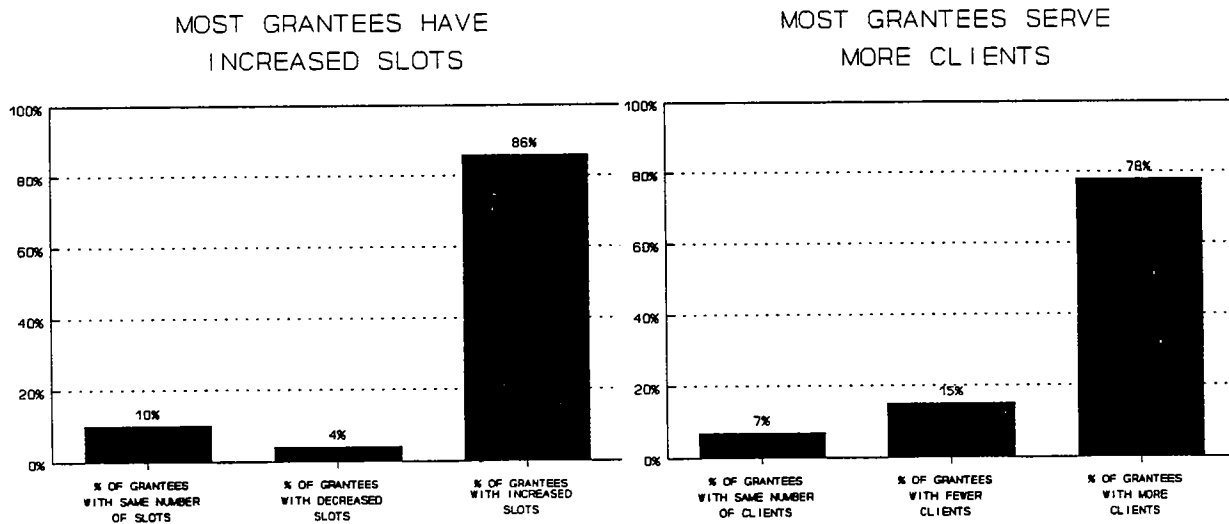
ALMOST ALL GRANTEES HAVE INCREASED CAPACITY AND MOST HAVE REDUCED THEIR WAITING LISTS

Most Grantees Have Expanded Their Programs

Almost all grantees (94 percent) have already achieved their expansion goals or anticipate doing so by the end of their extension periods; the remaining six grantees were not certain because of slow start-ups and difficulty in acquiring additional staff and space. In expanding their programs, most grantees used grant funds for new staff, increased salaries of existing staff, treatment services, building and renovations, operating expenses, equipment and supplies.

Most grantees have increased the capacity of their program. Eighty-six percent have added to their number of treatment slots and seventy-eight percent serve more individuals now than they did before the grant (Graph I below). In some cases, while programs increased slots, now that the grant program has concluded they serve fewer individuals, primarily because they no longer have funding to treat that increased number of indigent clients. Amongst grantees, a slot is most commonly defined for in-patient programs as a bed; for out-patient programs it is the ability to treat one individual in a given period of time or a unit of service.

GRAPH I



The remaining grantees do not report increased capacity (Graph I above). Some have the same number of slots and serve the same number of clients. A few grantees explain that the State cut their funding an amount equal to the grant. One grantee represents the sentiments of others by saying "The block grant was cut [by the State] right before the waiting list dollars came, so the waiting list dollars didn't increase anything, it just allowed us to continue at the same level." This was reported although

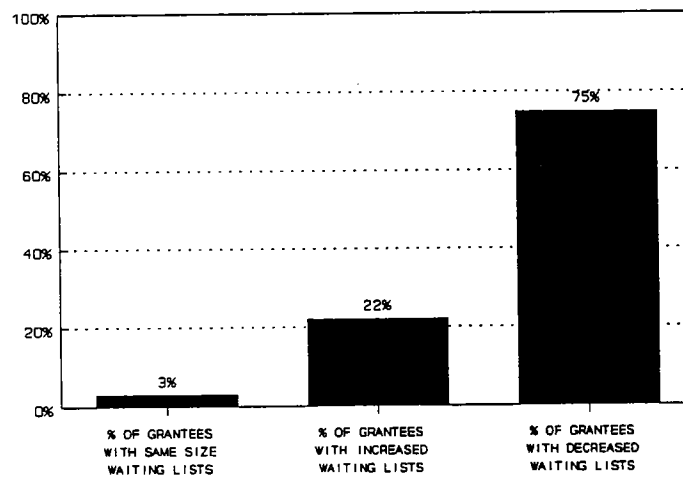
the Request for Application clearly states, "Grant funds must be used to supplement, not supplant, existing treatment service delivery activities". Others initially expanded their programs, but had to cut back once their grant was terminated because of a lack of continued funding. A few reduced their programs for reasons unrelated to the grant.

Most Grantees Have Reduced Their Waiting Lists and Waiting Periods

Seventy-five percent of grantees report a reduction in their waiting lists, including nine who no longer have a waiting list (Graph II below). The 22 percent of grantees who report an increase in the size of their waiting lists most often mention that demand for their program increased when they received grant funding. As one State respondent asserts, "Demand is driven by factors relating to awareness of services." Another states, "As treatment becomes more available, more people step forward."

GRAPH II

MOST GRANTEES HAVE
REDUCED WAITING LISTS

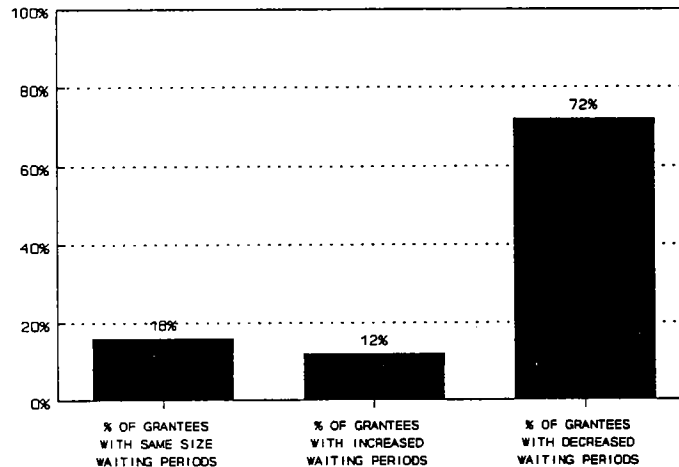


The size of waiting lists varies significantly. Of the programs surveyed, waiting-list size ranges from between 2 to 408. The waiting-list size is primarily determined by program size and by type of treatment modality. For instance, methadone maintenance programs generally tend to have less turnover and, therefore, larger lists.

Of the fourteen referring agencies surveyed, six mention that clients whom they refer to grant-funded programs have a shorter wait now to enter those programs than they did before the grant; one reports that its clients no longer have to wait.

Almost three-quarters of grantees (72 percent) also report a reduction in their waiting periods, the number of days a client must wait before entering a program (Graph III below). They include eight programs whose waiting times have been eliminated. As with waiting-list size, the range of waiting periods also varies widely, from a few days to more than one year.

GRAPH III
 MOST GRANTEES HAVE
 REDUCED WAITING PERIODS



More Women and Minorities Were Served

Over one-quarter of grantees (27 percent) notice an increase in the percentage of minorities served in their program since the grant; similarly, almost one-third of grantees (32 percent) notice a change in the number of women served. Respondents report both of these increases are attributable at least in part to the grant program. One grantee remarks that the ability to serve more clients allows a program to consequently serve more minorities and women, particularly pregnant and post-partum women in need of services. One grantee states that with grant funding they were able to hire bilingual counselors to do outreach for Hispanic addicts; another explains that they specifically targeted African-Americans with grant funds.

Respondents Claim a Shortage of Public Drug Treatment Programs

Almost all grantee and State respondents agree that there is a continued shortage in the number of publicly funded drug treatment slots in their State. Many, however, mention that there are available slots in private programs for those who can pay for such treatment themselves or who have insurance. One State respondent asserts that "If you have the right kind of insurance you can get into any program anywhere, but most people seeking treatment have no insurance." Another agrees: "Private

programs are prolific. City programs are the treatment of last resort so they are inundated with those not eligible for Medicaid."

In general, respondents feel there are more addicts needing treatment than there are programs to treat them. When asked if there are enough treatment slots in her State to serve the number of addicts seeking treatment, one grantee responds, "If that were the case, we wouldn't have waiting lists. Addicts should really be able to get treatment on demand." Other respondents mention a shortage of programs specific to a client population, treatment modality or geographical location.

RESPONDENTS' VIEWS OF PROGRAM'S SUCCESS ARE TEMPERED BY CONCERNS OVER CONTINUED FUNDING

Respondents Link Grant's Success With Availability of Continued Funding

While 60 percent of the grantees rate the waiting list reduction grant program successful, 40 percent of them feel it can be truly successful only if continued funding is made available. Although States were required to provide letters of assurance giving applicants "top priority" for continued future funding once the Federal grant terminated, it was not a guarantee that continued funding would be available. Two-thirds of the grantees who do not think the grant program is successful blame difficulties with continued funding. These concerns about continued funding are shared by States: less than half consider this grant program successful, with the problem of continued funding the most frequently mentioned reason. One grantee expresses the concern of many others when he states, "A one-year grant is a band-aid when surgery is needed. We need more of a commitment from the State." One State respondent says, "We hoped we'd get State money [through the legislative process], but without some absolute guarantee of State money the grant is no good. We never know how finances will be from one year to the next. This is a poor way for Congress to give money. It gets things going and brings them to a screeching halt, which is worse than not getting them at all."

Many Grantees and States Consider the Grant Program a Temporary Solution

Over one-half of grantees are either very or fairly certain of obtaining continued funding, but more than one-half of these believe it will only be for a limited time, blaming major cutbacks in the State budgets. Since they are unsure of the future, many grantees consider the grant program a short-term solution. One grantee voices this common concern when she says, "Short-term funding allows for a temporary solution to treatment needs in the community. Programs are developed to meet those needs, which raises expectations in the community. Programs abruptly end, leaving both addicts and the community disillusioned." Only 38 percent of the grantees report that their programs will continue indefinitely after the grant is terminated. Some programs say they will have to resort to client fees when the grant ends, but feel very few clients, if any, can afford to pay for treatment.

Two-thirds of the States are certain the programs in their State will obtain continued funding, but a quarter of them believe such funding will only continue for a limited time. Many State officials feel they are "at the mercy of the Federal block grant and State legislature" and cannot promise the programs indefinite funding. One State respondent says, "We were tied by our State legislature. It is even a political process to get an item on our own budget proposal to send to the State."

Some Grantees Believe The Grant Program Gave A Window of Opportunity for Treatment

Thirty-five percent of the grantees say the grant gave a window of opportunity to treat those people who otherwise would not have gotten help, the indigent clients in particular. Several States agree. One respondent sums up this sentiment when she states, "The grant did turn some lives around and a lot of clients got treated who wouldn't have before the grant, so for that reason the grant was very good."

RESPONDENTS EXPERIENCED SEVERAL ADMINISTRATIVE PROBLEMS

Grantees and States Report Initial Delays in Drawing Down Funds

Almost two-thirds of grantees (61 percent) experienced some delay in receiving their funds, with most blaming the bureaucratic process. In one State, funds were dispersed through several levels - from State to county to city - before actually reaching the program. One State respondent voices the concern of many when he admits that the "programs [in the State umbrella grant] experienced even bigger delays to get through our bureaucracy."

Similarly, over half the States report delays in receiving their money from the Federal government. One respondent states, "We can spend money as long as we get the [grant] award letter. Getting the award letter late delayed us." Another explains that while all five programs on the State application were approved, only two of these received funding, so that the State was forced to wait to see which programs got money and how much. Another State blames the delay on the paperwork needed to obtain funding.

Delays in receiving funding also resulted in many of the extensions requested by grantees to complete their expansion. Seventy percent of grantees required extensions of up to six months. The most frequently cited reasons include: (1) slow start-ups due to delays in obtaining funding; (2) difficulties in hiring new staff; (3) problems in procuring additional space; and (4) time needed to renovate present quarters.

Grantees and States Want a Different Funding Cycle for the Grant Program

State respondents believe the grant period should be longer, such as a three-year funding cycle, due to the lengthy State legislative process. States would like more time to adjust their budgets, and feel one year is not enough time to develop a permanent

alternative funding source. In the absence of increased funding, some recommend lesser amounts per year for a longer period. At the very minimum they recommend at least a longer time to draw down the funds. As one respondent states, "It was an incredible hassle for one year. If they do it again they should do it for a minimum of three years, even if less money is given each year." Respondents would also prefer that the grant fit into their funding cycle to reduce the problems which arise from the differences in State and Federal fiscal years.

Grantees agree with the States, citing administrative and other problems experienced in expanding services as reasons why a longer grant period is needed. The grantees would like more time to find qualified staff, a particularly difficult problem in rural areas. Adding new space and renovating existing quarters is time consuming, especially if there are construction problems. Grantees also feel that one year is not long enough to establish a presence in the community.

WAITING LISTS ALONE ARE NOT VIEWED AS A GOOD INDICATOR OF TREATMENT NEED

Most Respondents Say Treatment Need is Greater Than Waiting Lists Reflect

Two-thirds of grantees and more than half the States believe waiting lists do not give an accurate picture of the number of people seeking treatment, nor do they reflect the number needing treatment. One grantee reflects the views of others in saying: "A waiting list does not reflect the true need for treatment. It often does not include the discouraged addict, nor the non-referrals from discouraged referral sources. That is, when funding is scarce and lists are long, people tend to give up. That reduces referrals, which equals shorter/smaller waiting lists, which deceives funding sources into believing there is no problem." A State grantee contends that "waiting lists are an indicator of gross need for service, but are not accurate in showing magnitude."

In contrast, 15 percent of grantees believe that waiting lists are a good indicator of treatment need, or at least the best measure available. They feel that waiting lists at least show demand, if not the magnitude of demand.

More than half the grantees feel waiting lists underrepresent treatment need. Some claim that this is a population that does not wait: people who call for treatment during a crisis are not interested if not treated immediately. One grantee asserts that it is traumatic if "there is a waiting-list message on a machine - it is like a suicide hotline putting you on hold." Other grantees note there are some geographical areas not having treatment programs at all.

Only 27 percent of States systematically collect waiting-list data. The definition of waiting list varies from State to State and among different programs within a State. Some programs evaluate prospective clients before putting them on a list; others keep the names of all callers, and still others do not routinely keep waiting-list data. Some keep people on the list and offer limited services while they wait. The States not

routinely collecting waiting-list data survey their programs when they get an external request for such information.

Respondents suggest better measures of treatment need.

While most respondents could not offer a better measure of treatment need, some do suggest alternatives. These include doing studies of the prevalence of drug and alcohol use in a particular population, looking at utilization rates in programs, and recording data on calls to treatment hotlines or admission requests. Other suggestions include conducting outreach programs, having a central intake process for referrals, and querying referral sources such as hospitals and courts.

Some respondents thought that measuring waiting periods would be a more accurate indicator than waiting lists. As one respondent says, "Waiting periods tell the length of time someone must wait before getting treatment. It gives a truer picture of needs. Lists just tell how many - they could be waiting for weeks, months or years." However, most feel that a combination of waiting lists and waiting periods gives a more complete picture.

RECOMMENDATIONS

The Alcohol, Drug and Mental Health Administration (ADMAHA) should:

- ▶ Assure that waiting lists are not used as the sole basis for awarding a grant, but are considered in conjunction with other indicators of need such as utilization rates and prevalence studies.
- ▶ Support a longer grant period in future legislation of this type. Respondents recommend funding for at least a three-year period to correspond with the States' legislative cycles and to allow them time to start up and to get clients into treatment. At a minimum, some respondents recommend a longer time to draw down the funds.
- ▶ Require any future grants to have a maintenance of effort clause to enable programs to increase capacity without experiencing a concurrent cutback in State funds.
- ▶ Develop a uniform definition of a waiting list and a systematic way of maintaining a waiting list for use by all States. This will help both in planning future legislation and providing more meaningful data on a current basis.

COMMENTS

Comments on the draft report received from PHS, ASPE and the Office of National Drug Control Policy (ONDCP) concur with the recommendations of this report. Suggestions for changes in the wording and clarifications in the text have for the most part been incorporated into the final report. The actual comments received are in Appendix II.

The PHS claims that receipt of the grant award letters was not delayed from the Federal government, and that in every instance where a program received funds late the State had access to the grant funds shortly after award, but chose not to access the funds. Regarding this delay, we are reporting information obtained during the course of the study. However, in light of PHS's comments we will investigate this further.

The PHS claims that major construction and renovation costs were not allowed in the grant's legislation. Respondents reported building and renovation in order to expand services. In response to PHS's comments we will also investigate this further.

The ONDCP characterizes this report as a condensed version of the Waiting List Reduction Report prepared by OTI for Congress. In response, we would note that the data for this report was collected from OIG telephone interviews and was not based on OTI information. However, we provided OTI information based upon our data for purposes of their report.

APPENDIX I

SAMPLING METHODOLOGY

The universe of drug abuse treatment centers initially consisted of 361 facilities; however, the grants were awarded in two rounds. The first-round grants were awarded to 201 treatment centers by September 30, 1989; the remaining funds were awarded to 160 treatment centers by April 1, 1990. The universe was restricted to the 201 treatment centers which received funding by the September 30, 1989 date.

The universe of 201 facilities was stratified into three groups according to the date of program completion or requested extension. The first group included 61 centers which had successfully completed their expansion program. The second consisted of 72 centers which had requested a 3-month extension. The final group consisted of 68 centers that had requested a 6-month extension. A uniform sampling fraction of one-half was then applied to each stratum for a total sample of 100 treatment centers. The following table illustrates the sampling design:

TABLE I

<u>Status of Facility</u>	<u>Universe</u>	<u>Sample Size</u>
Completed program	61	30
3-month extension	72	36
6-month extension	68	34
Totals	201	100

As simple random sampling was used to draw the sample within each strata, any estimates made from the sample are unbiased.

APPENDIX II

COMMENTS TO THE DRAFT REPORT



DEPARTMENT OF HEALTH & HUMAN SERVICES

Mangan/Heal Reg. 2
Casneron
Brown
Beckel
Public Health Service

Memorandum

Copy Ruth

JUL 29 1991

Date
From Assistant Secretary for Health
Subject PHS Comments on the Office of Inspector General (OIG) Draft Report "Drug Abuse Treatment Waiting List Reduction Grant Program"
To Inspector General, OS

Attached are the PHS comments on the subject OIG report.

The report provides useful data on the extent to which the Drug Abuse Treatment Waiting List Reduction Grant Program reduces waiting lists for drug treatment by expanding the capacity of existing programs.

We concur with the report's recommendations and have taken or are taking action to implement them.

James O. Mason
James O. Mason, M.D., Dr.P.H.

Attachment

IG ✓
PDIG ✓
DIG-AS ✓
DIG-EI ✓
DIG-OI ✓
AIG-MP ✓
OGC/IG ✓
EX SEC ✓
DATE SENT 7/30

RECEIVED
OFFICE OF INSPECTOR
GENERAL
JUL 29 11:15

COMMENTS OF THE PUBLIC HEALTH SERVICE (PHS) ON THE
OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT,
"DRUG ABUSE TREATMENT WAITING LIST REDUCTION
GRANT PROGRAM," OEI-02-91-00420

General Comments

We appreciate the opportunity to comment on this Office of Inspector General draft report. The report provides important information and observations which will assist ADAMHA in structuring any future programs of this type.

Inasmuch as the grantee in most cases for these grants was the State, the report should distinguish between the programs which were subgrantees of the State and grantees which were independents not attached to the State umbrella application.

The awards for this program were made in accordance with the schedule published in the grant announcement. To the knowledge of grants management staff handling this program, receipt of the grant award letters was not delayed from the Federal government as stated in the report. Funds were available to States for drawdown two or three days following mailing of the grant award. Therefore, unless there are other facts to support the statement that Federal funds were delayed, we believe that statements should be removed which indicate that payment was delayed from the Federal government. In every instance where a program received funds late, the State had access to the grant funds shortly after award but chose not to access the funds.

The reasons most frequently given to the Office for Treatment Improvement staff by programs requesting extensions were: (1) subrecipients claimed that in order to receive the grant funds from the State they were required to revise and resubmit their applications to the State; and (2) subrecipients were required to meet their State's requirements (such as legislative approval) before being assured grant funds, a process that could take up to six months.

OIG Recommendation

Assure that waiting lists are not used as the sole basis for awarding a grant, but are considered in conjunction with other indicators of need such as utilization rates and prevalence studies.

PHS Comment

We concur. The Waiting List/Period Program is not scheduled for reauthorization. However, a new Capacity Expansion Program was proposed by the Department in the FY 1992 budget proposal.

This program is proposed to include factors other than waiting list/period as criteria for award.

OIG Recommendation

Support a longer grant period in future legislation of this type. Respondents recommend funding for at least a three-year period to correspond with the States' legislative cycles and to allow them time to start up and to get clients into treatment. At a minimum, some respondents recommend a longer time to draw down the funds.

PHS Comments

We concur. The new Capacity Expansion Program is proposed for a five year period.

OIG Recommendation

Require any future grants to have a maintenance of effort clause to enable programs to increase capacity without experiencing a concurrent cutback in State funds.

PHS Comments

We concur. Any grant program to increase capacity without experiencing a concurrent cutback in State funds should include a maintenance of effort clause. To use grant funds to fund programs currently funded by the State is supplantation which would not be allowed.

OIG Recommendation

Develop a uniform definition of a waiting list and a systematic way of maintaining a waiting list for use by all States. This will help both in planning future legislation and providing more meaningful data on a current basis.

PHS Comments

We concur. We will define the parameters of an acceptable waiting list through a consensus development process with the field.

Technical Comments

Page i, second paragraph, "509(e)" should be "509(E)."

Page i, third paragraph, (2), statement should be added stating, "demonstrate, as of the date the application was submitted, success..."

Page ii, fifth paragraph, it is not clear if "grantees" means subgrantees, the State as the grantees or direct grantees other than the State.

Page ii, the fifth paragraph. the second sentence, and page 8, last paragraph reads: "... over half the States report delays in receiving their money from the Federal Government." See our general comment regarding delays of Federal funds.

Page 1, third paragraph, ninth line, after "Public Health Service Act," insert "as amended by" and before "Public..."

Page 1, fourth paragraph, (2), a statement should be added stating "demonstrate, as of the date the application was submitted, success..."

Page 2, second full paragraph, second line, "to be used" should be replaced with "to be appropriated."

Page 2, last paragraph, first line, "100 grantees and subgrantees."

Page 2, last paragraph, last line, "who" should be replaced with "which."

Page 5, first line, "The block grant was cut right before the waiting list dollars came, so the waiting list dollars didn't increase anything, it just allowed us to continue at the same level." This is supplantation. The Request for Applications clearly stated that the waiting list funds were not to be used to substitute/supersede State funds, which were meant to continue assisting programs as they had in the past.

Page 5, first line, it should, also, be clarified that any reduction in the block grant was in the State's apportionment to the subgrantees of the block grant funds which the Federal government awarded to the State. This sentence without explanation suggests that the Federal government reduced the block grant to the State which it did not.

Page 7, "RESPONDENTS' VIEW OF PROGRAM'S SUCCESS ARE TEMPERED BY CONCERNS OVER CONTINUED FUNDING." The report should include the statement that States were required to provide letters of assurance giving applicants, submitted under the State's umbrella application, "top priority" for continued future funding once the Federal grant terminated.

Page 9, third full paragraph, fourth sentence, since construction and renovation (except for minor changes) costs were not allowed in the legislation for the grants, we are concerned with this implication that grantees have expended

Federal funds for heavy construction items which were not allowed.

Page 8, last sentence, it should be clarified whether the award was delayed from the Federal government to the State or other grantee or was delayed from the State to the subgrantees.

The following statements concern delay in receiving funds which we believe should be more clearly attributed to the States and not to the Federal program:

Page 2, first complete paragraph, second sentence, "Funds were usually awarded quickly, with priority going to those treatment programs judged to have the greatest need to expand their treatment."

Page 8, fourth paragraph, last sentence, "One State respondent voices the concern of many when he admits that the 'programs (in the State umbrella grant) experienced even bigger delays to get through our bureaucracy.'"

Page 9, first paragraph, end of the third line which addresses reasons for grantees requiring extensions, "(1) slow startups due to delays in obtaining funding..."



DEPARTMENT OF HEALTH & HUMAN SERVICES

Margaret Hobbs
Breton
Cameron Office of the Secretary
Region 2
Boebel Washington, D.C. 20201

JUL 11 1991

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Drug Abuse Treatment Waiting List
Reduction Grant Program," OEI-02-90-00420 -- COMMENT

Thank you for the opportunity to review the above-named draft report. I think the report provides useful guidance regarding the problems posed by one-year grant programs such as the Waiting List Reduction Program. The study also proved timely as it contributed to a Congressionally required study on this program. I would like to clarify, however, that while the idea for this study resulted from the routine OIG and ASPE staff level "brainstorming" discussions, the study should not be characterized as one that was formally requested by ASPE.

If you have any questions, please call Elise Smith at 245-1870.

2

Martin H. Gerry

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PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
AIG-MP	<input checked="" type="checkbox"/>
OGC/IG	<input type="checkbox"/>
EX SEC	<input checked="" type="checkbox"/>
DATE SENT	<i>7/15</i>

DEPARTMENT OF HEALTH & HUMAN SERVICES

Counsel to the Secretary
for Drug Abuse Policy

Washington, D.C. 20201

July 11, 1991

MEMORANDUM TO DICK KUSSEROW
INSPECTOR GENERALFROM: MARK BARNES
COUNSEL TO THE SECRETARY
FOR DRUG ABUSE POLICYSUBJECT: Draft Report of the Office of Inspector General entitled
Drug Abuse Treatment Waiting List Reduction Grant
Program -- COMMENTS


I am transmitting to you comments from the Office of National Drug Control Policy (ONDCP) review of this document, which I requested and also endorse. I understand that J.C. Comolli of my staff has spoken with Emilie Baebel from your office concerning the ONDCP review. Please let me know of any questions you may have concerning these comments.

Thank you for your attention to this matter.

ATTACHMENT

July 3, 1991

MEMORANDUM FOR MARK BARNES

FROM: Barbara Tenaglia 

SUBJECT: Drug Abuse Treatment Waiting List Reduction Grant Program

Mark, sorry for the delay in responding. Below are comments along with some pages with edits.

This report is basically a condensed version of the Waiting List Reduction Report that was prepared by OTI for Congress. It reviews the waiting list program and how it has reduced waiting lists. The IG's recommendations support our current legislative proposals, including:

- o assure that waiting lists are not used for the sole basis for awarding a grant. This is a very good point, and we should use it to respond to section 510 of the Kennedy bill which dropped utilization rates as one of the Capacity Expansion Program criteria.
- o support a longer grant period in future legislation of this type. Our CEP allows for this; however, OMB may oppose this recommendation.
- o require future grants to have maintenance of effort clause.
- o develop a uniform definition of a waiting list and a systematic way of maintaining a waiting list.

The report states findings; however, it fails to state that it is based on partial data as many of the grantees have received extensions through July 15 and therefore have not submitted data to HHS.

In addition, the IG reports that the waiting list program created 20,073 slots. However, the OTI report to Congress showed that HHS has no information regarding how many slots were actually created. Therefore, the IG report should state that 20,073 slots were funded.