Written Testimony Regarding Reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA)

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Submitted to the Senate Health, Education, Labor, and Pensions Committee

Senator Edward M. Kennedy, Chairman
Senator Michael B. Enzi, Ranking Member

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Mr. Chairman, Ranking Member Enzi and Members of the Committee, I am Rodger McDaniel. I am the Deputy Director of the Wyoming Department of Health with responsibility for the Mental Health and Substance Abuse Services Division. I am also a member of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). I am grateful for the opportunity to share my thoughts with you as you consider legislation re-authorizing the Substance Abuse and Mental Health Services Administration and am appreciative of the work of this Committee and your colleagues in the Congress to help the states meet the growing challenges of substance abuse and addiction.

Some time ago I came across a May 9, 1897, issue of the Saratoga, Wyoming newspaper, The Saratoga Sun. A front page editorial read in part:

> "*There is entirely too much drunkenness in this town for the comfort of peaceable and law abiding people. It is hardly possible for a lady to pass along the street without having drunken and profane language issuing from the saloons there. Drunk men and lewd women should be made to keep their places."*

Of course, these problems were not new to the 19th century west. From ancient times, societies have grappled with the problems caused by the excessive use of mind altering substances. For the better part of all of those efforts over many centuries, there was little in the way of science to illuminate the path. In the last decade, that has changed primarily because of an explosion of good science to provide guidance. However, it remains the case that both policy and practice are based more often than we would like on myth than on science.

The preface to Rethinking Substance Abuse: What the Science Shows and What We Should Do About It, a 2006 book edited by doctors William R. Miller and Kathleen M. Carroll includes this "to the point" history of attempts to remedy substance abuse and addiction.

> *Historically, problem drinkers have been whipped, dunked shocked, poisoned with potions, chained, dialyzed, terrorized, drugged with hallucinogens, Interferon, and all manner of psychiatric medications. More recently, the users of illicit drugs have been lectured to, fined, imprisoned," scared straight", given "attack therapy", and sent to boot camps.**** The bad news is that very little science has found its way into practice."*[i]

The problems associated with substance abuse have cut a wide swath across our society limiting the potential of individuals and institutions. According to the National Conference of State Legislatures, drug abuse costs exceed 350 billion dollars each year, accounting for more than 550,000 deaths.[ii] The neglected and abused children of addicted parents overwhelm the foster care system. Spending increases in the corrections system and Medicaid are driven in large measure by drug abuse and addiction. Homelessness and addiction are interrelated as well. A May 2005 report on homelessness in Wyoming

found substance abuse a major factor in 22% of the homeless population.[iii] I have attached a copy of this report to my testimony for the Committee record.

The Wyoming Department of Health is currently completing a study of the mental health and substance abuse needs of veterans of the wars in Iraq and Afghanistan. Those wars aside, it is recognized that the rate of alcohol dependence is greater among the veteran population than among others. The New York Times reported in March of this year that alcohol, though "strictly prohibited by the American military in Iraq and Afghanistan, is involved in a growing number of crimes committed by troops deployed to those countries."[iv] The well known linkage between post traumatic stress disorders and substance abuse and addiction is also a reliable predictor of the additional weight returning servicemen and women will put on already strained state substance abuse and mental health treatment services.

Despite the cause for concern, we are beginning to see signs of the success of the combined state, federal and local community efforts. First time meth use among Wyoming high school students has declined. Given the uniquely addictive nature of this dangerous drug, this is a significant success of our joint prevention efforts. From 1999 through 2006, first time meth use among high school students in Wyoming declined by about one-third. Importantly, Wyoming has also seen effective law enforcement efforts reduce the numbers of clandestine lab operations by more than 80% since 2001. Certainly meth continues to enter the state from Mexico and other places but the decline in state located labs is a meaningful development given the health and environmental dangers posed by these labs.

Five years ago Wyoming had few meaningful standards for providers. Today we have research-based standards applicable to any provider receiving state funds or court referrals. Providers certified under those strong standards have increased by 63% in the last five years meaning there are more providers who are better qualified than ever before. During that time, Wyoming has gone from three struggling drug courts to having 25 successful drug courts across the state with documented outcomes saving tax dollars and holding addicted offenders accountable while encouraging them into recovery.

Despite these successes, the challenge presented by the abuse of alcohol and other drugs continues to be daunting and costly. Addiction affects all Americans and virtually all public services.

I want to especially note the partnership we have experienced in Wyoming as Governor Dave Freudenthal, the First Lady, Nancy Freudenthal, and the state legislature have played key roles in providing necessary leadership and resources for treatment. The First Lady has been an especially strong voice raising the level of awareness about the problem of underage drinking. The Governor and the legislature have responded quickly and decisively to the high rates of methamphetamine use in our state.

State funding of treatment and prevention have increased significantly. In 2000, the 2.4 million dollars received by the state in the Substance Abuse Prevention and Treatment Block Grant represented more than one-third of Wyoming's expenditures on treatment and prevention. In FY2007 the Block Grant's contribution has dropped below 10% even though it increased to just over 3.3 million dollars. Our state now funds more than 90% of the treatment and prevention costs.

I would like to offer the committee three recommendations. The first involves strategies to replace the myths with the science in order to promote more effective prevention and treatment and more relevant public policy. The second is that Congress give states and local communities the flexibility they need to make the best use of their resources and community leadership to address their own unique substance abuse problem. Finally, I recommend that we stay the course on accountability, recognizing the progress that has been made and working together on a continual quest to improve client outcomes.

Moving from myth to science. I am not a clinician nor am I an expert on brain science. I am a systems person which is to say I think in terms of broad systems and how they can interact to achieve certain objectives. Far too often, systems such as the judicial system, child welfare, public benefits, correctional and educational systems operate in isolation from one another. People suffering from addictive disorders, however, live in a different world, one where their use of drugs is a part of a life organized around a combination of experiences. Addicts often exhibit failure in the school system and on the job, in their families, financial dysfunction, encounters with civil and criminal court systems, child abuse and neglect, sexual issues, health problems and more. The world of the addict is one in which systems self-organize and interact negatively around seeking and using drugs. Prevention and treatment efforts are often somewhere else, isolated from the many different systems that comprise the complicated world of addicted persons.

Mr. Chairman, over the last 40 years, I have viewed the substance abuse system from several perspectives. As a state lawmaker for 10 years, as a lawyer practicing family law for 20 years, as a jail and prison chaplain for 5 years, I worked with addicted persons and the programs that serve them in several capacities. However, it was not until I experienced these problems as a parent that I began to study substance abuse enough to ask hard questions like "why do people use drugs when the consequences are so dire?" Because our family had the resources necessary to purchase the best treatment in America, our family member did well and has gone on to enjoy a good life interrupted only briefly by substance abuse.

But while that was happening I was serving as a jail chaplain. There I saw countless addicts in the corrections and child welfare systems, continuing to live out actively hopeless lives, getting either no treatment or ineffective treatment. I began to look at the system and to ask questions about the science and what worked and why. In some measure, the difference between those who got help and those who did not were resources. But there was something more troublesome. Operational myths such as "the addict really has to want it before treatment will work" effectively substituted for the responsibility of the system to produce outcomes. Additionally, the known science was either ignored by or not known to many of the clinicians and policy makers whose decisions directly impacted lives.

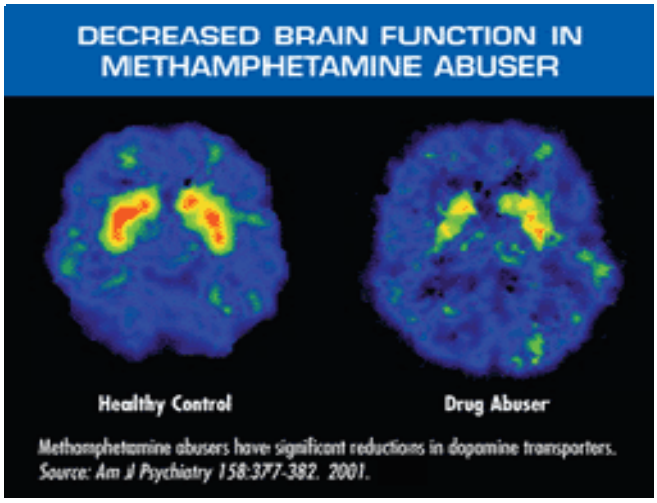
While many operate on popular notions that addiction is the result of character defects or bad parenting, the science teaches that addiction is a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful, even catastrophic consequences for the addict and those around him or her. An important goal of current neurobiological research is to understand, through the use of various scanning technologies, the neuron-pharmacological and neuron-adaptive mechanisms within

specific neuron-circuits that mediate the transition from occasional, controlled drug use to the loss of behavioral control over drug-seeking and drug-taking that defines chronic addiction.

Although significant work remains to be done, we have determined that drug dependence negatively impacts the orbito-frontal cortex rendering the individual to be insensitive to the future consequences of their behavior. The research has identified that part of the brain that is critically involved in the evaluation and inhibition of stimulus-reward associations, emotion processing, and decision-making and the regulation of social behavior.

In other words, while the decision to use and abuse drugs is a matter of choice, there comes a time when continued abuse turns on the addiction switch in the brain. That time can vary depending on factors ranging from genetics to environment to type of drug and frequency of use. But it is an actual re-wiring of the brain chemistry that trips that switch. Choice is replaced by a brain-driven compulsivity to use drugs as the addiction literally rewires the brain and "desensitizes" the addict from the consequences of their behavior.

A key SAMHSA goal is to identify ways of bringing this constantly changing and growing neurobiological knowledge to the treatment field in the form of evidence-based practices based on individual need.



(Reprinted from "Drugs, Brains and Behavior:
The Science of Addiction" a publication of NIDA, page 19.)

If lawmakers, policy makers, judges, social workers, therapists, parents and others could achieve a common understanding of addiction based on the science, we would be in a far better position to find real solutions.

As I listen to legislative debates, read child welfare caser plans or watch courtroom dramas involving drug use and addiction, I feel at times as though I am watching the six blind men describe the elephant. Everyone is using the same terms; e.g. *addiction, drug abuse, accountability, treatment.* But to each speaker, those words have a different meaning. If you ask the key players in the courtroom or many state legislative committees where they get the information upon which to decide matters of substance abuse, they will repeat the myths, talk about personal life experiences or reference the

popular cultural images. Ask them sometime how much of their information actually comes from the scientific literature and the data. In truth many of the players in this arena continue to be guided in whole or in part by the myths instead of the science.

I am often asked, "What is the one thing that could be done to solve the challenges posed by substance abuse and addiction?" I used to caution against looking for a "magic bullet." But I have come to believe there is one thing that would make a huge difference and that is exchanging myth for science in therapy, in courtrooms, and in law making. A former colleague of mine in child welfare work called this "the need to update people's stereotypes." Indeed if we could update the stereotypes related to addiction, countless lives and dollars could be saved.

Relying on the myths that have been debunked by good science is not simply a neutral activity. Resorting to myth when science would lead to a better decision is harmful both in terms of wasted lives and wasted dollars. I found a helpful, working definition for the word "myth." Myth is a lesson in story or anecdotal form which has deep explanatory or symbolic resonance for preliterate cultures, who use myths to preserve and cherish the wisdom of their elders."

In the context of substance abuse, the term "preliterate" can be read to refer to those who have not brought recent science to their thinking and practice. In my experience there are at least five such lessons frequently told in story or anecdotal form which have deep explanatory or symbolic resonance for these preliterate cultures who have used these myths to preserve the wisdom of their elders…deadly myths which are often at the heart of poor judicial and legislative decisions and harmful therapeutic practices.

1. The myth that "a person has to hit rock bottom before they are ready for treatment." Consider for a moment what that means. It means we watch while the addict both suffers and causes others to suffer. Hitting rock bottom often means the loss of jobs, health, homes and families en route to the bottom where addicts commit crimes, acts of domestic violence and child abuse, where there are victims of their acts and costly criminal processes or oftentimes death. Waiting for an addict to hit rock bottom ignores the fact that there is ample science to permit to use of early intervention. Courts can see the signs of addiction in the persons who appear before them for minor criminal acts. Schools, employers, the faith community and others are aware long before the addict hits rock bottom that a person needs help. The myth about hitting rock bottom is an excuse for doing nothing when it would matter most.
2. The myth that a person "really has to want treatment before it will work" is one that I find especially troubling. One of the most successful interventions, particularly for chronic, serious, high risk addicts is drug court. It is successful for a number of reasons but in general because the drug court judge creates an environment that coerces the addict into disrupting his or her pattern of drug use for a long enough period of time that the addict integrates other, healthier behaviors into his or her lifestyle, eventually replacing drug use altogether. The research is clear that coerced treatment works. Courts are not the only

place where coerced treatment can be effective. Employers have great capacity to force addicted employees to make hard choices.

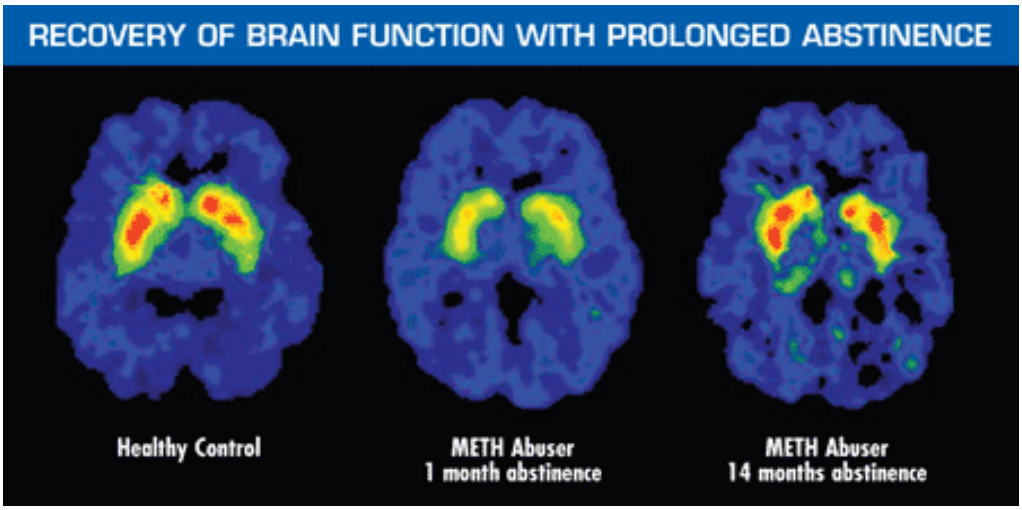
3. The myth that addiction can be resolved by longer and mandatory jail sentences and other penalties such as the loss of student loans or other government benefits. One of Wyoming's outstanding law enforcement professionals is the Chief of Police in Casper. Tom Pagel says it well. Chief Pagel says there are criminals who commit drug crimes for profit and there are drug addicts who commit crimes to feed their addiction. He cautions against treating them all the same in the criminal justice system. When I served as a jail and prison chaplain, I grew weary of watching the offenders and their families walk repeatedly through the revolving jail house doors. Addicts sentenced to longer, even mandatory minimum terms. Families left with children divided among relatives or placed in foster care by a system that knows children who have that experience are considerably more likely to have addiction problems themselves. Part of effective treatment means holding addicts accountable but there is little accountable about spending time in jail without treatment. As the brain imaging clearly demonstrates, addicts have a brain disease and jail sentences, regardless of length, will not change that unless accompanied by effective treatment for the neuron-chemically caused brain damage.
4. The myth that teaches addiction is a character defect exhibited by those who simply refuse to exercise self control. As a young lawyer I knew nothing about the science of addiction. Yet I often represented clients who would be threatened by judges with the loss of their children or with prison sentences if they took one more drink or used drugs one more time. To me, it seemed like a no-brainer. After all who would choose to use again when the consequences were so clearly contrary to their own best interests. But use again most of them did. The science explains the way in which addiction is characterized by the compulsive need to use even though there are such dire consequences. When you look at the brain scans of active addicts, it is clear even to a lay person that the changes wrought by drugs to key parts of the brain are significant. Legislative decisions and judicial practices built around the science of addiction are far different from those built on a belief that addicts should "just say no."
5. The myth that addicts should not use medications because that is "only trading one drug for another." This is among the more discouraging of all myths because I hear it often from certified, trained therapists who would know better if they had updated their own stereotypes for the science. Because addiction is a disease characterized, in part, by relapse, new prescription drugs have been developed that reduce the cravings and, therefore, the risk of relapse. This is an important example of how an understanding of the brain science leads to helpful therapies.

I do want to especially commend the National Institute on Drug Abuse, HBO and the Robert Wood Johnson Foundation for their recent work to make this important knowledge more understandable and accessible to citizens and policy makers alike.

NIDA has published a remarkable booklet entitled "Drugs, Brains and Behavior: The Science of Addiction." It is an inviting, informative, reader friendly work that joins the HBO/Robert Wood Johnson film documentary entitled "ADDICTION" as two of the most important public efforts in recent years to change the thinking on this critical issue.

The key to developing effective public policy as well as effective treatment and prevention is the ability to articulate the changes in the brain's reward system is the cornerstone. I am not an expert on the working of the brain but I do not think policy makers need to be if they can grasp the basic concepts. I have read books and listened to presentations that make all of this very complicated. I have also heard lay persons describe the neurobiology of addiction in a way that I can understand.

My first exposure to the brain science came during a methamphetamine conference in Walla Walla, Washington. I was seated with a group of Washington State legislators one of whom was a member of their Appropriations Committee. We watched a presentation that included slides of brain scans showing the progression from non-use to abuse to addiction and on to treatment and recovery. Especially informative are the brain scans of those persons who are fully and actively addicted. Even a lay person can see that in key parts of the brain where we make decisions and exercise judgment, the lights are off. Yet this is the picture of the brain of those who enter treatment. The Washington legislator looked at that slide and said, "Ah ha…so that's why our 28 day programs don't work!"



(Reprinted from "Drugs, Brains and Behavior:
The Science of Addiction" a publication of NIDA, page 25.
Attachment B is a larger image of this brain scan.)

The slide supports other conclusions as well such as why typical probation programs do not work as well as fully supervised drug courts and why the 15/22 rule of the Adoption and Safe Families Act can be an effective tool in coercing addicted parents into treatment and recovery if better understood by social workers and judges.

It is helpful of course that scientists and researchers have come to understand the way in which increasing, continuous drug use paves the way in the brain for addiction by altering the reward system but what is critical is that lawmakers, judges, social workers

and probation officers have a working knowledge of this information. Knowing that chronic drug use lowers the threshold of the brain's reward system and that withdrawal raises that threshold is information that should be used to design probation programs and clinical practices.

I would encourage Members of Congress to consider using the re-authorization of SAMHSA as an opportunity to explore strategies for expanding the knowledge of addiction related brain neuron-chemistry to those on the front lines, e.g. judges, social workers, corrections officials, therapeutic community and others working directly with addicts and their families. Unless those in the trenches are provided a basis for understanding this science, it will be many more decades and countless millions of lost lives and dollars before the science is integrated enough in the actual work of these systems to make a difference.

In fact, SAMHSA already has two important structures designed to infuse the latest science into our service systems: the Addiction Technology Transfer Centers (ATTCs) and Centers for the Application of Prevention Technologies (CAPTs). These regional entities, located throughout the U.S., work to translate the latest substance abuse science in order to create learning opportunities to improve the practices of States, counselors, prevention professionals and community coalition members. The CAPTs and ATTCs sponsor regional conferences, workshops, and training of the trainer events regarding evidence-based practices, provide customized technical assistance, develop training curricula and products, and create online courses and classes. Unfortunately, the ATTC's and CAPTs are under-funded, with the proposed FY 2008 budget seeking to eliminate funding for the CAPTs altogether.

These strategies should be pursued even as additional funding is provided to expand the brain and genetics research related to addiction disorders. But it is not enough that a select group of scientists are aware of the genetic impacts on brain development leading to addiction. The development of the science must be accompanied by a diffusion of the knowledge so that it can replace the myths that too often drive therapeutic practices and public policy choices. NIDA and other researchers knowing that brain development makes some folks more susceptible to addiction than others and that the reward circuitry of the brain may control one's reaction to chronic drug use…is important but it is not sufficient. It is when I start to hear discussions of the way in which chronic drug use changes the brain in the coffee shops around rural Wyoming, that I will know we have a winning strategy.

Systems improvement through flexible funding. Providing effective treatment and making good public policy also requires a recognition of the fact that drug use is generally experienced as a part of a larger universe of social problems. Drug use is usually accompanied by school failure, mental health issues, family dysfunction, domestic violence, problems with health, housing, jobs, child behavior and more.

People who chronically use drugs en route to addiction are frequently clients of the correctional, public welfare or child welfare systems. They come to the early attention of lower level criminal courts. Some are chronically homeless or out of work. As a result, addicts and chronic drug abusers fill the ranks of the clients of a variety of public service systems. Therefore, neither prevention nor treatment should be an endeavor isolated to a group of the usual suspects.

SAMHSA has been especially cognizant of the systems issue. Sponsoring training opportunities such as the June 2007 conference entitled "Achieving Common Goals" bringing together relevant agencies to discuss innovative ways to address common client problems is an example of their responsiveness.

It is equally true that the problems presented by drug abuse are different in different communities. For example, the 2005 Youth Risk Behavior Survey concluded that while 8.5% of high school students had tried methamphetamine during their lifetime, 77% had already used alcohol. A 2005 survey of law enforcement officials disclosed that in 10 of Wyoming's 23 counties, 59% of all arrests involved alcohol.

A number of Wyoming communities are experiencing high rates of meth use. Even more have continued to experience high rates of alcohol abuse. In others, there is a growing concern about prescription drugs. States and communities need flexible funding streams that allow them to address their unique substance abuse challenges.

Virtually all of the "systems" necessary to comprehensively treat and prevent substance abuse are local systems. They include the local court system, a local public and private treatment provider system, local child welfare system, local schools, public health, housing, business and faith communities and family systems. Systems improvement is vital to positive outcomes for addicted persons. While the federal and state governments can encourage local systems improvement, it will actually happen only through the empowerment of local community leadership.

Accordingly, my state and others would benefit from a flexible funding approach giving states room to navigate through their unique drug problems, their unique political and economic systems, their unique geography, and their unique set of resources.

Wyoming's drug court program is an example of the sort of flexibility that allows funds to be used creatively in different communities to achieve broad common goals. The state legislature has provided funding within a framework that requires local drug courts to use the 10 components of an effective drug court. Beyond that, local communities and courts may decide how to use the state funding to meet local needs. In some communities there is a priority for adult felony courts, in others the need is for juvenile courts, or family treatment of DUI courts. A critical ingredient of the success has been the fact that the legislature has provided for coordination of the program though the office of the single state authority.

Another example of our approach to systems improvement coupled with flexibility is our new contracts with substance abuse providers. Each public treatment provider is now being asked to enter into a memorandum of understanding with their local child welfare, public welfare and corrections systems to create a shared set of goals and practices to assure effective treatment of common clients across their systems. At the end of this process, we expect there will effectively be a single system, single case plan, and single set of shared values that persons who need services will experience when they walk through anyone of those doors with a metal health or substance abuse problem.

This flexibility should be applied to the Substance Abuse Prevention and Treatment Block Grant which has been an effective and efficient funding stream to support vital services to Wyoming citizens. The drug problem is much more a community problem than a national problem. No one has more at stake in meeting the challenge than the neighbors of those who are addicted and their families. No one has more to lose or more

to gain than the folks who live in the community or the neighborhood where drug use causes chaos. Given flexibility, these community leaders will make the right choices.

Accountability. I am comfortable that I speak for all state administrators when I say we are as concerned as any Member of Congress about the accountability of all of us to produce good outcomes.

Wyoming has experienced technical problems in getting its system on line but we are there now and so is nearly every other state. I believe the states, working with SAMHSA and NASADAD, have made excellent progress on the establishment of the National Outcome Measures. I especially want to recognize the hard work of our Governor and the Wyoming Legislature in demanding outcome data as they have supported greater investments in the treatment system.

NASADAD can tell you more about the other states but in Wyoming the legislature has enacted statutory requirements that the Department of Health use outcome measures for treatment programs. We are using the National Outcome Measures (NOMS). The legislature further enacted a measure requiring that I, as the SSA, withhold funds from all provider contracts until and unless we have a written agreement on measuring outcomes. Finally, the Governor and the legislature have demanded that our system measure outcome data across agency systems in order to broadly assess outcomes on a longitudinal basis.

The provider community has stepped up and agreed to measure outcomes based on the NOMS. Our contracts require each provider to report NOMS quarterly on all clients. As this data accumulates, we will be in a better position to improve services, identify best practices in our rural state and to inform policy makers as they grapple with funding and legislative decisions.

Wyoming and other states are fully committed to NOMS reporting. Yet I do want to express concern about a FY2008 budget proposal to penalize 5% of the Substance Abuse Prevention and Treatment Block Grant for those states that are unable to report NOMS by the end of this year. If we are unable to do so, and I do not currently expect that to be the case, it will not be because of any reluctance to do so on the part of the state agency or the providers. It would result from gaps in our data infrastructure and the ongoing technical challenges of effectively integrating data collection and reporting technologies.

I agree with NASADAD that providing positive incentives is better and more effective public policy than imposing block grant reductions that will directly impact our ability to provide necessary treatment and prevention services to citizens.

Additionally, we are exploring the use of a process similar to the Children and Family Services Reviews under the Adoption and Safe Families Act. Under that process every state child welfare system is evaluated using a common tool to determine the extent to which the states are meeting the safety, well-being and permanency needs of children in state care.

One of the tools used to improve performance of the child welfare system is the Citizen Review Panel enabling consumers and other citizens, along with child welfare professionals to actually participate in case reviews in order to have the sort of transparency that actually improves systems. We are considering a process that would mimic that same consumer centered process in order to review treatment practices for the

purpose of enhancing accountability by making the substance abuse treatment system less mysterious and more transparent.

Conclusion: Thank you for this opportunity to appear before your Committee and to offer my views on the important work before you. Please know that the Office of Wyoming Governor Dave Freudenthal and the Wyoming Department of Health welcomes any opportunity to be of assistance in your work. Additionally, NASADAD stands ready to support and work with this Committee on issues related to substance abuse and mental health – including SAMHSA reauthorization. NASADAD's expertise and commitment to improve service delivery represents a wonderful resource.

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[i] Rethinking Substance Abuse: What the Science Shows and What We Should Do About It, William R. Miller and Kathleen M. Carroll editors, Guilford Press (2006) at page *xi*

[ii] *Substance Abuse as a Cross-cutting Issue* by Matthew Greer, National Conference on State Legislatures (November 30, 2006)

[iii] *Homelessness in Wyoming,* Wyoming Interagency Council on Homelessness (May 2005)

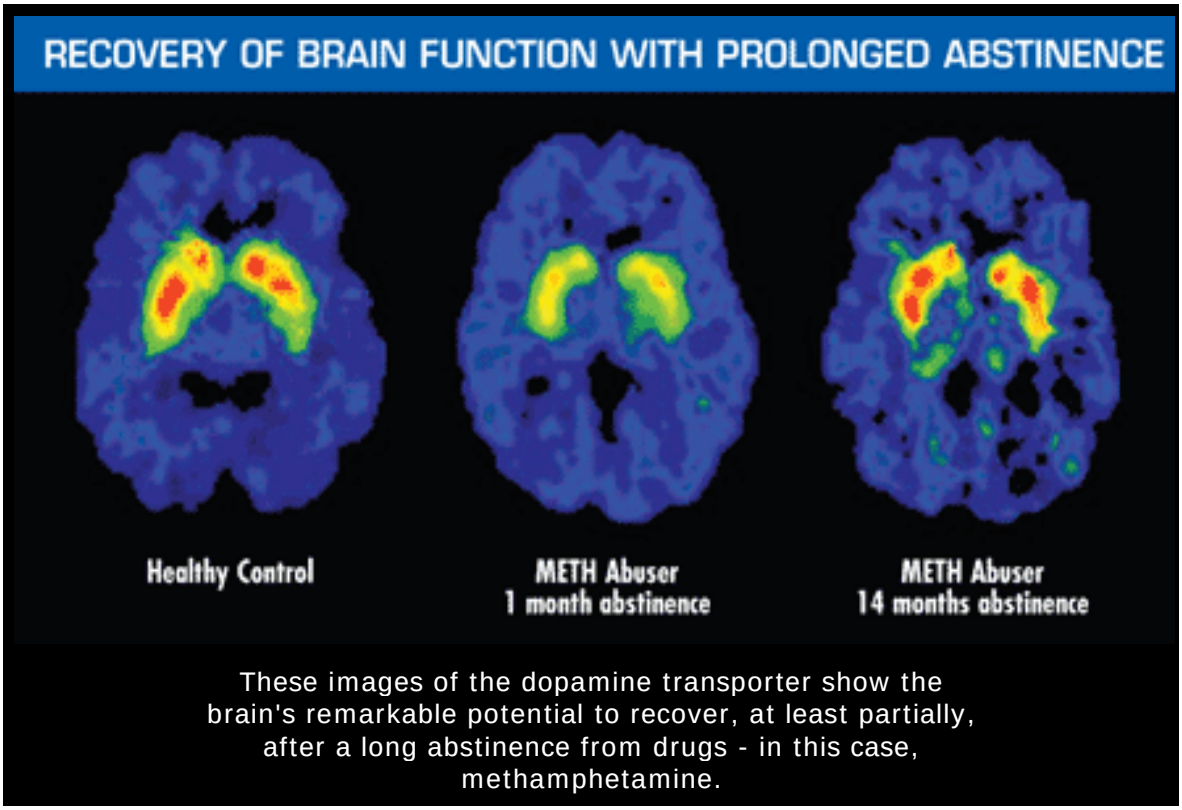
[iv] New York Times newspaper March 13, 2007

ATTACHMENT A

Wyoming
Substance Abuse Prevention and Treatment Block Grant Awards

Federal Year	SAPT Award		State Funding	Total Funding	% SAPT Funding	% State Funding
FFY2007	$3,305,977	SFY-2008	$ 30,965,682	$34,271,659	9.65%	90.35%
FFY2006	$3,299,412	SFY-2007	$ 23,293,913	$26,593,325	12.41%	87.59%
FFY2005	$3,333,448	SFY-2006	$ 19,753,778	$23,087,226	14.44%	85.56%
FFY2004	$3,333,335	SFY-2005	$ 15,466,986	$18,800,321	17.73%	82.27%
FFY2003	$3,193,795	SFY-2004	$ 15,393,328	$18,587,123	17.18%	82.82%
FFY2002	$3,048,693	SFY-2003	$ 15,209,480	$18,258,173	16.70%	83.30%
FFY2001	$2,751,260	SFY-2002	$ 8,303,744	$11,055,004	24.89%	75.11%
FFY 2000	$2,452,377	SFY-2001	$ 4,755,678	$7,208,055	34.02%	65.98%

ATTACHMENT B



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