RECOVERY NOW INITIATIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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RECOVERY NOW INITIATIVE

THURSDAY, FEBRUARY 27, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:07 a.m., in room 2154, Rayburn House Office Building, Hon. Mark E. Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder, Davis of Virginia, Mica, Blackburn, Cummings, Davis of Illinois, Bell and Ruppersberger.

Staff present: Christopher Donesa, staff director and chief counsel; Nicholas Coleman and Elizabeth Meyer, professional staff members; John Stanton, congressional fellow; Nicole Garrett, clerk; Julian A. Haywood, minority counsel; Earley Green, minority chief clerk; and Teresa Coufal, minority assistant clerk.

Mr. SOUDER. Good morning, and welcome to all of you for the session's first meeting of the 108th Congress. We have a full agenda for this session, and I'm very much looking forward to the opportunity to continue working on it with our distinguished ranking member, the gentleman from Maryland, Mr. Cummings.

I would also like to welcome Chairman Tom Davis of the full committee to our hearing today and to thank him publicly for the strong personal interest and support he has demonstrated for the work of this subcommittee.

I would finally like to thank and specially recognize our new vice chair, the gentleman from Georgia, Mr. Deal and all of the new Members on both sides of the aisle.

The subcommittee will be most intensely focused in the beginning of this Congress on the reauthorizing legislation for the Office of National Drug Control Policy and its programs. Next week we will begin a series of hearings on that legislation. Our topic for today, however, is so important that I thought it should be the natural first meeting for the subcommittee.

Today's hearing will consider the significant new drug treatment initiative announced by President Bush in his State of the Union Address. Drug treatment, specifically getting treatment resources where they are needed, is one of the cornerstones of our national drug control policy and strategy and must be a prominent part of any sensible drug policy.

The necessary emphasis on law enforcement and homeland security issues during the last Congress prevented the subcommittee from addressing treatment issues to the extent they deserved. So

I particularly wanted to begin with treatment at the center of our agenda today.

The President's initiative is a substantial, innovative and compassionate step forward. I commend his personal interest and support in emphasizing drug treatment as a priority item in his domestic agenda. His proposal will take a big step forward to make drug treatment fully available in the United States. Perhaps just as importantly, however, it will also break new ground by taking steps toward greater availability, accountability and innovation in the treatment choices available to help addicted Americans get well.

The President's initiative would provide $600 million over the next 3 years to supplement existing treatment programs. That amount of money is intended to pay for drug treatment for most Americans who now want it but can't get it, many of whom can't afford the cost of treatment and don't have the insurance that covers it. It could help up to 100,000 more users get treatment. The program also has enormous potential to open up Federal assistance to a much broader range of treatment providers than are used today.

Through the use of vouchers the initiative will support and encourage variety and choice in treatment and could open up and support a significant number of new options for drug users to get treatment. Finally, the emphasis on accountability should help us make significant progress in the most difficult issues of drug treatment policy, finding and encouraging programs that truly work to help and heal the addicted as well as ensuring a meaningful and effective return on taxpayer dollars spent on treatment.

I am pleased to welcome today's excellent witnesses for the first public hearing and detailed discussion of this important Presidential initiative. From the Office of National Drug Control Policy we are joined by Director John Walters, who has enthusiastically and energetically worked to outline and develop the program. From the Substance Abuse and Mental Health Services Administration, we are joined by the Administrator, my fellow Hoosier, Charles Curie. Thank you both for your leadership. We will later be joined by Dr. Jude Boyer-Patrick, who has been a leading treatment professional in the State of Maryland, to receive her insights.

It is a real pleasure to have all of you here today, and the subcommittee looks forward to discussing the initiative with you in depth.

[The prepared statement of Hon. Mark E. Souder follows:]

Opening Statement
Chairman Mark Souder

"Recovery Now: The President's Drug Treatment Initiative"

Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Committee on Government Reform

February 27, 2003

Good morning and welcome to all of you for the Subcommittee's first meeting of the 108th Congress. We have a full agenda for this session, and I am very much looking forward to the opportunity to continue working on it with our distinguished Ranking Member, the Gentleman from Maryland, Mr. Cummings. I would also like to welcome Chairman Tom Davis of the full Committee to our hearing today, and to thank him publicly for the strong personal interest and support he has demonstrated for the work of the Subcommittee. And I would finally like to specially recognize our new Vice-Chair, the Gentleman from Georgia, Mr. Deal, and all of the new members of the Subcommittee on both sides of the aisle.

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Mr. SOUDER. I now yield to the ranking member, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I am very pleased that we are holding this hearing today. I'm glad that the administration is taking a closer look and putting a greater emphasis on treatment. Treatment is something that I have preached about since I came here some 6½ years ago.

But before I go into my official statement Mr. Chairman, I'd like to welcome to our subcommittee, Chris Bell from Texas, Linda Sanchez from California, and certainly Dutch Ruppersberger, my Maryland colleague, who has worked with me prior to coming to the Congress in so many drug issues in the Baltimore area, and our districts literally are connected to each other. So I welcome him. I know that he will be a tremendous asset to our committee.

Let me just say a few things right here. Mr. Chairman, there is no simple issue that is more important to me than the issue of drug treatment. Baltimore City, the city I represent in Congress, has been devastated by recent epidemics of crack cocaine and heroin addiction. There are some 65,000 people in Baltimore addicted to illegal drugs, roughly a tenth of the city's population, and these people desperately need treatment, and effective treatment.

It is interesting to note while I applaud the President's effort with regard to treatment, and I think it is absolutely wonderful, I must tell you that when I returned to my district the day after and talked—after the State of the Union and folks were talking about the program in Baltimore, we saw it from a whole different perspective. When the President talked about helping 300,000 people, the people in my district said, well, we've got 65,000 right in 1 of 435 districts—we've got 65,000 just in our district. And so that is not necessarily a criticism, because one thing that I must say is the drug czar are—Walters is making a study, marching toward the right direction as opposed to staying still or going backward, and I do appreciate that. I want to make that real clear, but I want to put this in context, too.

Last year, Mr. Chairman, you convened a field hearing in Baltimore at my request, and we heard testimony concerning the results of a ground-breaking study entitled Steps to Success: The Baltimore Drug and Alcohol Treatment Outcome Study. Commissioned by the Baltimore Substance Abuse Systems, Inc., and conducted by the University of Maryland, Johns Hopkins University and Morgan State University, the study examined nearly 1,000 treatment participants in 16 licensed, publicly funded treatment programs. The findings indicate a marked reduction in drug and alcohol use, criminal conduct, risky health behaviors and depression among individuals who voluntarily entered publicly funded outpatient drug and alcohol treatment programs in Baltimore City.

In the judgment of the Baltimore City Health Commissioner Peter Beilenson, Steps to Success proved conclusively that drug treatment is effective in Baltimore City. The study remains the largest, most comprehensive and most thoroughly documented study of its kind to focus on a single city. The Baltimore study's findings reinforce those of other drug treatment studies, including a report by the Institute of Medicine which found that, "an extended abstinence, even if punctuated by slips and short relapses,

is beneficial in itself and may serve as a critical intermediate step toward lifetime abstinence and recovery."

In announcing the National Drug Control Strategy and drug control budget last year, President Bush and the Office of National Drug Control Policy Director John Walters expressed a strong commitment to, "healing American's drug users," pledging an additional $1.6 billion in drug treatment funding over 5 years.

For this the administration received high praise from treatment experts and advocates, and deservedly so. There has not always been strong bipartisan support for funding drug treatment. It seems, thankfully, that we are finally beyond questioning the value of treatment and firmly on the road to funding recovery. The question that remains is how aggressively, and what is the most effective and efficient means of reaching people in need.

In his recent State of the Union Address, President Bush proposed a new drug treatment initiative called Recovery Now to be funded with $600 million over the next 3 years. The proposal's reliance on State-issued vouchers is a sharp departure from the way the Federal Government has funded drug treatment through the Substance Abuse and Mental Health Services Administration since SAMHSA's creation in 1992. For 10 years the vast majority of Federal funding for drug treatment has been allocated to States by way of a population-based formula under the substance abuse prevention and treatment block grant.

This year the drug treatment system is undergoing significant change as the block grant transitions to a performance partnership grant. This change is already altering the relationship between the States and SAMHSA, with a goal of providing greater flexibility to States in exchange for greater accountability.

Among other changes, States are in the process of upgrading their computer systems in order to collect and convey additional data on program performance, and I applaud that.

Like the existing Targeted Capacity Expansion Grant designed to help States respond quickly to emerging treatment needs, Recovery Now will operate parallel to the substance abuse partnership performance grant. The initiative will require Governors to submit proposals for State-run voucher systems that will operate subject to Federal guidelines that are presently under development. A request for applications will issue later this year.

As we will hear from the administration witnesses, Director Walters, SAMHSA Administrator, Charles Curie, Recovery Now is intended to give people in need of drug treatment a broader array of treatment options by expanding the network of providers who will be eligible to receive Federal funding for providing treatment services. As we all observed, the President took pains in his State of the Union Address to emphasize that pervasively sectarian faith-based organizations would be part of the expanded provider network. The standards to which these groups will be subject is an important issue for Members like myself who are deeply concerned about the implications permitting the use of Federal funds by programs that would discriminate on the basis of religion against employees or people seeking treatment or both. I have often said that we cannot allow our tax dollars to be used to discriminate against us.

The Recovery Now initiative is also designed to increase provider accountability by making reimbursement to providers contingent upon their demonstrated effectiveness, determined according to a set of evidence-based outcome measures. I agree with that. I think that is very good. This is a novel approach in the public health field. It aims to create healthy competition among providers to deliver the most effective treatment.

As we explore all of this new ground, I'm delighted that we'll have the outside perspective of an experienced medical practitioner and researcher in the field of child and adolescent mental health and substance abuse. Dr. Jude Boyer-Patrick of Brooklane Health Services in Hagerstown, MD, is a woman of deep faith, an addition in mental health specialists, and a shaper of public policy through her service on Maryland's Drug and Alcohol Council and the Maryland Drug Treatment Task Force. She will offer her informed insight concerning a variety of outstanding concerns relating to Recovery Now, including how State standards for care, licensing and certification will fare under the proposal, State administrative costs and possible obstacles to implementation, standards that will be applicable to faith-based treatment providers, challenges to providers posed by the voucher reimbursement system, protecting the existing substance abuse grant from erosion, and ensuring the maximum participation by the States under initiative—under the initiative's competitive grant structure.

And I'm also pleased, too, that Dr. Andrea Barthwell, the Deputy Director for Demand Reduction, is with us today. She, working with the drug czar—that has been most cooperative with our office. And let me finally say this, too, to the drug czar, Mr. Chairman. The drug czar has been extremely responsive to the needs of the Seventh Congressional District of Maryland. He has paid several visits to our district already. He attended the funeral of seven people—of six people and then seven. There was a seventh later on—who died as a result of a fire, where drug salespersons fire-bombed a house and literally burned up six members of this household who had been cooperating with police. And later—it was a mother and five children—he attended that funeral and made one of the most moving comments that I have ever heard in my life by anybody on anything.

He has been there for us, and he has worked very closely with us trying to bring some remedies in a short period of time to our district, and so I do applaud you, drug czar. I always call you the drug czar. I'm trying to fix it up so it sounds real nice in public, but I thank you.

And so, Mr. Chairman, again, I am glad that we're holding this hearing. I think that this is a step in the right direction, and I also want to thank Chairman Davis for his interest in this issue. And I think just having him as the chairman of our overall committee heightens the visibility and the opportunities that we will have to explore all of these new issues and new programs so that, again, we can use our tax dollars in a most effective and efficient manner.

[The prepared statement of Hon. Elijah E. Cummings follows:]

Representative Elijah E. Cummings
Ranking Minority Member
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Committee on Government Reform
U.S. House of Representatives
108th Congress

Hearing on "Recovery Now: The President's Drug Treatment Initiative"

February 27, 2003

Mr. Chairman,

There is no single issue that is more important to me than the issue of drug treatment. Baltimore City, the city I represent in Congress, has been devastated by recent epidemics of crack cocaine and heroin addiction. There are some 65 thousand people in Baltimore addicted to illegal drugs – roughly a tenth of the city's population – and these people desperately need treatment: effective treatment.

Last year, Mr. Chairman, you convened a field hearing in Baltimore at my request, and we heard testimony concerning the results of a groundbreaking study, entitled, *Steps to Success: The Baltimore Drug and Alcohol Treatment Outcomes Study*. Commissioned by Baltimore Substance Abuse Systems, Inc., and conducted by the University of Maryland, Johns Hopkins University, and Morgan State University, the study examined nearly 1,000 treatment participants in 16 licensed, publicly funded treatment programs. The findings indicate a marked reduction in drug and alcohol use, criminal conduct, risky health

behaviors, and depression, among individuals who voluntarily entered publicly funded outpatient drug and alcohol treatment programs in Baltimore City. In the judgment of Baltimore City Health Commissioner Peter Beilenson, *Steps to Success* proved conclusively that drug treatment is effective in Baltimore City. The study remains the largest, most comprehensive and most thoroughly documented study of its kind to focus on a single city.

The Baltimore study's findings reinforced those of other drug treatment studies, including a report by the Institute of Medicine which found that: "An extended abstinence, even if punctuated by slips and short relapses, is beneficial in itself and may serve as a critical intermediate step toward lifetime abstinence and recovery."

In announcing the National Drug Control Strategy and drug control budget last year, President Bush and Office of National Drug Control Policy Director John Walters expressed a strong commitment to "healing America's drug users," pledging an additional $1.6 billion in drug treatment funding over five years. For this, the Administration received high praise from treatment experts and advocates, and deservedly so. There has not always been strong bipartisan support for funding drug treatment. It seems, thankfully, that we are finally beyond questioning the value of treatment and firmly "on the road" to *funding* recovery. The question that remains is, How aggressively? And what is the most

effective and efficient means of reaching people in need?

In his recent State of the Union address, President Bush proposed a new drug treatment initiative called "Recovery Now," to be funded with $600 million over the next three years. The proposal's reliance on state-issued vouchers is a sharp departure from the way the federal government has funded drug treatment through the Substance Abuse and Mental Health Services Administration since SAMHSA's creation in 1992. For ten years, the vast majority of federal funding for drug treatment has been allocated to states by way of a population-based formula under the Substance Abuse Prevention and Treatment Block Grant.

This year, the drug treatment system is undergoing significant change, as the block grant transitions to a performance partnership grant. This change is already altering the relationship between the States and SAMHSA, with the goal of providing greater flexibility to States in exchange for greater accountability. Among other changes, States are in the process of upgrading their computer systems in order to collect and convey additional data on program performance.

Like the existing Targeted Capacity Expansion (TCE) grant – designed to help States respond quickly to emerging treatment needs – "Recovery Now" will operate parallel to the Substance Abuse partnership performance grant. The initiative will require governors to submit proposals for state-run voucher systems that will operate subject to federal guidelines that are presently under development. A request

for applications will issue later this year.

As we'll hear from the Administration witnesses, Director Walters and SAMHSA Administrator Charles Curie, "Recovery Now" is intended to give people in need of drug treatment a broader array of treatment options, by expanding the network of providers who will be eligible to receive federal funding for providing treatment services. As we all observed, the President took pains in his State of the Union address to emphasize that pervasively sectarian faith-based organizations would be part of the expanded provider network. The standards to which these groups will be subject is an important issue for Members like myself who are deeply concerned about the implications permitting the use of federal funds by programs that would discriminate on the basis of religion against employees or people seeking treatment, or both.

The "Recovery Now" initiative is also designed to increase provider accountability by making reimbursement to providers contingent upon their demonstrated effectiveness, determined according to a set of evidence-based outcome measures. This is a novel approach in the public health field that aims to create healthy competition among providers to deliver the most effective treatment.

As we explore all of this new ground, I'm delighted that we'll have the outside perspective of an experienced medical practitioner and researcher in the field of child and adolescent mental health and substance abuse. Dr. Judith Boyer-Patrick of Brooklane Health Services in Hagerstown, Maryland, is a woman of deep faith, an addiction and

mental health specialist, and a shaper of public policy through her service on the Maryland Governor's Drug and Alcohol Council and the Maryland Drug Treatment Task Force. She will offer her informed insight concerning a variety of outstanding concerns relating to "Recovery Now," including:

> how State standards for care, licensing, and certification will fare under the proposal;
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> state administrative costs and possible obstacles to implementation;
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> standards that will be applicable to faith-based treatment providers;
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> challenges to providers posed by the voucher/reimbursement system;
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> protecting the existing Substance Abuse grant from erosion; and
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> ensuring maximum participation by States under the initiative's competitive grant structure.

Thank you, again, Mr. Chairman, for holding this important hearing and thank you to all of the witnesses for appearing before us

today. I look forward to hearing your testimony.

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Mr. SOUDER. Now I'd like to yield to the chairman of the full Government Reform Committee, Mr. Tom Davis of Virginia.

Mr. DAVIS OF VIRGINIA. Mr. Souder, thank you, and thank you for holding your hearings and your leadership. And I thank my friend from Maryland for his comments and for his leadership on this issue as well.

This is not a partisan issue at all. This affects people, Republicans, Democrats, inner city, wealthy, suburbs, rural areas. It is a tremendous responsibility for this committee and for the drug czar, for lack of a better title, to undertake, and we want to give you the tools.

And over the past year drug use among young Americans has been on the decline, I think, due in large part to our joint administration, congressional—our joint work and our substantial drug prevention efforts, but when it comes to addressing the complex dilemma of drug addiction, prevention is only one part of the equation. Treatment of substance abuse, as my friends have said, and addiction is also essential to the goal of decreasing the number of users.

Because addiction has so many dimensions and disrupts multiple aspects of an individual's life, treatment is never easy. Drug users need a support system of family, friends and institutions to help guide them to treatment and recovery.

I know firsthand the consequences that substance abuse can have on a family. My father was a career alcoholic, he actually served two tours in the State prison system in Virginia for alcohol-related offenses. It is not just the victim. The whole family struggles with these issues, and it affects an extended family as well.

The President's 2003 National Drug Control Strategy highlights the importance of healing America's drug users and getting treatment resources where they are needed most. I appreciate John Walters and Charlie Curie of the Substance Abuse and Mental Health Services Administration for being here this morning to discuss the President's drug treatment initiative, an important outside-the-box element of the President's strategy.

According to the Office of National Drug Control Policy, roughly 6 million Americans are in need of drug treatment, but a large number of these users fail to recognize their need for treatment or don't have access to treatment programs. So the administration has proposed a significant increase in drug treatment funding that will expand access to substance abuse treatment in communities across America.

The new treatment program would devote $600 million over 3 years for a new initiative to fight drug addiction. It aims to expand access to treatment centers for an estimated 100,000 alcohol and drug abusers annually through a voucher system that will let the government monitor where the dollars are being spent. Too many Americans in search of treatment simply cannot get it. As proposed, the program would give people vouchers to seek drug rehabilitation treatment centers of their choice, including community and faith-based treatment organizations.

Just a note on faith-based organizations. I will never forget as a member of the county board in Fairfax having the Salvation Army come forward with a drug and alcohol rehabilitation center

adjacent to some residential neighborhoods, and a band of associations came out and fought it, but we prevailed. We zoned it. It came in and has over 125 individuals at a time it can take. And I was there after it was built, and I was there the first year when people came up and gave testimony for a year without drugs and alcohol. There are 2- and 3-year pins, and the interesting thing about the faith-based is they take not just the medical side of it, but they look at the heart, they look at the soul to heal the entire person.

These can be successful programs as well. I think sometimes we fail to utilize these as well. I'm happy to see that is a part of this program, because in many cases that is the answer is changing the whole person from the inside.

As proposed, the program gives people vouchers to seek drug rehabilitation treatment centers of their choice. Obviously there is much more to this complex proposal than I've outlined. I'll leave it up to our witnesses this morning to elaborate on that initiative and provide all the details, but with let me make a couple more points.

First, we all know that drugs affect people from all walks of life, and addiction does not discriminate. I believe that making funding available through the voucher program to a wide range of providers, including faith- and community-based programs, schools, health care providers, employers and law enforcement agencies, better ensures the substance abusers will be matched with a treatment program appropriate for them. The plan, plain and simple, broadens the network of treatment providers.

Second, there is much about the proposal's details that I like on the face. It relies heavily on collaboration with the States. It fosters competition among providers. It promises flexibility in terms of the systems developing in individual States, and it mandates strict oversight of programs to ensure their effectiveness.

Finally, I've just returned from a trip to Colombia with Chairman Souder. We'll be going back before long because the battle going on there against narcoterrorism is our battle as well, but it is clear to me as we continue to wage war on the supply side of the drug equation, we need to reaffirm our commitment to address the demand side as well.

Again, Chairman Souder, I thank you for organizing today's important hearing to review the President's treatment initiative. This will be the first in a series of hearings planned to evaluate all of the components of the President's 2003 drug strategy. I look forward to the input from my colleagues on the other side as well. Many of them have worked in their own districts on this program, and it is important to them as well. And we can work on this in a bipartisan way. I think we can come up with a good result. I look forward to hearing the testimony this morning from the officials responsible for developing and implementing the program. Thank you.

Mr. SOUDER. I thank the Chairman.

[The prepared statement of Hon. Thomas M. Davis follows:]

Statement of Chairman Tom Davis
Hearing on "Recovery Now: The President's Drug Treatment Initiative"
Subcommittee on Criminal Justice, Drug Policy and Human Resources
January 27, 2003

Over the past year, drug use among young Americans has been on the decline, due in large part to the Administration's substantial drug prevention efforts. But when it comes to addressing the complex dilemma of drug addiction, *prevention* is only one part of the equation. *Treatment* of substance abuse and addiction is also essential to the goal of decreasing the number of users. Because addiction has so many dimensions and disrupts multiple aspects of an individual's life, treatment is never easy. Drug users need a support system of family, friends, and institutions to help guide them to treatment and recovery.

I know first-hand the consequences that substance abuse can have on a family. My father was an alcoholic, and his struggle with booze left my mother to raise my siblings and me alone. Because of what I witnessed as a child, I have never touched a drop of alcohol, never smoked a single cigarette.

The President's 2003 National Drug Control Strategy highlights the importance of healing America's drug users and getting treatment resources where they are needed most. I appreciate John Walters from the Office of

National Drug Control Policy and Charlie Currie of the Substance Abuse and Mental Health Services Administration for being here this morning to ~~discuss the President's drug treatment initiative, an important, "outside-the-box"~~ element of the President's Strategy.

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The new treatment program would devote $600 million over three years for a new initiative to fight drug addiction. It aims to expand access to treatment centers for an estimated 100,000 alcohol and drug abusers annually through a "voucher" system that will let the government monitor where the dollars are being spent. Too many Americans in search of treatment simply cannot get it.

As proposed, the program would give people vouchers to seek drug rehabilitation treatment centers of their choice, including community- and faith-based treatment organizations. Obviously, there's much more to this complex proposal than I have outlined, but I will leave it up to our witnesses

this morning to elaborate on the initiative and provide all the details on how it would be implemented.

But let me make a couple more points before closing.

First, we all know that drugs affect people from all walks of life and addiction does not discriminate. I believe that making funding available through the voucher program to a wide range of providers, including faith and community based programs, schools, healthcare providers, employers, and law enforcement agencies will better ensure that substance abusers will be matched with a treatment program appropriate for them. The plan, plain and simple, broadens the network of treatment providers.

Second, there is much about the proposal's details that I like on their face: it relies heavily on collaboration with the states; it fosters competition among providers; it promises flexibility in terms of the systems developed in individual states; it mandates strict oversight of programs to ensure their effectiveness.

Finally, I have just returned from a trip to Colombia with Chairman Souder. We'll be going back before long, because the battle going on there against narco-terrorism is our battle as well. But it's clear to me that as we continue to wage war on the supply side of the drug equation, we need to reaffirm our commitment to addressing the demand side as well.

I would like to thank Chairman Souder for organizing today's important hearing to review the President's treatment initiative. This will be the first in a series of hearings planned to evaluate all the components of the President's 2003 Drug Strategy. I look forward to hearing testimony this morning from the senior administration officials responsible for developing and implementing this program.

Mr. SOUDER. Before yielding to Mr. Davis, I want to elaborate. Both Mr. Cummings and Mr. Davis and I have made—actually all three of us made references to some of what the committee is going to be doing, and as I said, our primary focus, because we're trying to move a bill through the full committee and the subcommittee in a reasonably expeditious manner for the ONDCP reauthorization, we're focusing on more particular elements of the national ad campaign, the HIDTAs. And so over the next few months, we'll continue our work on the borders, which are critical, but part of our oversight.

In the faith-based component, this subcommittee also has oversight over all faith-based programs, not just on the treatment, and today we're focusing on treatment in general, which would include the vouchers, but not zeroing in on faith-based, and I appreciate working with the minority. I have made a commitment we will have a separate hearing talking about that issue alone inside the treatment question, in addition to basically 2 years of looking at the range of faith-based. We're going to have disagreements on how much government funding and which type of government funding should go in, but we're going to look at the other parts of the faith-based initiatives as well, which would include a much broader program where we may have wide agreement, as well as the more narrow controversial part, which is when government funds are involved in the treatment program.

And then as far as the tragedy with the Dawson family in Baltimore, we've made a commitment that later this spring we'll be doing a hearing there to look at how the government should be providing protection for those who work with the government who are threatened, and they should not be out there to be terrorized by the dealers and their networks, and it is a broader question in a policy way of how we're trying to protect those who are working at the grassroots level. And I definitely appreciate the leadership of the ranking member with that.

With that, I'd like to yield to the long-time acting member of this subcommittee Mr. Davis of Illinois if he has any opening statement.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. Let me just, first of all, commend you and the ranking member, Mr. Cummings, for the aggressive manner in which you have approached the work of this committee. I've been very pleased to travel with you to Fort Wayne, IN, for a field hearing, and I want to thank you for the hearing which you conducted at my request in Chicago.

I also want to welcome the witnesses. It seems as though the seventh number of districts must have some affinity for Director Walters, I was pleased to visit with him and with you at the Safer Foundation not very long ago where we had a tremendous experience.

I also want to welcome Mr. Curie, and I definitely want to welcome my neighbor, my friend and long-time associate Dr. Andrea Barthwell, who has had firsthand hands-on experience working on the ground with these issues and problems as a practitioner with the Human Resources Development Institute and other entities. And so, Dr. Barthwell, it is indeed a pleasure to see you.

Very briefly, Mr. Chairman, let me just suggest that this hearing is so important, and the work of this committee is so important. We all know that much of the crime, much of the prison population explosion, many of the problems associated with reentry are all associated with drug use and abuse, and so when we deal with the issue of reducing the presence of drug use and abuse in our society, we're dealing with needs that cut across all races, all economic groups all parts of what makes this Nation what it is.

I'm pleased to see that prevention, treatment and reduction are all a part of a strategy, and I think all of those components must be effectively used.

We've had some discussion about the utilization of the faith-based approach, and as one who is a strong component—strong proponent, I've seen faith-based programs work, I've seen people involved in them. My district has a serious drug problem because of its poverty and because of its location and because of where it is, Chicago, IL, in the heart of the Midwest.

Programs can work, do work. I would make a strong plea that we make every effort to eradicate any possibility of discrimination that could possibly exist, and that we let an idea that is really a great idea, a tremendous idea, let that idea stand on its merits and let it work on its merits by taking away any possibility that any person, because of their religion, their religious thoughts, their religious beliefs, could possibly not acquire the services and the benefits.

I look forward to discussion, I look forward to development and implementation, and, again, I thank you, Mr. Chairman, and appreciate all of the witnesses who have come to share.

Mr. SOUDER. Thank you, Mr. Davis.

Mr. Clay, do you have any opening remarks?

Mr. CLAY. Thank you, Mr. Chairman. First I'd like to acknowledge your foresight for holding this important debate concerning the President's recently announced antidrug treatment program, the Recovery Now initiative. America needs an effective drug treatment program that will work. Previous efforts by law enforcement agencies have already proven that drug eradication initiatives alone have not stopped the problem of drug adduction, even in the best of scenarios.

Plain and simple, drug addiction should not be viewed as a criminal problem, but rather, it should be perceived as a medical challenge. The increase in human drug addiction is a societal problem that is a challenge that transcends race, class and financial standing.

The Recovery Now initiative is an ambitious step in the right direction to alleviate the challenge of rampant drug abuse in the 21st century.

And, Mr. Chairman, I ask unanimous consent to submit my statement into the record.

Mr. SOUDER. Without objection, so ordered.

[The prepared statement of Hon. Wm. Lacy Clay follows:]

Statement of the
Honorable William Lacy Clay
Before the
Government Reform Committee
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Thursday, February 27, 2003

"The Recovery Now Initiative"

Thank you for yielding, Mr. Chairman, first I would like to acknowledge your foresight for holding this important debate concerning the President's recently announced anti-drug treatment program, "The Recovery Now Initiative." America needs an effective drug treatment program that will work. Previous efforts by law enforcement agencies have already proven drug eradication initiatives alone have not stopped the problem of drug addiction -- even in the best of scenarios. Plain and simple drug addiction should not be viewed as a criminal problem, but rather it should be perceived as a medical challenge.

The increase in human drug addiction is a societal problem. This is a challenge that transcends race, class and financial standing. "The Recovery Now Initiative." is an ambitious step in the right direction to alleviate the challenge of rampant drug abuse in the twenty-first century.

While, I feel that this initiative is a step in the right direction I must admit that I still have serious reservations about the proposal's long-term effectiveness and application to reach those that it is intended to assist the most. I hope that this distinguished panel of experts will be willing to address our concerns so that we might eventually work together in support of this worthwhile initiative. Mr. Chairman, I ask unanimous consent to submit my statement into the record.

Mr. SOUDER. I thank Mr. Clay for being here today, as well as Congresswoman Blackburn from Tennessee and Congressman Ruppersberger. We'll have many Members in and out this morning, and I appreciate the patience of our witnesses.

Before proceeding, I would like to take care of a couple of procedural matters. First, I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record; that any answers to written questions provided by the witnesses also be included in the record. Without objection, so ordered.

Second, I ask unanimous consent that all exhibits, documents and other materials referred to by Members or the witnesses may be included in the hearing record; that all Members be permitted to revise and extend their remarks, and without objection, so ordered.

I would also like to ask the members of the committee and the minority in particular, we didn't notice Dr. Andrea Barthwell, who is going to be here to support the Director, but in case she fields some questions, is it OK if I swear her in at this time?

Mr. CUMMINGS. Yes. I think that is a great idea. I think you need a sign, too.

Mr. SOUDER. Without objection, we'll include you on the first panel, because we didn't notice it in the committee. So we need to go through that procedure.

If each of you could rise and raise your right hands, it is the practice of this subcommittee as an oversight committee to ask the witnesses to testify under oath. If you'll raise your right hands, I'll administer the oath.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that each of the witnesses responded in the affirmative.

We'll now hear from Director Walters. We thank you first for your leadership. We very much appreciate that, and I look forward to hearing your testimony today.

STATEMENTS OF JOHN P. WALTERS, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY, ACCOMPANIED BY ANDREA BARTHWELL, DEPUTY DIRECTOR FOR DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY; AND CHARLES G. CURIE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Mr. WALTERS. Thank you. I'd like to thank Chairman Davis for being here and for the conversations and the support we've already had since he took the chairmanship. It has been a busy time, and he carved out time not only to meet and talk at some length with myself, but also, as he mentioned, travelled to Colombia and began looking at some of these programs and the crush on business.

I'd also like to thank you, Chairman Souder, for the tireless work you've already done on this. We have personally travelled together through a number of countries in this hemisphere, including Bolivia, Colombia, Canada, as well as worked extensively on this issue, and I look forward to working with you again and thank you for your dedication here.

I'd also like to thank Ranking Member Cummings for his kind words. As he knows, and I've said to him privately, it has been one of the pleasures of this job working with him on some of the problems in Baltimore. We know we don't make people well sitting in our offices and making the policy. We've tried to be more proactive, because I know the reality that Baltimore faces of no city, I believe, in the history of this country has suffered more from the problem of substance abuse and addiction than Baltimore, and our goal is to make it the best example of a city that comes back. And that is not something we do alone, but it is part of what our partnership requires.

Also Mr. Davis, it was my pleasure to meet with you in Chicago, and he spent time with us at the Safer Foundation in part of an effort to also try to work with a variety of providers and to learn what goes on in the country as we shape policy and program.

So, thank you all. You've all been very active, and I look forward to working with other members of the committee as this process goes on.

If it is acceptable to the committee, I'd like to ask that my written statement be included in the record, and I'll just summarize some of the things and then proceed as we get to questions with the topics you think are most appropriate.

We're here as a next stage to ask your help in allowing us to implement the ambitious program outlined or proposed by the President in the State of the Union. We believe that the centerpiece, as your comments have indicated, to what we need to do about the problems of drugs is to treat more people who have dependency. It is not the only thing that we do, but it is a crucial part of what we're going to do if we're going to make this problem smaller.

I'm pleased to be joined by Administrator Curie, who we've worked with tirelessly, and by Dr. Barthwell, whose expertise and whose background as former president of the American Society of Addiction Medicine. She has been willing to generously give of her talents and time. I could not do what I do without her help, and I would like to publicly say that and thank her, and for the tireless work that she has given to this effort.

The initiative that we have proposed in expanding treatment complements the other Federal support to treatment, but it does provide a new way to direct those dollars. We've consulted with some of the foremost treatment and professional associations throughout the country throughout the last year, and we've consulted with them since the announcement of this proposal.

We've been gratified by the endorsements we've received from individuals and organizations such as Lawrence Brown, the president of the American Society of Addiction Medicine, the society that Dr. Barthwell was president of previously; Mark Parrino, president of the American Association for the Treatment of Opioid Dependence; Linda Hay Crawford, executive director of Therapeutic Communities of America; Arthur Dean, chairman of the Community Antidrug Coalitions of America; Melody Heaps of National Treatment Accountability for Safer Communities [TASC]; Phoenix House, the Nation's largest nonprofit substance abuse agency; National Black Alcoholism and Addictions Council; the National Asian Pacific Americans Families Against Substance Abuse; Pride Youth Pro-

grams, the largest youth prevention organization; the National Association of Drug Corps Professionals; and Alcohol and Drug Problem Association of America. These are some of the foremost groups in the country. We've benefited from their expertise and consultation, and we appreciate their support as these efforts go on.

We've made clear, and you all agree, we have to push back against the problem of illegal drugs. We ought not to surrender. We ought not to be cynical. We ought to do our job to make this a smaller problem in America. The President forthrightly set the national goal of a 10 percent reduction in 2 years and a 25 percent reduction in 5 years of the number of Americans who use drugs. There are hopeful signs that show that we're making progress.

The Monitoring the Future Survey of 8th-, 10th- and 12th-graders released in December showed that last year we had drops of 11 percent for 8th graders and 8.4 percent and 1.2 percent respectively for the 8th, 10th and 12th grade populations. We've had other surveys that indicate that drug use may be declining in different rates shown by different surveys. The Pride Survey of School Children found a 14.3 percent decline in past month's drug use by junior high school students. This is an important, encouraging momentum, but we have to follow through. We're not where we want to be. We want to capitalize; we want to accelerate on this.

What treatment means for our policies can be seen, I think, in the National Drug Control Strategy, because it is the center of three pillars. The first is stopping drug use before it starts through education and community action. The second, as Congressman Cummings mentioned, is healing America's drug users by getting treatment resources where they are needed and helping people successfully get into recovery and stay there. Third, we are dedicated to disrupting the market that is the drug trade, the poison that is marketed to too many Americans and infects, of course, peoples throughout the world.

These strategic pillars are designed to work together to give balance and to give a magnitude of power that neither one of them alone would provide. When substance abuse treatment leads to recovery, we advance our goals. The demand for drugs goes down. The economic basis for the drug trade is damaged. Prevention is strengthened because drug users are the carriers of the disease of drug addiction. Most importantly, we save lives, of those who are users, of those around users, and of the communities which use affects.

The scope of the need for treatment that we affect is outlined in the National Drug Control Strategy, and some of you in your opening remarks have alluded to his. We have identified roughly 6.1 million individuals needing treatment because of the nature of their drug use, abuse or dependence; 76 percent, however, have yet to recognize that need. That is 4.7 million people that are in a form of what we call the denial gap. Seventeen percent did receive treatment at some time during the year, previous year's survey, in a specialty facility. That's 1.1 million people. Five percent need treatment and recognize the fact, but nevertheless did not seek it, over a quarter of a million people, and 2 percent, approximately 100,000 persons, sought treatment, but did not receive it for their substance abuse or dependence.

This latter group have demonstrated an immediate need for services and a willingness to seek help. They deserve a response to their courageous efforts to change. This response is a central feature of the President's voucher initiative. That is not to say we do not intend to strengthen efforts to reach the other people in these categories, but we have people who are coming forward for help and are not being helped today. We'd like to start with that population in more cases and more places.

The vouchers provide immediate impact and access to treatment. As we've tried to define the program, the $200 million a year for each year, fiscal years 2004, 2005 and 2006, complements the nearly $3.6 billion budget for substance abuse treatment, a total increase of $271 million over the President's fiscal year 2003 request.

As intended with those without recourse, the private insurance or other Federal support such as Medicaid can be used for substance abuse, dependency and abuse, including alcohol. It builds on current State incentive grants, the Substance Abuse Prevention and Treatment Block Grant, and the Targeted Capacity Expansion Grants, as some of you mentioned.

The initiative, we hope, will expand treatment capacity. The initiative builds on community outreach to overcome the denial gap. It will serve more people more efficiently and will increase effective treatment. A broader base of treatment providers, proprietary, nonprofit, government-run, nongovernment-run providers, we hope, will be encouraged to enter the system. Existing treatment providers will be held to higher expectations of performance, and expanded capacity will be targeted to actual local need.

The so-called IMD exclusion that has prevented some providers to provide residential care in larger institutions would not hinder this program. The so-called IMD exclusion would be lifted. The initiative would not exclude those providers who offer resources tied to faith as part of the process of recovery, as some of you have mentioned.

The current medical and mental health providers have an opportunity to offer substance abuse services that would be funded if they are effective. The initiative builds on a system of professional assessment and referral with the provision of vouchers flexible enough to meet individual need. Whenever a person receives medical care, they can enter the system. Additional community resources can play a role with employers, family members, schools and houses of worship. We have many people who need assessment who are not facing up to their need, and we know when we create gaps, people fall through those gaps. We want the assessment, the referral and the resources to be tied more closely together.

The initiative uses the instrument of choice to broaden and strengthen the treatment system. It brings target treatment resources into line with actual community need, enables a better match of specific specialty service need with treatment modality. It provides flexible services, offering a continuum of care from early intervention to detox to in-patient residential services depending on the need.

The initiative insists on performance outcomes and rewards efficient services that deliver on the promise of recovery. Standards will be built into the system when States compete for the grants,

and the standards are required to measure effective outcomes built on a competitive State grant system with State oversight for eligibility to provide services; insists on monitoring and reporting of outcomes for continued participation.

Evidence-based and standardized treatment assessment and referral will be a part of this program, and a variety of measures can be used to evaluate effectiveness. Criteria must include abstinence from substance use as one of its factors.

We will work with the States to adapt these requirements and needs to State situations, and we will allow the program to be deployed with maximum, hopefully, ability to use the resources and capability of individuals, States and communities as well as their needs.

Because the initiative represents new money, States have an incentive to meet our standards and improve their treatment systems, we believe, to a greater extent. The initiative brings accountability to substance abuse treatments. We not only want to reach those who have not before had access to treatment, we want to insist on those who receive treatment actually achieve recovery in more cases.

In 2002, nearly 1.2 million individuals received treatment services, but too often they did not achieve full recovery. The treatment system must be strengthened, with effectiveness being the key requirement, and also, when they fail, to get them back into treatment, into another form that is more effective to them. We will reward what works with this system. We'll have a system that expects to make a difference, and the voucher is a tool for shaping and improving that system, we believe.

The key to accountability is a mechanism of payment. Full reimbursement follows from demonstrated successes is what we are proposing as a guideline as we work out the specifics of this program.

Let me close by saying that healing America's drug users is the responsibility of a compassionate Nation. I have not met a single Member of Congress or a member of the public that doesn't believe that, and too many people are disheartened by the number of people who don't get help and are not healed. We insist on doing better, and the President has charged us and the administration with being more aggressive and more direct in meeting that cry for better results as a Nation for those who are suffering.

Providing effective resources for recovery saves lives and strengthens our country. When people accept their responsibility to change, we can meet them and help free people from addiction. This initiative is an important new tool in meeting these challenges, and I appreciate the opportunity to talk to you today about it and to work with you in helping more people integrate back into the opportunity that we all want for all Americans. Thank you very much.

Mr. SOUDER. Thank you very much.

[The prepared statement of Mr. Walters follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Statement of John P. Walters
Director of National Drug Control Policy
Before the House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

"The President's Treatment Initiative"

February 27, 2003

Chairman Souder, Ranking Member Cummings, and distinguished members of the Subcommittee:

I appreciate the opportunity and the honor of appearing before you today to present our current thinking on how best to reduce substance abuse in America. With your help, and following the lead of the bold initiative put forward by President Bush in the State of the Union Address, it is the goal of my office to make a measurable difference in the fight against illegal and addicting substances.

Our able partner in the enterprise that I will focus on today is the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA). We have an effective working relationship organized around a division of labor. It is the primary responsibility of the Office of National Drug Control Policy (ONDCP) to provide policy guidance for our undertakings, while it falls to SAMHSA to design and carry out the implementation of those policies. I am especially pleased to acknowledge the presence of Charles Curie, SAMHSA Administrator, whose knowledge and capabilities are essential to our efforts.

We must push back against the problem of illegal drugs in this country, and to do that we must provide meaningful help to Americans currently trapped in dependency on substances that they abuse and that are damaging their lives. No nation, no civilization, can fail to take a stand against that which destroys its youth, which corrodes its communities, and which degrades human dignity and freedom. We have a responsibility here that cannot be left to others.

In the policy community we face many social ills. Crime and violence, family disintegration, mounting health care costs, deteriorating neighborhoods, child abuse and neglect, school failure, lowered productivity, infectious diseases, homelessness, hunger, self-destructive behavior; the list is long and daunting. Increasingly, we recognize that in each one of these social ills there lurks, all too often, a common denominator -- substance abuse and dependency. If we would heal ourselves as a nation and fulfill our promise as a free people, we cannot turn away from this destructive legacy. Substance abuse and dependency undermine our personal character as well as the larger fabric of our nation. But defeat is not inevitable, and drug addiction needn't be a death sentence. Everyday, courageous people face their problem and change. They leave behind their old lives for lives of recovery. We have powerful and meaningful work to do here. We can help move people to recovery.

Allow me to establish the specific context for today's principal topic. According to data from SAMHSA's 2001 National Household Survey on Drug Abuse (NHSDA), an estimated 6.1 million Americans are in need of treatment for substance abuse involving illegal drugs. Yet for too many, the treatment that they need is either not available or not effective even when they choose to confront their problem and seek help. This is an unacceptable policy problem.

It is the goal of the President's Treatment Initiative, committing $600 million over three years, to meet this challenge by significantly improving and expanding the treatment system in America. It will do so by providing additional resources to existing federal support for substance abuse treatment, and by changing the way that those federal dollars are spent. By creating new pathways of funding, and channeling more resources through those pathways, we believe that we can achieve an expansion in treatment capacity, an enhancement of treatment access, an enabling of true consumer choice, an infusion of new providers into the treatment system, an upgrade of treatment standards, and a requirement of demonstrated effectiveness.

We intend to make more services available to more people, and to do so more effectively. The Initiative will include proprietary and faith-based organizations as appropriate providers of services. We intend to monitor outcomes closely and reward success, "training" the existing treatment system into a more responsive and accountable structure that can save more lives. The underlying fundamental requirement is effectiveness. Through vouchers, linked to client choice, we will be able to reward what works, and see that resources follow successful outcomes.

People struggling to achieve recovery need help. They deserve a treatment system that is available, affordable, and flexible -- one that provides a full continuum of options, that is accountable, and that, above all, demonstrates success. We will build that system -- but not by doing no more than carrying on business as usual. The Federal Government already makes an extensive investment in treatment services. Just spending more money is not the answer to our current problems. The key is to spend that money more wisely, and more creatively to connect individuals with the treatment to which they will best respond. We believe that a program built around the provision of vouchers that go directly to clients will lead to a transformed and improved treatment structure throughout the nation.

Through a voucher mechanism of payment, built on professional assessment, referrals, and immediate access to appropriate and effective treatment, we will assist more Americans to attain the critical alcohol and drug treatment services that are necessary to heal their addiction.

The President's FY 2004 Budget includes $200 million in new resources for this effort. Total proposed funding for this initiative is $600 million, $200 million a year in 2004, 2005, and 2006. Combined with prior year requests, this increase in funding will meet the President's commitment to provide an additional $1.6 billion for treatment services over five years.

In total, the President's FY 2004 Budget includes $3.6 billion for substance abuse treatment programs, an increase of $271 million over the President's FY 2003 request. In addition to new funding of $200 million for drug and alcohol treatment vouchers, the FY 2004 Budget includes:

- An increase of $16 million for the Drug Courts program, providing for a total program level of $68 million in FY 2004. Successful drug courts provide alternatives to incarceration by using the coercive power of the courts to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, and strong aftercare programs.
- An increase of $36 million for research efforts conducted by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, bringing total NIDA funding to $996 million in FY 2004.

The effort we are presenting today will complement these and other existing substance treatment programs and mechanisms of funding (such as the Substance Abuse Prevention and Treatment Block Grant, State Incentive Grants, and Targeted Capacity Expansion Grants) to strengthen existing services at the same time that we broaden the base of treatment providers.

This initiative is crucial to our overall national drug policy. The 2003 National Drug Control Strategy was recently presented to the public and the policy community. That document outlines our overarching strategy for reducing drug use, and for moving us closer to the realization of the goals we have set for ourselves and to which we expect to be held accountable. We have pledged to reduce current drug use by 10 percent in two years, and by 25 percent in 5 years.

Not long ago, those goals appeared to many in this country as, at the least, ambitious, and at worst, unreachable. Given the alarming rise in drug use witnessed over the last several years, a rise that almost eliminated the reductions that we had once achieved and which gave every indication of continuing, there was reason for concern.

I am heartened to be able to report, however, that genuine progress has been made. Particularly encouraging has been the most recent study of drug use by young people, NIDA's school-based Monitoring the Future survey, which often serves as a harbinger of our future as a nation with respect to drug use. Drug use among young people, for the first time in several years, is going down in many areas, signaling what we sincerely hope will be a process of recovery for the nation.

So there are grounds for hope. But there is still much to do. Drug use is a complex social problem, involving law enforcement issues, international interdiction efforts, and public health consequences. Our National Drug Control Strategy is built on three pillars: Stopping Use Before It Starts through education and community action; Healing America's Drug Users by getting treatment resources where they are needed; and Disrupting the Market, by attacking the economic basis of the drug trade. These strategic pillars are designed to work in coordination with each other. Effective action on any one of them is intended to augment the impact of the others.

Currently, we have broad programs that address the prevention of drug use and that focus on reducing the supply of illegal drugs. They have been effective, with actions at home and abroad producing measurable impact. But central to our strategy is Healing America's Drug Users. When we move people away from drug use that they have already started, we reduce the demand for illegal drugs and further our strategic goals. But that is not all that we accomplish.

We are also meeting a fundamental duty of our society, which is to provide resources to people in need, giving them the knowledge, the impetus, and the means that are essential for their recovery.

We now recognize the role of drug users, particularly those early in their developing dependency, as carriers or vectors for the spread of the disease of drug use. Accordingly, we are developing programs that reach people early in their drug use trajectory, before major damage has been done and before they can spread the disease to others. Early intervention promotes faster, more sustainable recovery, and further serves to protect others in the community. When we move people away from a life of drug use and into recovery we not only reduce the demand for drugs, we save lives. Building effective treatment for substance abuse is not only sound policy, it is a responsibility that we willingly undertake.

But we need to be flexible in our policy response. The population of Americans needing treatment can be divided into several categories, each of which calls for a different policy focus. The largest share of the 6.1million abusing or dependent individuals identified in the NHSDA as needing treatment are those who fail to recognize that need. These individuals, whom we refer to as the "Denial Gap" population because they have yet to acknowledge their jeopardy, represent 76 percent of the total (4.7 million persons). The next largest population, about 17 percent (1.1 million) represents those who received treatment at some time during the year at a specialty facility. Another 5 percent (276,000) represent those who need treatment and, while they do recognize the fact, nevertheless did not seek that treatment. For these people, the crucial need is for motivation to change. Finally, approximately 2 percent, or slightly over 100,000 individuals, sought but did not receive treatment for their substance dependence. These individuals demonstrate an immediate need for services, and a willingness to seek help. They deserve an immediate response to their efforts.

There are some clear policy implications contained in these numbers. The first is that we have an urgent responsibility to provide access for those people courageous enough to face their addiction and who are trying to get the help they need. Every day counts for these people and for their families. The new voucher initiative is targeted to such people, giving them resources for immediate help.

The second implication is that too many Americans who need treatment are deceiving themselves, failing to see the damage that they are doing to themselves, their families, and their nation. We must face down this denial and motivate these people to seek help. We must make it no longer acceptable to say, "this is not my problem," while we turn the other way. The initiative speaks to this issue as well, providing a way to expand treatment capacity at the same time that we seek to increase the number of clients seeking services through outreach. People can be trained to look for the signs of dependency and then to act on those signs.

There is yet another policy implication represented in these numbers. The existing treatment system has several dimensions. A one-day census of clients in treatment conducted by SAMHSA shows that in 2002, a count of 1,164,829 individuals received services. Of these clients in alcohol and or drug abuse treatment, 121,000 were in hospital or inpatient/residential facilities, while over 1 million were receiving outpatient services. Roughly 300,000 were in

private, for-profit facilities, 650,000 in private nonprofit facilities, 160,000 were in state or local government owned facilities, and 39,000 were in federal government owned facilities. Currently, then, some 200,000 persons were served in some sort of government facility, while nearly a million were served in private facilities, with the majority of those being supported by some sort of public funding.

The critical point is that for too many of them, regardless of how they were served, the treatment they received did not lead to full recovery. The reasons are many-fold. Relapse is a reality for some in any situation of dependency. In some instances, individuals did not stay in treatment long enough to benefit fully. In other instances, individuals may not have been appropriately matched to the kind of treatment modality that would have served them best. In yet further instances, whether clients had recovered fully or not after leaving the facility or after discharge is simply not known, because providers were not able to monitor and assess the impact of treatment. While some providers are effective, the treatment field is plagued by high turnover, low pay, and in some instances, insufficient professional training and commitment. In addition, appropriate monitoring of patient outcomes after treatment is largely inadequate.

Remarkably, though there is a public perception of long waiting lists for treatment services, the insufficiencies are often local rather than systemic. In fact, a recent review of the most current available data on overall treatment capacity, calculated across all types of providers, showed a range of utilization rates between 66 and 80 percent of capacity. Clearly, we must do a better job of getting clients matched to resources that are currently available and that they can access with appropriate funding. This deficit is particularly pronounced when it comes to certain types of specialty treatment such as provisions for juveniles, for services in rural areas, for the needs of women and mothers, and for those who suffer from co-occurring mental health disorders. We simply have not done enough to meet the needs of these populations, and spending more federal dollars is not the complete answer. Again, we believe that the voucher initiative presented today is a much-needed tool in shaping a better system that does not leave these gaps.

For those who sought treatment but were unable, for whatever reason, to attain it, the best response is to improve access to treatment services and provide more pathways to recovery. Where lack of resources is the impediment, we must provide the funding support that gets people the help that they are seeking. A treatment voucher can offer immediate help. For those who need treatment but have yet to acknowledge the fact or seek the help that is available, the policy response should be somewhat different. They must be made aware of their risk, and motivated to seek the help that they need. This response involves an extended outreach effort, using the resources of communities, employers, schools, court referrals, personal physicians, religious leaders, family members, and caring others to guide these individuals to the care that they need.

Clearly, there is little to be gained by motivating larger numbers of people to seek treatment if the existing treatment system is unprepared for the increased load, remains insufficiently capable of providing effective outcomes, or cannot acquire and report systematic information about post-treatment patient status. The challenge of transforming the above inadequacies of the current system can be met by the provisions of the initiative we are discussing today.

There is yet one more troubling problem presented by substance abuse and dependency. The sad reality is that, for some, addiction is a chronic, relapsing condition, and we must provide continuing support for their recovery. Though everyone now acknowledges that drug addiction is a fundamental disease of the brain and that recovery is a life-long process, too often the treatment system has taken those realizations and allowed them to become an excuse for ineffectual outcomes. That is, we must not settle for the easy assumption that people don't have to change. We should build a proactive treatment system that believes it can make a difference, that expects recovery, and that acts as if success were within reach for all. To do otherwise is to fail those whose very lives may depend upon the confidence that they can, the hope that they will, and the demand that they must stop their destructive behavior and begin to heal.

Moving people to treatment is the first task; matching them to the right treatment modality is the next. But achieving access to truly effective treatment, the kind of services that lead to genuine recovery, is the most important goal.

The current treatment system will need strengthening and broadening in order to accomplish the goals we have set. For those currently seeking help, we must ensure that the right kind of help is available, accessible, and funded. As we progressively move the larger population from denial to seeking help, we must ensure that an adequate treatment system is in place and able to respond. This may require an increase in infrastructure and in qualified personnel. And for any individual approaching treatment, we must ensure that they are offered a full continuum of choices for the type of treatment that they individually require. While the type of services may vary, each must contain the expectation of genuine recovery, expressed principally as abstinence from substance use.

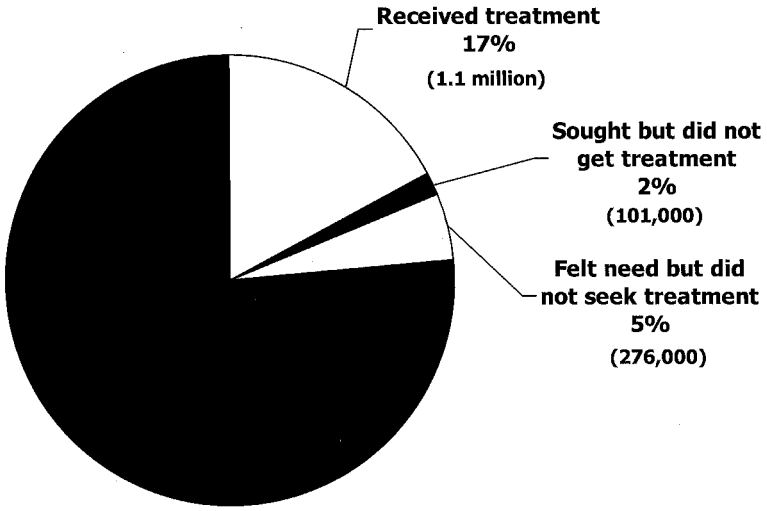
Let me now bring forward some of the reasons behind our current approach to funding. The first is that the $600 million in the initiative represents new money that becomes available through a competitive process. As such, we can attach provisions to these new dollars with the expectation that states will have an additional financial incentive to respond. That is, we can impose stronger obligations on states to monitor and improve their treatment systems. We can raise the standard of care throughout the system, and drive accountability into the process.

Second, there are currently two streams of substantial Federal treatment funding to the states: the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Programs of Regional and National Significance (PRNS). The President's FY 2004 request for the SAPTBG is $1.8 billion, with an additional $0.6 billion for the PRNS. These programs represent a remarkable level of commitment. There is nevertheless a tendency for funding inertia to limit our capacity to bring on line a newer, more flexible mechanism for rewarding performance and more effectively targeting capacity expansion and access. The new treatment funding provided by the initiative --$200 million per year – will be added to the PRNS over the next three years, starting in FY 2004. Putting this money in the form of vouchers into the hands of clients will help us ensure that actual need at the local level will help drive the existing treatment system into congruence with that need. By activating individual choice we are giving even greater responsiveness to current efforts that target treatment dollars through programs to the states.

Finally, if this program is as effective as we anticipate, a voucher mechanism of indirect funding potentially can become a format through which other federal dollars may be routed, thereby substantially increasing the flexibility, responsiveness, and impact of all available funding streams.

In conclusion, we are pleased to present to you today our cooperative efforts to reinforce, broaden, and make accessible pathways to recovery for Americans suffering from substance abuse and dependency. The hallmarks of the approach proposed by the President are enhanced outreach, consumer choice, stronger and more diverse providers, a full continuum of options, requisite accountability, higher standards of effectiveness, and honest recognition of the challenges that we face. People in need of treatment have a responsibility to themselves and their families to seek the help that they need. They also have a claim upon us as a compassionate nation to ensure that such help is available, accessible, and keeps its promise of recovery. Today, with this initiative, we move closer to meeting this national responsibility.

Most of those in need of drug treatment did not seek treatment.

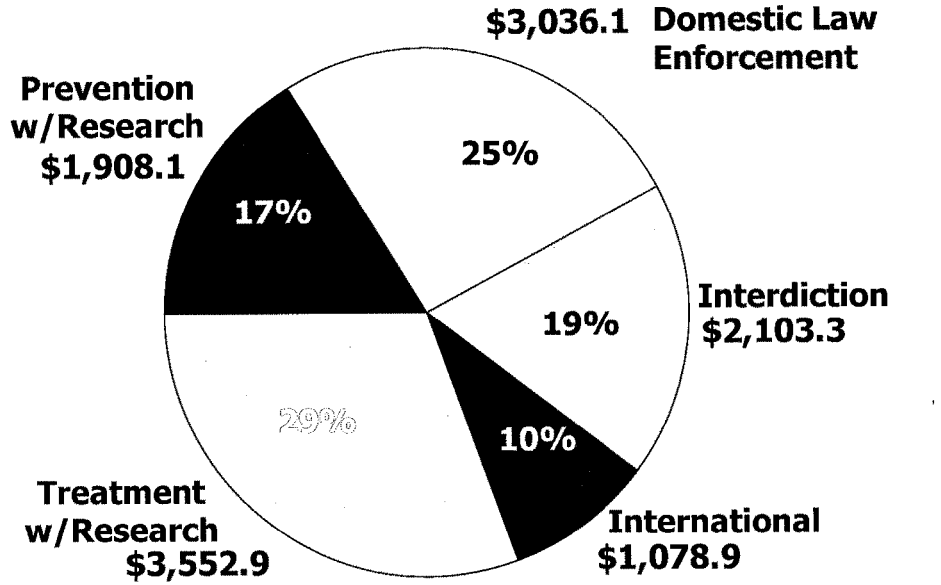


Total in need of treatment = 6.1 million

- Source: SAMHSA, *2001 National Household Survey on Drug Abuse.*

2/2003

FY 2004 President's Request, by Function
Total Resources: $11.7 Billion



(Dollars in Millions)

2/2003

Mr. SOUDER. I'd like to now welcome my long-time friend, fellow Hoosier, Charles Curie. Everything he says that's right today is because he was born in Indiana. Everything he says that's wrong is because he lived in Pennsylvania too long. Welcome, Mr. Curie.

Mr. CURIE. Thank you, Mr. Chairman. I appreciate the opportunity to be here. I appreciate, too, the opportunity to, again, see my good friend and fellow Hoosier. I think last time I had an opportunity to meet with Ranking Member Cummings, as well as Mr. Davis was at the field hearing in Fort Wayne, IN. And I was back home in Indiana that day, and it was, I thought, also a tremendous field hearing focusing on that intersect with criminal justice which you emphasize today, which is a very important part of all we do.

Also, Chairman Davis, it has been a privilege and pleasure to speak with you beforehand, and appreciate your support, as well as members of the subcommittee, Mr. Clay.

I would like to ask that my written testimony be submitted as part of the record, and on behalf of Health and Human Services Secretary Tommy Thompson, I'm very pleased to share this opportunity with Director John Walters, with whom we have forged a very strong relationship with and have appreciated very much the partnership, the guidance and the direction and the leadership that Director Walters has provided, as well as the relationship with Dr. Andrea Barthwell. I've appreciated that very much, and it has been, I think, a great collaboration within the administration.

And it is a privilege to discuss President Bush's proposed substance abuse treatment initiative today. This new initiative continues to fulfill the President's promise to invest $1.6 billion new dollars in addiction treatment over 5 years. Of that $1.6 billion he proposed in the State of the Union, $600 million over the next 3 years is for this initiative. The first $200 million installment is included in the President's proposed 2004 budget for the Substance Abuse and Mental Health Services Administration [SAMHSA]. SAMHSA's statutory authority for administering this program is provided under sections 501 and 509 of the Public Health Service Act.

SAMHSA's vision, a life in the community for everyone, is clearly consistent with the President's substance abuse treatment initiative. SAMHSA's vision is achieved by accomplishing our mission, building resilience and facilitating recovery. Working together with the States, local communities and public and private sector providers, we work to ensure that people with or at risk for mental or addictive disorders have an opportunity for a fulfilling life, a fulfilling life that is rich and rewarding and includes a job, a home and meaningful relationships with family and friends.

To provide treatment services for people who have substance abuse problems, SAMHSA currently funds, as has been mentioned, the Substance Abuse Prevention and Treatment Block Grant and Targeted Capacity Expansion Grants. The block grant with its required maintenance of effort will continue to support and maintain the basic treatment infrastructure which exists in States throughout the country.

For fiscal year 2003, the block grant totals nearly $1.8 billion. Targeted Capacity Expansion Grants, which total approximately $320 million for fiscal year 2003, are awarded to State and local

governments to address new and emerging substance abuse trends and to respond with treatment capacity before problems compound. This ensures us flexibility and gives us agility to meet treatment needs in the most relevant way.

The President's new substance abuse treatment initiative provides a third funding mechanism to expand substance abuse treatment capacity. It will utilize vouchers for the purchase of substance abuse treatment support services. Specifically, it clearly enables us to accomplish several objectives that have long been identified by those in the field, policymakers, legislators, and the very people we serve, as critical to moving the substance abuse treatment field forward.

The first objective is to recognize that there are many pathways to recovery. For the first time individuals will be empowered with the ability to choose a provider, whether nonprofit, proprietary, community-based or faith-based, that can best meet their needs. The very personal process of recovery can include meeting a person's physical, mental, emotional and spiritual needs. In particular for many Americans, treatment services that build on spiritual resources are critical to recovery. We must work to ensure that all Americans are allowed a full range of treatment services, including the transforming powers of faith. Denying these resources for people who want to choose and need them denies them the opportunity for recovery. Vouchers will allow recovery to be pursued in an individualized manner, and, in other words, we're able to realize the epitome of accountability, which is consumer choice.

The second objective is to reward performance. The voucher program will offer financial incentives to providers who produce results. Outcomes that demonstrate patient successes, including no drug or alcohol use, employment and no involvement with the criminal justice system, will be used in determining ultimate reimbursement. Never before have we been able to so clearly recognize outcomes as part of the quality and effectiveness equation.

Finally, the third objective is to increase capacity. The new resources will expand access to treatment and the array of services available. Vouchers can be used to pay for medical detox; in-patient, out-patient treatment modalities; residential services; peer support; relapse prevention; case management and other services supporting recovery.

To implement the President's initiative, we plan to issue a request for applications late this summer, early fall. The RFA will be based on SAMHSA's State and Senate grant model and will be awarded to Governors' offices. We believe the Governor is key to ensuring a coordinated approach among various State departments such as State drug and alcohol authorities, mental health authorities, departments of education, child welfare, Medicaid and criminal justice agencies. After all, each of these arenas provide services to people with addictive disorders.

We are working with the States, because they are our primary resource for substance abuse treatment services. These services are funded through State revenue and Federal programs, including SAMHSA's block grant, Targeted Capacity Expansion Grants and some Medicaid dollars. We want to ensure the new voucher pro-

gram is coordinated and integrated into these State-operated programs.

We'll be working with multiple stakeholders, including States, providers and national associations, to develop the RFA. The RFA will include broad standards and consistent performance expectations. Financial data will be used to monitor costs and to ensure that funds will be used for appropriate and intended purposes. Performance data will be used to measure treatment success and ultimately to measure the success of the voucher program.

We expect that successful applicants will establish the following: Demonstrate a need based on data; present the most feasible approaches consistent with the voucher program's guiding principles; eligibility criteria for providers; eligibility criteria for clients; criteria for matching clients with appropriate treatment; standards costs/reimbursement for treatment modalities.

Critically, States must use these funds to supplement and not supplant current funding; therefore truly expanding capacity.

We see the President's initiative as a unique opportunity to bring profound change in the financing and delivery of substance abuse treatment services. As the President said, our Nation is blessed with recovery programs that do amazing work. Now we must connect people in need with people who provide the services. We look forward to working with you, the Congress, our Federal, State and local partners to make this program successful for the people we all serve. Thank you.

[The prepared statement of Mr. Curie follows:]

TESTIMONY

OF

CHARLES G. CURIE, M.A., A.C.S.W.

ADMINISTRATOR
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION

BEFORE THE

HOUSE GOVERNMENT REFORM COMMITTEE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND
HUMAN RESOURCES

FEBRUARY 27, 2003

Good morning Mr. Chairman and members of the Subcommittee. On behalf of Health and Human Services Secretary Tommy Thompson, I am very pleased to share this opportunity with Director John Walters to discuss President Bush's proposed substance abuse treatment initiative.

This new initiative continues to fulfill the President's promise to invest 1.6 billion new dollars in addiction treatment over five years. Of that 1.6 billion, the President proposed in his State of the Union $600 million over the next three years for this initiative. The first $200 million installment is included in the President's proposed 2004 budget for the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's statutory authority for administering this program is provided under Sections 501 and 509 of the Public Health Service Act.

SAMHSA's vision - a life in the community for everyone - is clearly consistent with the President's substance abuse treatment initiative. SAMHSA's vision is achieved by accomplishing our mission: Building Resilience and Facilitating Recovery. Working together with the States, local communities, and public and private sector providers, we work to ensure that people with or at risk for a mental or addictive disorder have an opportunity for a fulfilling life, a life that is rich and rewarding and includes a job, a home, and meaningful relationships with family and friends.

To provide treatment services for people who have substance abuse problems, SAMHSA currently funds the Substance Abuse Prevention and Treatment Block Grant and Targeted Capacity Expansion grants. The Block Grant, with its required maintenance of effort, will continue to support and maintain the basic treatment infrastructure that exists in States throughout the country. For FY 2003 the Block Grant totals nearly $1.8 billion.

Targeted Capacity Expansion grants, which total approximately $320 million for FY 2003, are awarded to States and local governments to address new and emerging substance abuse trends and to respond with treatment capacity before problems compound. These grants ensure us flexibility and give us agility to meet treatment needs in the most relevant way.

The President's new substance abuse treatment initiative provides a third funding mechanism to expand substance abuse treatment capacity. It will utilize vouchers for the purchase of substance abuse treatment and support services. Specifically, it clearly enables us to accomplish several objectives that have long been identified by those in the field, policy makers, legislators and the very people we serve as critical to moving substance abuse treatment forward.

The first objective is to acknowledge that there are many pathways to recovery. With a voucher, for the first time individuals will be empowered with the ability to choose the provider, whether non-profit, proprietary, community-based or faith-

based, that can best meet their needs. SAMHSA recognizes that the process of recovery is very personal and can take many pathways, including physical, mental, emotional, and spiritual. A voucher will allow recovery to be pursued in an individualized manner. In other words, we are able to realize the epitome of accountability, which is consumer choice.

The second objective is to reward performance. The voucher program will offer financial incentives for providers who produce results. Outcomes that demonstrate patient successes, such as cessation of drug or alcohol use, employment, and no involvement with the criminal justice system, will be used in determining reimbursement. Never before have we been able to so clearly recognize outcomes as part of the quality and effectiveness equation.

Finally, the third objective is to increase capacity. The new resources will expand access to treatment and the array of services available. Vouchers can be used to pay for medical detoxification, in-patient and out-patient treatment modalities, residential services, peer support, relapse prevention, case management, and other services supporting recovery. We anticipate that the initial phase will fund treatment for approximately 100,000 people per year. Moreover, currently excluded residential treatment centers can now become eligible to provide substance abuse services. Unlike the exclusion provisions under Medicaid, clients will be able to access residential treatment programs with 16 or more beds through this program.

States are our primary resource for substance abuse treatment services. These services are funded through state revenue, and federal programs including SAMHSA's Block Grant, Targeted Capacity Expansion grants and some Medicaid dollars. We want to assure the new voucher program is coordinated and integrated into these State-operated programs.

So, SAMHSA will issue a Request for Applications (RFA) late this summer or early fall. Only Governors' offices will be eligible to apply for funds under the program, since the Governor is key to assuring a coordinated approach among various State departments, such as state drug and alcohol authorities; mental health authorities; departments of education, child welfare, Medicaid, and criminal justice agencies. After all, each of these arenas provides services to people with addictive disorders.

States that choose to participate will be largely responsible for developing many of the details and can tailor their application to meet their particular needs. They may use a range of models for implementing treatment vouchers, including implementation by a State or sub-State agency or implementation of all or part of the program through partnership with a private entity. Within a State, the program may be targeted to areas of greatest need or areas where there is a high degree of readiness to implement such an effort.

States will have some flexibility to design the type of voucher that is appropriate for their systems. However, as initially contemplated, the voucher would likely

have no face value. The voucher would be presented by a client to a provider, and would allow the provider to obtain reimbursement from the organization in the State administering the program.

The system could be designed such that there are various types of vouchers for different types of services. Providers would be allowed to obtain reimbursement for the actual cost of their services, not to exceed a maximum amount for different types of services. These cost ranges will be determined by an analysis of historic cost data. We have stated numerous times that we will require that States are accountable to us for outcomes and costs. This is how we anticipate establishing the cost side of the equation.

The RFA will include broad standards and consistent performance expectations. States must provide a reasonable plan for ensuring that providers receiving voucher payments provide quality and effective treatment and other services supporting recovery. Standards for providers wishing to participate in the program will be developed. At the same time, States will be required to submit as part of their application a detailed plan to broaden the base of providers and ensure that a wide variety of provider organizations, including faith-based organizations, are eligible for voucher reimbursement.

States must also establish a process for screening, assessment, referral, and placement for treatment that is appropriate for the individual client -- from brief interventions to more intensive treatment.

Clients will be assessed where they appear for treatment, will be given a voucher for the appropriate level of care (e.g., brief intervention versus more intensive treatment), and then will be referred to a variety of providers who could offer that level of care. The professionals providing the initial assessment will determine appropriate level of placement.

I mentioned earlier that the voucher program will create financial incentives for providers who produce results. Therefore, the key to accountability in this program will be the system of reimbursement. Payment to providers will be linked to demonstration of treatment effectiveness measured by an array of outcomes, which must necessarily include the lack of client drug and alcohol use following discharge.

In designing and implementing the program, States clearly must establish a process to monitor outcomes and cost of the voucher system and be prepared to make adjustments. This performance data will not only be used to measure treatment success but ultimately to measure the success of the voucher program.

So, in summary we expect that successful State applicants will establish the following:

$ Need based on data on rates of abuse and dependence

- $ Documentation of the most feasible approaches consistent with the voucher program's guiding principles.
- $ Eligibility criteria for providers;
- $ Eligibility criteria for clients;
- $ Criteria for matching clients with appropriate treatment; and
- $ Standard costs/reimbursement for treatment modalities.

Critically, States must use these new funds to supplement, and not supplant, current funding, thereby truly expanding capacity and the array of services available.

We see the President's initiative as a unique opportunity to create profound change in the financing and delivery of substance abuse treatment services.

As the President said, "Our Nation is blessed with recovery programs that do amazing work." Now, we must connect people in need with people who provide the services. We look forward to working with you, the Congress, our Federal, State, and local partners to make this program successful for the people we all serve.

Thank you for this opportunity to speak with you. I will be glad to answer any questions you may have.

Mr. SOUDER. Thank you both.

I'd like to start with a capacity question. Director Walters in his statement talks about the utilization rate, in that there is a deficit of those actively seeking of around 100,000. In your statement it says it is particularly pronounced in areas for juveniles, services in rural areas, needs of women and mothers, and those who suffer co-occurring mental disorders.

And in Mr. Curie's statement, you did two things, and this is the first question I have to try and reconcile with this, and it gets directly to the heart of where the program is going to go, because you said that at the end there that there is a—that the Governors will have to show an increase in capacity, but you also described the—that this will—the vouchers could be used for medical detoxification, in-patient or outpatient treatment, modalities, residential services, peer support, relapse prevention, case management and other services supporting recovery, not all of which is the first round of a treatment.

So my first question is, is the 100,000 shortage of people who are seeking people at the initial stages who can't get that, or would that include relapse prevention and other types of things?

Mr. WALTERS. Well, I can let my more expert colleagues elaborate, but the 100,000 is not a census, so we have an estimate based on a survey of the country that is a statistically representative sample, but it doesn't have the fine grain to kind of tell us precisely where that 100,000 people are, all their demographic characteristics, because of the cost of having such an extensive survey.

Fortunately, however, the drug dependency, the drug problem is too big, but it is not so big that you don't have to do fairly intensive surveying to kind of find the demographics of small subpopulations. We know from other data, though, that in particular areas there are underserved populations of some of those that you enumerated, and we have, as I think you alluded to, the ironic situation or the tragic situation I guess is the better way to put it, of surveys for the last 10 years of capacity utilization of looking at, given the slots we have of various kinds, how full are they on any given day, show that roughly 20 to 25 percent are vacant on any given day. At the same time, we have people who are on waiting lists. We are not doing as efficient a job as we would like to do, and I think most people would like to do, in matching need to services.

What the voucher does is you pay for the actual service you get. So it would be more efficient, we believe, and we're spreading it over the range of services, because in individual areas, some of these things are going to be more of a priority than others. But the remarks you cited from Mr. Curie are reflective from what I've seen and I'm sure you've seen going around the country. In many cases specialized services for women or even single men, a smaller population, who have dependent children—services are lacking. In many cases juvenile services are lacking. Many times for adults there aren't the different kinds of services and modalities that we need. But what this would hopefully do is expand the number of people who would offer services of different kinds by responding to the need, and also get the people who have the need directly with the resources to get the services when we assess them as having the need. And I'll let anybody else elaborate.

Mr. CURIE. Thank you. In addition—and I agree with Director Walters' answer completely—the 100,000 figure comes from our household survey, data derived from that, and basically individuals in the sample across the country who responded to questions which would have indicated that they have a drug and/or alcohol problem, and the added feature they responded, they recognized they had a problem, and they have tried to seek treatment, could not find it. It would be anticipated that in that 100,000 would be a range of individuals, perhaps first-time individuals reckoning with it as well as individuals who have dealt with this before in their life.

Mr. SOUDER. Thanks. My time is about up. I assume we will have a second round. But it leads to a fundamental question about the program. Is the goal to expand the services predominantly, or is it to better target the services, or is it to make the services more effective, all of which theoretically could be done, but aren't necessarily overlapping goals? And we may have to have some prioritization.

And also perhaps in a followup written response, I would appreciate receiving some more particulars on, for example, the services of rural areas. What I found when I was on the children and family committee is that many don't service rural areas very much, but the numbers are fairly small that would be impacted. What you have to do when you have limited dollars is to figure out when you're targeting subgroups, is that going to be out of 100,000, is that 1,000 people, but it takes up x amount of the budget versus a waiting list in Baltimore where it may be higher?

Another variable that I would suggest that you have just addressed in your response on the vouchers to some degree is the mismatch between capacity, because as a casual observer I would say if you have health insurance, and if you are more wealthy or have a job, you are more likely to get drug treatment. The problem is that mismatch in that the capacity may not match, particularly your proposal that you referred to in the testimony about going to residential centers with 12 beds, which may be able to be more at the grassroots level which are not currently in the program.

But one additional thing for the record I would like to see is that in the list, you didn't include prison population, and you didn't address directly whether low-income and minority groups are having a more difficult time. I assume that comes partly under your targeted programs in SAMHSA. But if we don't get back to it today, if you could respond to those in a written way.

Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, I just want to followup on something that you just raised that I hadn't thought about. Mr. Curie and Director Walters, when we talk about need-based on data, rates of abuse and dependence, when you have an area like Baltimore and Maryland, the State, we have a lot of people—we have one of the highest prison populations in the country, and a lot of those folks went in there because of drugs, and sadly they come out still with a drug problem. Would that be part of the determination—in other words, you have one area that's got 8,500 people coming out a year, and you have another area of—where maybe only 500 people come out a year coming back into a community, and you can show in the past that there has been a drug—some

kind of correlation—I don't just want to say that because somebody comes out of the prison, they have a drug problem—but do you see that as something that would be taken into consideration, because that's a major issue?

Mr. WALTERS. Yes. In fact, Mr. Davis visited the Safer Foundation that's helping to reintegrate people who are coming out of jails and prisons, some of whom are also getting drug treatment services at the site we visited as well as other reintegration help. This is the kind of flexibility we would like to build into the program to allow States to provide those services where the need is and to prioritize them. We're not saying that the whole system isn't working. You know this as well as I do. We visited the center in Baltimore together. There are people doing outstanding work and serving important parts of the population. But there are gaps, and there are just overall capacity problems. So we would like to work with States and localities to both target where the needs they see are and also optimize the opportunities they believe there are to expand capacity. There may be a need that they don't think they have yet got the resources for, so a first stage may be to try to do some training or try to get more people capable of meeting that need. We're not trying to say one size fits all here, but this is still going to be a partnership with the States.

Mr. CUMMINGS. What we have here, Mr. Curie, is that we've got two programs under SAMHSA, as I read your testimony, and this adds a third tool to try to address this big problem. And so do you see any way that now we have these two programs that already are existing in competition in any way with regard to this third program, and how will that—how do you see the transition going in your department?

Mr. CURIE. Excellent questions. Clearly one of the reasons we have wanted to select and utilize the States in the process of implementation of this program is States—is where drug and alcohol programs are primarily implemented. They're responsible for the block grant as well as both communities and States Targeting Capacity Expansion Grants and leave these States as a point of integration. So we want to avoid any sort of not maximizing the funds or any sort of competition, but we want to make sure all three major types of funding mechanisms are aligned and are working together. And currently now, as Director Walters indicated, for the criminal or justice population there are dollars in various States from the block grant that are working toward both in conjunction with drug courts as well as reentry programs as well as we have Targeted Capacity Expansion Grants that are targeted. We also have a partnership with the Department of Justice with the major reentry initiatives, and we see those continuing.

We obviously, as Director Walters indicated, would be looking at States as they propose how they would use this voucher program of how they would address a criminal justice population. That's clearly not precluded. One caution is obviously treatment within the prisons has historically been the criminal justice department's responsibility. So we would want to be careful there's not supplanting.

Mr. CUMMINGS. I was talking about once they get out, you can always project how many are going to come out.

Just to piggyback on something the chairman mentioned, whenever I see anything like this, I try to think as a lawyer, and I think about the counterarguments and how do we get consensus. And I can imagine that someone who is from a small rural area, for example, I have a lot of rural areas, would have the concern that the chairman just raised—that, you know, how do you make sure that when you have problems in those areas, that the money just doesn't all go to the big areas? Because, I mean, if we took a Baltimore City situation, and that is just 1 out of 24 counties, by the way, in Maryland, with 65,000 addicts, you know, if I am Congressman Souder, I might say, oh, my God, is all the money just going to go to that glaring problem as opposed to the problem that we saw in Fort Wayne, which I don't think is as glaring, but for the people that are affected, it is pretty bad.

So how do you all see that? I know you have your two programs already, but about this program and making sure we don't have a situation where—and I know this is sort of arguing against my own self, but I want to make sure the program happens, and I know how the Congress works. So how do you assure that Fort Wayne gets its due also? And he hit on this, and I don't know whether you had a chance to answer that.

Mr. WALTERS. Well, we are aware that this is a problem that is not uniform, but also does not affect simply one area and not another. The rural problem tends to be less intense, as you indicated. There's no question the heart of this problem is in major urban areas, but that is not to say methamphetamine or heroin or cocaine don't exist in rural areas.

The real problem for treatment in rural areas is that if you provide services on the basis of building a facility or supporting a facility, sometimes in sparse areas—I was in New Mexico a month ago meeting with Governor Richardson, and people are coming hundreds of miles to try to get services. Well, if you have a juvenile or an adult, to have them pull up stakes and have them move, that creates enormous problems, as you can imagine, or the cost of transportation.

What the voucher would do, instead of trying to build them and make the people come to the services, it would provide a mechanism to local health clinics, local physicians, local institutions could add more easily the services closer to the people. It won't completely solve everything. And I think we are interested in showing how this mechanism can work in rural areas as well.

So we would want to look at and we will have to write the regulations in a way that does recognize that is a need we look at specifically, so we don't just say it's sheer numbers, so that concentrations of populations would dominate all the money. I have to go where the concentrations of need are as well.

So I would not want to mislead you. And you know we are going to end up driving this money to large urban areas because that is what we have to do now. But I do think it is important to say that we are not neglecting—I don't know of another tool that would more effectively solve the problem of access in rural areas than this program.

Mr. CURIE. I would just add that clearly, the standards in the RFA we issue would be looking to States to demonstrate how they

would assure that they're going to be addressing hard-to-reach areas, and if the vouchers are there, it also provides incentives for services that perhaps had not been there before.

Mr. SOUDER. The challenge is how to build certain flexibilities, much like in heavily rural Appalachia. You simply can't have the same size hospitals and clinics in every single place in the United States.

Dr. Barthwell.

Dr. BARTHWELL. I just wanted to add that we've heard this figure, 65,000 addicts in Baltimore who on any given date, need treatment, and there has been a critical rule of thumb that has been followed for some time, and it's borne out over years that at any given time, on any given day, only about 15 percent of people who have chronic severe debilitating forms of addiction are seeking assistance for that. That is based on a number of things: their own belief in their potential to recover, their own belief in their ability to get help, the way in which people around them reinforce their desire to change, whether people put pressure on them to take action for the behaviors that are being observed, and the cultural conversation about addiction and nondependent use.

So if we were to look at that 65,000 people that need help but are not seeking help or not able to get help, they would distill to 9,750 who today would feel as if they should go somewhere and seek help. And there's a lot of consistency with figures in the National Household Survey. We're already treating about 17 percent. Two percent said they went out at some point during the year and sought treatment, but didn't get it. So this program is going to extend that figure to about 19 percent. So we're doing a little bit better than we have done.

We also expect in our office to increase the pressure to change the cultural conversation so that more people recognize that they have a problem and develop a desire to change and are compelled by the people around them to go out and seek treatment. So we think that this President's treatment initiative is going to address the 2 percent that went out and sought help and didn't get it, but we fully expect if we can continue to change the cultural conversation about drugs in America, that number of people who feel as if they need help on any given day is going to go beyond that 19 percent, and we should prepare for having people seek treatment earlier so that they are not experiencing chronic severe debilitating forms of disease. They're getting off that treadmill much earlier than they have been.

Mr. SOUDER. Chairman Davis.

Mr. DAVIS OF VIRGINIA. Thank you very much.

Accountability is an issue that's been discussed here. It's the mainstay of the program. In your testimony you both have stressed this will be outcome-based programs; that, in short, the Federal dollars will not go to programs that don't show demonstrable results. In connection with this, just a few questions. How do you ensure that the results will be effective? Will you test users? What happens to a provider that isn't effective? What's the time period for measuring?

Mr. WALTERS. We talked about the general principles because we haven't written all the regulations and the specifics yet, but these

are the general principles we have in mind. Once the person comes in, is assessed, is referred to a treatment provider, gets the services, after the services are completed as decided by the provider, that there's a postservice assessment. We can talk about how long afterwards or what the full ramifications are.

We care that a component of that assessment is whether or not the person receiving the services is abstinent. As Mr. Curie said in his testimony, we can look at involvement with the criminal justice system; other kinds of issues of stability, like employment and others, and we probably should, because for some varying degrees of severity of the clients that you take in, you can expect varying degrees of complications and relapse.

But we do not want to send the message that the system is a revolving-door system. We do want to send the message that the system is one built on a premise that while we say we believe in it, we don't believe we can make people well categorically. Sometimes when you talk to people, they won't say this in the open. They will say, well, what we really need to do is be a little more hard-headed. There is a category of user out there that we can't help, and we ought to be more efficient in resources by trying to identify that hard-core category and move resources to those outside the hard-core category.

We, in the strongest possible terms, deny that premise. We have been to programs that have taken people in the most severe possible state and brought them to recovery. We are not identifying throw-away people. And the way to most effectively treat them earlier on as well as later is to have programs that have to demonstrate accountability. Too much of the system now, despite excellent people in the field, too much of the system pays no matter what the results are; move bodies through. This would give providers an incentive to move people from services into transitional help, worry about how they reintegrate with their families, with their jobs, with their housing and stability. It would not just give no incentive to finish the services, kick them out the door and submit the bill. I am not saying good providers do that. They don't. But there's not enough incentive, we think, in the system to identify those who are better.

So we want an assessment at some period of time, and perhaps 90 days after services are provided, that includes a test to find out whether or not they are abstinent and rewards on the basis who are effectively getting people into recovery. If the client is not in recovery, we intend to try and structure the system so they can go back and get services from another provider that may help them get in recovery, because we know that if there is relapse, the quicker we get people back into services and treatment, the better off they are. We don't want to let go of them and have them fall through the cracks on the back end if there is a relapse either.

Now, that is more difficult than the current system frequently provides, but if we are serious about the science and the medicine and the result that we know programs can make here, we ought to make that an expectation in the structure to a greater degree. And we ought to reward people who have results, and we want the reimbursement system to drive people who provide ineffective care

out of business. If you don't produce results, you can't make up in volume what you failed to do on individual cases.

Mr. DAVIS OF VIRGINIA. Let me ask Administrator Curie a question. If you could capsulize why this is better than the previous Federal treatment centers and why the $200 million per year couldn't be better spent or just as well spent as part of the block grant to the States.

Mr. CURIE. Thank you, Chairman Davis.

Clearly what this initiative offers that we have not been able to achieve or attain up to this point in time is: One, as Director Walters outlined, a more efficient, quicker pathway to accountability being a clear measure around these new dollars. And you can do that with a new initiative as we shape it with the standards in the RFA.

Second, consumer choice, which we referred to as the epitome of accountability, clearly is essential here. It is not an issue of certain providers having received block grant dollars year after year and being primarily—while they have been a mainstay—and again, we anticipate many of those providers are going to be eligible providers to receive and benefit from this voucher program as they are able to expand capacity. But again, consumers will be in the driver seat, so to speak, in terms of where they choose to obtain their treatment.

I think the other aspect is that with these new dollars and with the focus on taking a look at expansion of capacity, we also can be very clear about the array of services that encompass recovery and using recovery as a framework. And again, as the voucher program succeeds, and as we move ahead with implementation, we're going to be in a position to gauge those results from the outset if we have the agreed-upon outcomes.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Mr. SOUDER. Before yielding to Mr. Davis of Illinois, I would like to welcome Mr. Bell of Texas to our opening hearing this year.

Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

Following up on the voucher program, how do we ensure that individuals won't just kind of shop around from place to place looking for a miracle cure? Let's say I am at the Davis Center for a month, and nothing seemed to have happened that has changed my desire. And I say, well, I am not sure these Davis people can do it, so I am going to run over to the Cummings Center. How do we prevent that from happening with the voucher program?

Mr. WALTERS. One of my colleagues is more expert, but my experience in visiting centers is that's the course that can happen right now. You can walk from one place to the other. You can drop out. We have problems with retention as a part of the programs.

One of the things this program would do is, of course, in order to receive the reimbursement for the voucher, you have to show that you are able to provide full services; you got to be able to retain people as well as the results of that retention and successful recovery. So in a certain manner here, we are making the provider accountable by saying you have to keep people in. We know for treating this disease, unlike, as an example, an attack of appendicitis where you go to the doctor, you have a pain, you want to get

better, you comply. You know that we have been involved in this in a long time, but there is a lot of denial. People frequently come in and say, I don't really want to stop using; I just want to get it back to where I had more control of the fun I am having with drugs. And that is a problem we all deal with in providing these services. But we think the best way to do that is, one, make the provider responsible for retaining contact with the individual so they get effective services, and then measuring the effect of those services afterwards, and if they are not effective at doing that, then moving people to another provider who will be effective. So we are trying to address the shopping properly by the provider more than we are trying to change the behavior of the individual client.

Mr. CURIE. Along with the outcome monitoring that Director Walters just described, also this system will be driven in large part, too, by initial assessment, in terms of assessing the need of an individual and a voucher being issued based upon that assessment in terms of what the best course of treatment and services would be for that individual. So it is not a voucher that is going to have a face value to it to be able to go from place to place at just clearly what the consumer entirely would want to do, but it is going to be structured around the assessment of that consumer's need as well. And we'd be expecting accountability to be built into the system that once a voucher is issued, that there would be oversight in terms of a case management aspect of this as well.

Mr. DAVIS OF ILLINOIS. Dr. Barthwell, you mentioned changing the culture of conversation as a way of convincing more of this large pool of individuals who are in denial that they are in need of services. Could you elaborate a little bit more on that in terms of what some of the techniques and approaches might be?

Dr. BARTHWELL. The demand reduction and implementation plan of the strategy involved communicating very broadly with Americans that the drug use problem is not just prevention or treatment, particularly focused on chronic severe debilitating forms of the disease and trying to drive more money in the system to build a better ambulance at the bottom of the cliff. It really also has to be about creating systems where we can check the behavior of individuals who have moved past the barricades that say don't start drug use and to get nondependent users to recognize that they are on a course that is going to change the trajectory of their life long before that happens.

So we are trying to put speed bumps along the way, if you will, to get the attention of the nondependent user, and we also want individuals around the nondependent user who typically looks the other way saying, well, they're doing something, and it's not something I might do, but it really isn't affecting me, to start to take some responsibility to compel the user to get off of that pathway.

So our strategy is built around prevention programs, strengthening our prevention programs and recognizing that all of our efforts converge upon those two big goals, to reduce drug use by 10 percent in 2 years and 25 percent in 5 years, to get the nonuser to increase their resolve not to use, and to deter the use. And we do that by having the messages that they receive at home mirror those in community institutions and having our laws and standards mirror those to really communicate very clearly in a concrete

way to young children that drug use is wrong and drug use is not a good thing to be involved in.

With individuals who have started using, whether they are non-dependent users or problematic troubled users, we want to increase their desire to change by increasing their awareness of their need to change. And we are looking at putting in place more programs that detect use to deter, because we know the detection programs do, in fact, deter use. We are also looking at when those detection programs fail to deter, that the earlier identification be linked with an intervention. So we are working very closely with SAMHSA to have them drive programs into hospital emergency departments where physicians get better training in identifying someone who comes in after a vehicular crash and intervening them and linking them with a brief and early intervention.

There is a tremendous amount of science. We want to apply this in a very broad way to drug use. And finally, for people who have more chronic severe debilitating forms of the disease, we want to increase their desire to change and help them to stop using. And we think that the programs that we can do, this being among them, to improve the ability of treatment programs to reach an individual where they are so they can acknowledge addiction, commit to recovery, and work them to reduce or eliminate inducements to use are going to enable us to have better success rates from our programs.

Naturally if you have a program that accepts all comers with no screening, they get one out of four individuals to stop at the end of the treatment program. We can do better than that. We have programs that get 97 out of 100 who enter to stop. We want to supply the science and technology that's being employed in a two-tiered system to more a public system, and we think this voucher system helps us achieve that.

Mr. DAVIS OF ILLINOIS. Thank you, Mr. Chairman.

Mr. SOUDER. One question I wanted to insert, I think, that potentially would address a couple of the questions here, one relating to the potential switching, from the Davis clinic to the Cummings clinic, that the second part which would have to do with the smaller residential centers with 12 beds, how do they meet the standards you're developing? And even the third one you just alluded to, which is prescreening and potentially screening out, we had some informal discussions, and I wonder whether this was going to be part of any of the standards of controlling some of the payment to the groups. In other words, if you don't complete the program, and you don't stay clean, the firm itself doesn't get the money. If that is the accountability, if there is a real action for not making sure your people are cured, in effect, or at least through your program are clean, then the financial burden and the standards are going to be placed on the person who's doing the program, or they're not going to get paid. And I am wondering if you are actually involving that or whether you see that coming in the standards.

Mr. WALTERS. That is our intent, and we will work with the States to make sure that the way we build that in doesn't create impossible work demands. I would expect—although it is going to vary from State to State. There is some delayed reimbursement. In some States there is now an audit after reimbursement to see

whether or not services were provided effectively, and they may pull some money back or sometimes may involve some additional money. So there is already in the system some structures that are not unlike what we are proposing.

What we are proposing is an assessment afterwards and standards that fit the basis of the severity of the individual case that individual providers face. We are not trying to drive them simply to cream, as Dr. Barthwell indicated, although, as she said, we want to help the people we can help more effectively. On the one hand, we are not trying to make people not treat a category of people. On the other hand, the creaming is understood as something we really could help now. We want to help them. And so—but the goal here is to use the addiction severity indices that have been developed to compare like candidates and to have real measures of effectiveness.

Not to get too far ahead of us, but my personal view and not the administration, we have knowledge from the research we have been funding, and the programs we have looked at involves sometimes much more expensive, involved treatment. It's very hard to fund that when the issue is how many slots you are funding. You find cheaper treatment, and, therefore, the people who may be helped by the more expensive treatment are not given those services, and as a result their outcomes are frequently not very good.

I believe that if we begin a process that assesses people and shows severity up front, provide the different set of providers, and we look at the outcome of those providers, and we begin to say, let's not spend money on something that's going to be cheap and ineffective, let's spend greater money, but instead of just people saying, this must be better, you'll have a system that shows the results to concretely justify the more intense expenditure of resources because of the outcome. We begin to have a system that can continuously show us what's happening here, and so we can better manage and make judgments about investment of resources for effective outcomes.

Mr. SOUDER. Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman.

My concern has to do with the cost of the program. The President proposed spending $600 million over 3 years to significantly enhance the availability and accountability of drug treatment in the United States. Does that mean diverting funds from existing programs? And what will be the basis for the voucher distribution among the States? Will it be based on population, needs or what? Has that been devised yet?

Mr. CURIE. These are all new dollars. They're not being taken from any other pot of money. And these are all new dollars to the Substance Abuse and Mental Health Services Administration for that period of time. We are in the process of developing standards by which, as we issue an RFA, we'll be having States apply. Obviously, we want to have it based on both documented need. Also we recognize there's difference between States such as California and Rhode Island. So we're in the process now of honing in in terms of what would make sense for some sort of allocation, but, again, we want to base it upon need.

Also the key here—we use statements that this is a competitive process. I want to stress that when we say competition, we're talk-

ing at a couple different levels. One, States have to compete against the standards of the RFA. They have to demonstrate that what they're developing is going to be meeting the standards of the RFA. And, again, we want this implemented in as many States as possible across the country. At this point we're not precluding the possibility of trying to do something in every State. Some States may choose not to apply. But we also recognize that in dealing with $200 million, once we have a response to the RFA, we will have a clearer idea as to the breadth of the program across the country.

Mr. CLAY. On a somewhat related matter, being from Missouri, initially methamphetamine was manufactured and for the most part used in the rural parts of the State. Now law enforcement is turning up these laboratories in urban areas. Have you all noticed a trend where the use is migrating from rural parts of a State to urban parts of a State? And any of you can try to tackle that one.

Mr. WALTERS. It's very general. The general trend of methamphetamine has been that it started in the Southwest and moved across the country. For example, we have had it for several years in Los Angeles. We had it move to some other cities in the West. Sometimes it has started in rural areas, but there are also, usually depending on whether it's being produced in small labs, which are frequently associated with the rural use, but there are also large superlabs, as you probably know—some are in the United States, sometimes there are superlabs in Mexico—and then bringing large quantities in, which can be more directly marketed into urban areas. It can't be marketed in rural areas, but they can be moved in because some of the organizations are also selling other kinds of drugs, heroin, cocaine, marijuana. So they have already established patterns of use.

But we have this moved essentially from the West to the East, and in some cases it is first seen in a State in rural areas, but sometimes it has also been showing up in an urban area just depending on how it's produced and what the introduction route is.

Mr. SOUDER. Mr. Bell.

Mr. BELL. Thank you, Mr. Chairman, and thank you all for your testimony here today.

As the Chair kindly pointed out in his welcoming remarks, I hail from the State of Texas where drug treatment is a critical need, just as I'm sure it is in many other States. Interestingly, just this past year, in December, the Texas Commission on Alcohol and Drug Abuse did a study where they found that the total impact of substance abuse in Texas cost the State's economy more than $26 billion, and they broke that down—came down to about $1,244 for every man, woman and child in the State. So you can see it is having a devastating impact on the State of Texas.

But my concern is this: With States suffering through historic budget crises—in my State of Texas, the legislature is looking on a $10 billion shortfall in this legislative session—my concern is the cost of administering a program such as this. Not only are States adjusting to the new data requirements under the performance partnership grant, but those who choose to participate in this voucher program, based on my reading, will have to bear the brunt of the administrative costs.

When considering pending State budget cuts, administering these programs could adversely affect the very people we intend to serve. Currently only small portions of existing grant dollars can be used toward administrative costs, and under this voucher program, my question is will there be caps placed on the dollars going toward administrative costs? And if so, are you concerned about the burden this may place on the States and what can be done about that?

Mr. WALTERS. We certainly are concerned about the problem of how much of the resources we want for services get pulled off in nonservice delivery here. And I met, in fact, with Dave Wanser from Texas, single State agency, just a month ago and talked about the pioneering program Texas has and linking electronically individual providers to a reimbursement system that will save enormous amounts of money. I think SAMHSA is already interested in doing this so that the paperwork is not a matter of multiple copies of different forms, but a Web-based system where information about clients, the assessment and case management information, is wed to reimbursement information, and that pulls from that the information we need, from reports. We're not sending multiple forms and requirements. We're reducing the staff costs. We want to cap the administrative costs of this program.

We also want to reduce administrative costs, although we are seeing some variation here. Different States have different capacities.

We also want to reduce the cost of providing services that are not utilized. One of the things I mentioned earlier that is attractive, especially in this budget climate, is that we would pay for the services provided. We are not paying for a facility or a place where there's a bunch of slots, and the maximum we could hope for was use 100 percent, but usually we're going to use less than that. When we pay for vouchers, we're paying for an actual delivery of service to an actual individual.

Yes, there probably would be some additional expense associated with the followup assessment. Right now I suppose there may be some additional assessment or cost in providing the reimbursement perhaps, or to bring new providers in line. But I don't think, given what we know about the system now, that is likely to be significant, and I think it's just not pie in the sky promises that the savings on efficiency, the savings on funding programs that work, the savings on giving programs incentives to change as a result of the reimbursement mechanism should vastly outweigh the costs that are involved here, but we would not allow uncapped administrative expenses as a part of this program.

But I would let Mr. Curie talk about the structure that we have decided on so far.

Mr. CURIE. We're anticipating that in the standards, that we would be giving guidance in regards to use of any of the dollars to cover administrative costs to the State, and, again, we would anticipate that being capped. At the same time these—one major advantage is that we're not requiring any State match or efforts made of these dollars. So that also gives the States some greater latitude with these dollars.

Dr. BARTHWELL. I would also like to add that we do expect that there is a clinical assessment that is done before a person is matched, and that the post-treatment assessment would be clinically allowable costs and not a part of the administrative overhead. We also spoke with Don Weitzman, who is the associate director of Dakarti yesterday, and you have a 5 percent administrative overhead allowable in Texas, and last year you didn't use all of it. So they are actually operating at—a little slimmer in the way of administrative costs than some States are.

Mr. BELL. Thank you.

Mr. SOUDER. I would like to yield to Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

As I listen to the questions of my colleagues, I just wanted to ask you about a few other things. Director Walters, if I've got a Cadillac program, and then I've got a Pinto program, and I've got a voucher, Cadillac program costs me $100, the Pinto $20, how do I control—I know the States have regulations, but how do you foresee having some kind of balance here? I know at the end you will look at the results and see, and you will maybe look at some costs from the beginning, but the other person goes in there and every week he's going in there, $100, $100, $100, and then—but he could have gone to the $20 program that may have been just as an effective. Because, as we all know, sadly, and all we have to do is look at Medicaid fraud, a lot of times when people find a way to reap dollars, they do it. We have a few bad apples; 99 percent of the people are great, but the few—and with the limited amount of money that we're dealing with, I am just trying to make sure that we have the safeguards that we need.

And so all of you have talked about how we, the Federal Government, what we say to the States. And so how do you deal with that kind of situation, because I can see that happening because I have seen it just trying to help people get treatment. One program is sky high, and another one is real low. What do you foresee there?

Mr. WALTERS. I will let my colleagues who have more experience respond in more detail. I think this program for the first time lets us address that problem. We will assess people at the point where we give them a referral and give them the voucher. If they need more expensive residential treatment rather than outpatient treatment, that would be a determination made at the point of assessment. Then the referral would be for that category of treatment with providers, I presume, in the States—although we haven't settled all this yet—that would agree to provide those services within a certain range of costs. If we find then that some of those providers can provide effective services at a much lower cost, then we obviously would have the information that's necessary to say, why don't we learn from what they're doing and provide more people effective treatment at the lower costs.

There may be some variation. There always is in circumstances and situations. One size doesn't fit all. You can't always compare people that are in more expensive environments. And I suppose there is some variation. For the first time—it is not that the voucher is good for anything you want, it would be determined on the basis of the assessment, what range of intensity and expanse of services. And then within those particular providers, we would

have over time an indication of what was the more cost-effective route, whether it is more costly or less costly.

Obviously, we would like to be as efficient as anybody, but we would begin to have the data that shows who is making the difference.

Mr. CUMMINGS. You went right where I wanted you to go, the data. Do you foresee a day, once we get the data, that we might say, the Cadillac program, we love you, you're nice and all that, but we just can't—do we—do you see a date when we say that either you are going to bring your costs down, or we are going to have to say this is one program you cannot use with the voucher? Do you foresee that kind of thing?

Mr. WALTERS. Sure. I would imagine with responsible stewardship that we would build into this partnership with States saying, if you don't do with a lot more money what you can do with less money, because there's always going to be limits here—but if the system works, we would begin to have a record of each provider so we not only can refer you to somebody, we can tell you what their effectiveness is. There really is consumer choice based on knowledge, and that's when it has meaning, and that's when you begin to say we are providing a system that maximizes the skills we have as a Nation to make people well and to help them get into recovery and stay there. It's not a shot in the dark.

Mr. CUMMINGS. Just on that note, when you said that, it reminded me of health insurance open enrollment thing where you sort of pick and choose. Do you foresee a time when maybe you may say—have some kind of document that says just based on pure data that this is what we have seen, these are the results? I don't know how deep you want to get into that. Do you follow me?

But again, following the yellow brick road, trying to get to the most effective and efficient use of dollars, it seems to me like you would almost have to, at some point in this evolution of making the program the best that it can be, get to there where you are actually listening to stuff and what's reasonable and what's not.

Mr. CURIE. I think you have actually addressed the ultimate place we want to be, and that is if you want to call it scorecards or report cards at all levels. In other words, we are going to require States to have a credentialing process, which I would view as a dynamic process, as we establish standards, and in that credentialing process also permissible rate ranges based on modality being part of that as well; and then as time goes on, as you indicated, in terms of a list of outcomes, that there can be a day which we would hope for that when consumers are making choices, and they have a choice of certain providers within a particular modality based on the assessment, they can make an informed choice based upon a scorecard of outcomes, consumer satisfaction and make an informed choice. And I think that that is part of the evolution that we see in this process.

Mr. CUMMINGS. Just one other thing I want to say on the record, Director Walters, and I forgot to say this from the very beginning. I want to say it publicly. Deputy Director Salzburg has been absolutely incredible. She has been to my district twice in the last 3 or 4 months trying to help us address some very pressing needs, and I just wanted to make sure I said that on the record.

Mr. SOUDER. I want to make sure, in the responses to Mr. Cummings' questions, that one of the big innovations in this program is this idea of going down to the small residential centers of 12 people to look at Hispanic, African American and other minority centers that have traditionally been excluded. We don't want to make something so bureaucratic and so scorecard-oriented that small providers can't get into this, because part of what's been happening is rather than necessarily a Pinto, let's say VW Bugs of the world actually may be producing as good a result or better than some of the big ones, particularly in the hard-to-reach population, but they haven't been involved in these kind of programs.

As a firm believer in capitalist principles, which I believe you're building into this program, in effect if someone doesn't provide an effective program, they're going to go broke because they won't get paid. If you withhold some of the payment, they won't be there for very long. Most of these places are struggling already, and what we don't want to do is make it so that only the people that know how to work the insurance system or the people who know how to fill out the forms or the people that know how to market with their advertising programs are eligible to do drug treatment, because so much of this is happening by the love and the individual commitment, and that's partly the innovation of your program. So don't overbureaucratize the program in developing it.

Mr. Davis had an additional question, too.

Mr. DAVIS OF ILLINOIS. Generally and oftentimes when we talk about reentry, people begin at the point of an individual's termination of sentence, and they're now ready to come back into the community. And while I recognize that while incarceration is in effect, these individuals under the jurisdiction of the various justice and correction facilities and institutions of which they are a part—but I really think you folks know more about treatment than they do—are there any serious efforts under way to convince justice and corrections people that they should look seriously to increased treatment while individuals are under their jurisdiction, are incarcerated?

Mr. WALTERS. Yes. In my written statement, in our own budget we are proposing an expansion of Federal support for drug courts. We have tried to allow more Federal resources of treatment to go into the criminal justice system in various levels. We would like to do more of this. We would like to have this program also have the flexibility based on States' determination of need of helping people who come into the criminal justice system if they need a voucher for treatment.

I know there is a view that in some places people come in once, and they get harsh sentences. The problem we face in most jurisdictions that I have visited is the people come in over and over again, and it's not until something serious enough happens that they finally get into the criminal justice system or they get into something like drug court. It's the reverse.

We're not reaching out to people when we first should assess them because of lack of capacity or resources or lack of confidence that it really is going to be cost-effective. We did not just say that we believe treatment would save lives and save money. We're trying to build a system that acts on that principle in a more aggres-

sive way, so when someone comes in or when someone is in another community setting where they show signs of needing services, there's more people to assess them, and there's a more direct link between if you discover it, you can actually help them.

Of the roughly 6 million people we talked about needing treatment, 23 percent are kids. They're in schools. They're in pediatricians' offices and general practitioners' offices. They're coming into community centers. They're coming into the criminal justice system as their problems get worse. Before they become a serious felon, or before they drop out of school, or before they fall away from home or don't see pediatricians anymore, we want to encourage people that reach out to them by giving them a clear statement of obligation—that's the cultural change that Dr. Barthwell spoke about—but also we want to provide a direct tool to use to get these people help even if it's less intensive help earlier on, because we know that creates the greater chance of recovery.

Mr. DAVIS OF ILLINOIS. I am saying specifically, though, while they're in the penitentiary, while they're in jail, are we talking to wardens and prison officials saying that you folks might want to look at increasing the amount of treatment that you provide to these individuals while they're inmates?

Mr. WALTERS. Sure. We also agree that we think to optimize this we need to pair the incarcerated treatment that we're providing to reintegration programs out in the community. I think there's no question we increase the effectiveness of those programs when we do that, and dramatically. So we want to do that as well.

But I don't want to be understood to be in any way evasive. We want more treatment in the places where people have problems are, and one of those places is prison.

Mr. SOUDER. Before yielding for Mr. Mica, I have some additional written questions I will submit.

I also want to reiterate a couple of points that you have made here, and I think they've significant, and we look very much forward to seeing how it comes down to the details. And when you put your RFPs out, the idea of having the different dollar size based on the assessment because some people are going to take more treatment is a very valuable tool. I think your tough accountability standards is a new innovation that we need to have, and actually having accountability with that, not just that they did the test, but that would be tied to whether or not the company gets its full funding. I think this should also lead to those programs that are effective being even stronger programs and more known for their effectiveness.

But your flexibility in the vouchers and reaching out to new groups with flexibility of addressing it is another important innovation, and you have expanded in a little more detail today that has been very helpful, and we will be very much looking at the specifics.

Clear, we didn't get into the faith-based fireworks today. We know we're going to be dealing with that. We look forward to working with you. We know part of the difficulty this is—many of these very effective programs are predominantly religious, and clearly dollars can't be used from the Federal Government for the religious portion of it, and this is going to be our most hotly debated part

on the Hill. And as we move through our hearings on faith-based in general and on this program, we'll look at those nuances. I have differences with some of my colleagues in how far we can go on that, but there are Constitutional limitations, and this is going to be probably the toughest part of your RFPs when you put it out, and I look forward to working with you as you develop that.

Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. And one of my concerns is that we've made some of the treatment programs sort of swinging doors, and we have people coming in and out of these programs for a short period of time and not very successful results. It appears from what we've seen there are a couple of successful programs. The faith-based have a very high rate of success that I've seen, and then longer-term treatment programs that are sort of holistic in their approach, they address a whole range of problems, but not the short 30-day, sometimes 60-day.

Is there any way we can be assured that this new program, voucher program, is directed toward these more successful programs? Is there any way to start taking money out of these—they are sort of treatment mills that have sprung up that aren't that successful. I mean, we need to put the money where they can do the most good. Can you respond?

Mr. WALTERS. Yes. One of the fundamental principles that we try to build into this is that the reimbursement system based on an assessment of the effectiveness of the services provided would be a vehicle for determining effectiveness and changing the dynamic of the marketplace so that programs are not affected—that are not effective do not continue to be funded. So the direct way to stop the revolving door, whether that is a result of taking in people, letting them drop out at high rates or taking in people, giving them adequate care, is that there will now be on a case-by-case basis under this program an evaluation of what happened to the person, and the payment to the provider will be based on being successful. It will vary depending on the severity of the individual.

Mr. MICA. Will there be some way to stop—I mean, you're going to be getting data that will be received sometime much later in the treatment process, much later. Will you have an automatic cutoff if this isn't successful, and what data are you going to encourage the States to use in establishing whether their programs receive funds under this new program?

Mr. WALTERS. We'll work with them on some of the specifics, but the general principles that we've talked about in closing in the program is that some point after services are completed, like, for example, as I said earlier, 90 days, there's a subsequent assessment of the individual. That assessment, we are saying, must include whether or not they are abstinent. It can include other factors, have they been involved with the criminal justice system, are they employed and stable, but it must include are they continuing to use substances——

Mr. MICA. Maybe I should back up, because this is 90 days into it. Most programs I have seen that are successful are longer term. When we get in trouble is when we have these 30-, 60-, 90-day wonder programs, and they're out for a little while, and they're back in for another 30- or 60-day shot at a program. And some-

times this is—I mean, I can give you many cases of just people I personally know that have had family members with an addiction problem, and we have the mills that are treating them, and we don't have the results.

That's why I go back to the original part. Is there any way to make certain that this is directed toward programs that already have records of success like faith-based, where we have—you know, some of mine have a 90 percent success rate. Or DETAP, for example. You're familiar with DETAP?

Mr. WALTERS. Uh-huh.

Mr. MICA. I mean, we visited there. I think Chairman Souder and I were up there, maybe Mr. Cummings joined us, but they took some people that had been addicted for years and had criminal records and in and out of the system and treatment programs all over the place, and they turned some of those folks around. I thought it was a miracle program, quite frankly, and that is the kind of program I'd rather spend the money on. And I'm not sure that this new program is so directed, especially when you tell me that after 90 days——

Mr. WALTERS. I don't think I was clear. I meant 90 days after the program says it's completed the services to the individual. If those services take 180 days——

Mr. MICA. Can you back up and go to, again, how do we ensure that the money gets to these successful programs? Do you have some criteria right off the bat to——

Mr. WALTERS. We would work with the States to determine who is eligible to be a provider under this program. They would indicate who they would allow as a referral, and since it is a competitive process, we can look at the strength of the criteria they use to select and for effectiveness as a part of the choice of whether or not they are a participant. In addition——

Mr. MICA. Do you have any kind of rating system in place or certification of these programs?

Mr. WALTERS. Well, there is a certification system now in place.

Mr. MICA. No. I mean, based on success.

Mr. WALTERS. It varies. I'll let Mr. Curie talk about——

Mr. MICA. Because maybe that is something we should look at. Again, I see dozens and dozens of treatment centers across the landscape and, again, the revolving door that concerns me, and I have no problem. I'll put all the money that we could possibly put into programs that are successful, but it's just the frustration of, again, putting people in these short-term mill programs that have sprung up and that aren't successful.

Ms. BARTHWELL. Might I add a little bit to that. There is very clear criteria that's been established by the American Society of Medicine. There are others. It's been employed in the State of Illinois. It's been employed in Massachusetts. So there's experience in both the research domain and the clinical domain that shows that there's a good relationship between the severity of the disease and the intensity and the length of treatment in terms of predicting an outcome.

The American Society of Addiction Medicine's domains that they measure are acute intoxication or withdrawal; the biomedical problems; the emotional behavior, complications associated with it; but

more importantly as it relates to why someone would need one of the long-term therapeutic community; relates to assessing their treatment acceptance or resistance, whether they have an insight into the nature of their disease and whether there's a potential that they're going to be compliant, whether they're highly symptomatic and have skills to keep them sober, and whether they need structure and support.

But not everyone who uses drugs who comes in for treatment needs a DETAP village in order to be successful, and what we want to drive into this program is an assessment as they enter treatment to determine who would need that so that they don't get the 30-day program.

Mr. MICA. I just don't like two tries and you're out of these quick-shot treatments.

Ms. BARTHWELL. We certainly hope they don't get matched to them if they need something more.

Mr. MICA. You just hear so many people that have had their kids in or their family members in time after time, again, and they are programs that I don't think are successful. And most of the programs are geared to this shorter-term treatment. So I'm trying to figure out how you—how we give some preference to the longer-term treatment.

I mean, OK, you've got an individual who is addicted, and they have one shot at maybe one of your one-stop, quick-wonder treatment programs, but then two and three bites at the apple. When do we sober up and say we need—this person needs some—if we're going to put Federal money into this, we need a program that is going to be successful and has some basis for success.

Mr. WALTERS. I hope—I'm not sure that we're doing what we should do here. We need to convey to you that concern is at the center of what we're doing, that the current structure—I think sometimes even in the private market, but certainly in the government market, has drifted not in all cases and not all places we want to have a slot for everybody, and we're not so much concerned about the results of that experience in enough cases as we are the fact that we can say there's something there. The worse thing we can have is not something—we still don't have something for a lot of people as we talked about, but our goal by this case-by-case monitoring and evaluation and reimbursement on the basis of effectiveness is to drive the system to produce better results for each individual, even if they're more intensive and involved, so that we have the ability to both see cost efficiencies, but also to see cost efficiencies that may involve much greater investment up front that actually works.

Mr. MICA. Well, just—and I know my time is expired, but, again, I think we ought to look at something, because, folks, we're paying for this. Everybody says long term is the expensive. Well, you go back and look at these cases you're doing of 30 and 60, the short term, but you do 4 or 5 of them, and then the interlude disruption, the social disruption, they're out committing crime, they don't have a job, they're back in the system, and we're doing long-term, in effect, because most of them have three and four shots, and they're still addicted. And you add that up, and I'll bet it's less than the cost of a longer-term successful program. So at some point I think

we've got to find some way to make this successful and what works being funded, at least from our Federal investment standpoint.

Thank you. I yield back the balance of my time, Mr. Chairman.

Mr. SOUDER. Thank you. We'll use it very wisely.

I appreciate you all being here today and fielding the many questions and taking the time with us. I'm sure there will be many followups, and this is just the start of your adventures on the Hill, but we appreciate starting with your committee and thank you for your work, all three of you.

With that, if Dr. Boyer-Patrick would come forward and remain standing.

If you'll raise your right hand. As you heard, as an oversight committee, we take our witnesses under oath.

[Witness sworn.]

Mr. SOUDER. Let the record show the witness responded in the affirmative.

Thank you for your patience. You get the opportunity to be the first one on Capitol Hill to respond to the Federal Government's initial proposal in the treatment programs. Welcome.

STATEMENT OF JUDE BOYER-PATRICK, M.D., M.P.H., HAGERSTOWN, MD

Dr. BOYER-PATRICK. Thank you, Mr. Chairman, and good afternoon, and to the members of the subcommittee——

Mr. SOUDER. Could you hold just a minute? The mic isn't on.

Try it again.

Dr. BOYER-PATRICK. We'll start again.

Good afternoon, Mr. Chairman, and members of the subcommittee, with a special hello to Ranking Member Elijah Cummings from my home State of Maryland. Thank you for inviting me to testify about the administration's new drug treatment voucher initiative.

As an addiction specialist and a child adolescent psychiatrist at Brooklane Health Services, which is a 50-year-old private nonprofit behavioral health program founded by the Mennonites in Hagerstown, MD, and the former medical director of an addiction program in Annapolis, MD, and a member of the Maryland Governor'S Drug and Alcohol Council, I have spent significant time thinking about how to expand and improve the drug and alcohol treatment system and maximize treatment options for my patients.

Investing new funding in the treatment system is critical, because the treatment gap looms large, both in my State and nationwide. In Maryland there are approximately 250,000 individuals who need drug and alcohol treatment, while nationwide that number is much larger.

The administration through President Bush and drug czar John Walters have shown great leadership by proposing an additional $600 million in the drug and alcohol treatment system at a time when there are many competing priorities of national importance.

However, while the drug treatment voucher program proposes significant additional funding, the program will require safeguards to ensure that it provides the most effective treatment in an efficient manner. These safeguards include ensuring that the voucher program supports evidence-based practice. The science of addiction medicine has greatly advanced during the last several years

through genetic studies, brain imaging and medication development. It is important that the focus on evidence-based treatment continue, and that drug and alcohol treatment expansion helps to support access to this cutting-edge care, holding faith-based programs accountable to the same standards of care, performance and licensure certification as all other licensed or certified programs so that patients receive appropriate quality care for this medical condition. States must have the power to require uniform licensing or certification of all addiction treatment programs, including those provided by faith-based groups, to avert malpractice and maximize the life-saving power of these services, protecting States, local governments and drug and alcohol treatment providers against unfunded costs of the voucher program.

Because the voucher program is a new program that will have separate administrative systems attached to it at the State, local government and treatment provider level, it is important that States, local governments and providers are able to use voucher grant or other Federal funding to pay for these costs. For example, it will be difficult for States, local governments and providers to pay for the tracking costs associated with the performance outcome component of the voucher proposal without voucher funding or other Federal technical assistance funding. Ensuring that providers receive payment for the treatment they provide, as referenced above, the voucher program proposes to track the outcomes of treatment to evaluate treatment programs.

While evaluation and performance studies have long been part of the treatment system, and many providers, especially the ones in Maryland, are comfortable with this fact, I am greatly concerned about the voucher program's proposal to base payment for each patient's treatment on resulting outcomes. First, the time it takes to gather outcome data would create a significant delay in the time it would take to pay providers, and this day would harm most programs financially. Second, no other medical treatment bases payment for past services on outcomes. For example, physicians treating hypertension or diabetic patients also receive payment regardless of whether those patients take their medications, eat a proper diet, exercise, or modify their other health behavioral problems.

Performance-based payment for previously provided treatment is inappropriate. Using performance measures to evaluate past performance as a way to manage future investments in the drug and alcohol treatment systems and its providers would be a better goal. Provide patients with real choices. The voucher program should require faith-based providers to clearly state that patients have the right to choose another provider, including secular medical model treatment providers before treatment should begin.

Prohibition of diversion of substance abuse prevention and treatment block grant funds to the voucher programs and to ensure that the new funding expands drug and alcohol treatment in as many States as possible.

Finally, I urge Congress to require that the administration, while developing the program, and States, while implementing the program, set up advisory councils to guide them through these efforts.

In Maryland I have participated in the Maryland Drug and Alcohol Council and the Maryland Drug Treatment Task Force, where

both have reshaped and guided Maryland's drug and alcohol treatment system by gathering expert advice as well as public input. Our system of care in Maryland has greatly improved as a result of this process.

Expanding alcohol and drug treatment and prevention is critical. So many lives depend on these services. I hope that Congress and the administration will consider seriously the recommendations I have discussed today.

Thank you for hearing my testimony, and I would request that my written remarks be added to the data. Thank you so much, and I'll be happy to answer any questions.

[The prepared statement of Dr. Boyer-Patrick follows:]

Jude Boyer-Patrick, M.D., M.P.H.

ADDICTION, CHILD/
ADOLESCENT PSYCHIATRIST

AT BROOKLANE HEALTH SERVICES

IN HAGERSTOWN, MARYLAND

TESTIMONY BEFORE THE

HOUSE COMMITTEE ON GOVERNMENT REFORM,

SUBCOMMITTEE ON

CRIMINAL JUSTICE, DRUG POLICY AND
HUMAN RESOURCES

ABOUT THE BUSH ADMINISTRATION'S

DRUG TREATMENT VOUCHER PROGRAM

FEBRUARY 27, 2003

Testimony of Jude Boyer-Patrick, M.D., M.P.H.
Brooklane Health Services
Hagerstown, Maryland
February 27, 2003

Good afternoon, Mr. Chairman and members of the Subcommittee, with a special hello to Ranking Member Elijah Cummings from my home state of Maryland.

Thank you for inviting me to testify about the Administration's new drug treatment voucher initiative. As an addiction specialist and child/adolescent psychiatrist at Brooklane Health Services, a fifty-year old private, non-profit Mennonite behavioral health program in Hagerstown, Maryland; the former Medical Director of an addiction treatment program in Annapolis, Maryland; and a member of the Maryland Governor's Drug and Alcohol Council, I have spent a significant time thinking about how to expand and improve the drug and alcohol treatment system and maximize treatment options for my patients. Investing new funding in the treatment system is critical, because the treatment gap looms large, both in my state and nationwide. In Maryland, there are approximately 250,000 individuals who need drug and alcohol treatment, while nationwide between 13 and 16 million individuals need treatment – an 80% treatment gap.

The Administration, through President Bush and Drug Czar John Walters, have shown great leadership by proposing to invest an additional $200 million in the drug and alcohol treatment system at a time when there are many competing priorities of national importance. However, while the drug treatment voucher program proposes significant additional funding, the program will require safeguards to ensure that it provides the most effective treatment in an efficient manner. These safeguards include:

- **Ensuring that the voucher program supports evidence-based practice.** The science of addiction treatment has advanced greatly during the last several years, with genetic studies, brain imaging and medication development. It is important that the focus on evidence-based treatment continue and that drug and alcohol treatment expansion efforts help to support access to this cutting-edge care because it will save lives and improve the effectiveness of the services provided. This includes requiring providers to use assessment and placement criteria developed by national experts such as the American Society of Addiction Medicine. In some instances, States have mandated that providers use such criteria. This type of progress and evidence-based practice should be supported and implemented by the voucher program.

- **Holding faith-based programs accountable to the same standards of care, performance and licensure or certification as all other licensed or certified programs so that patients receive appropriate, quality care for this medical condition.** States must have the power to require uniform licensing or certification of all addiction treatment programs, including those provided by faith-based groups, to avert malpractice and maximize the life-saving power of these services. Currently, many faith-based programs operate effectively while being held accountable to such standards.

Testimony of Jude Boyer-Patrick, M.D., M.P.H.
Brooklane Health Services
Hagerstown, Maryland
February 27, 2003

- **Protecting States, local governments, and drug and alcohol treatment providers against unfunded costs of the voucher program.** Because the voucher program is a new program that will have some separate administrative systems attached to it at the State, local government and treatment provider level, it is important that states, local governments, and providers are able to use voucher grant or other federal funding to pay for these costs. For example, it will be difficult for States, local governments, and providers to pay for the tracking costs associated with the performance outcome component of the voucher proposal without voucher funding or other federal technical assistance funding. Tracking outcomes measures is very expensive – we have worked on this issue extensively in Maryland – and providing support to all levels of government and providers when undertaking such an important task is crucial for its success.

- **Ensuring that providers receive payment for the treatment they provide.** As referenced above, the voucher program proposes to track the outcomes of treatment to evaluate treatment programs. While evaluation and performance studies have long been a part of the treatment system and many providers, especially the ones in Maryland, are comfortable with this fact, I am greatly concerned about the voucher program's proposal to base payment for each patient's treatment on resulting outcomes.

  First, the time it takes to gather outcome data would create a significant delay in the time it would take to pay providers and this delay would harm most programs financially. Secondly, no other medical treatment bases payment for past service on outcomes. For example, providers treating terminally ill cancer patients receive payment, despite the fact that their patients will die. Physicians treating hypertensive or diabetic patients also receive payment regardless of whether those patients take their medication, eat a proper diet, exercise, and modify their other health-related behaviors. Performance-based payment for previously provided treatment is inappropriate. Using performance measures to evaluate past performance as a way to manage future investments in the drug and alcohol treatment system and its providers would be a better goal.

- **Providing patients with real choices.** The voucher program should require faith-based providers to clearly state that patients have the right to choose another provider, including secular, medical model treatment providers, before treatment begins. It is important to ensure this right to appropriate care for some of the most vulnerable members of society.

- **Prohibit diversion of Substance Abuse Prevention and Treatment Block Grant Funds to the voucher program.** The Block Grant is the bedrock of federal funding for the drug and alcohol treatment system. Many communities rely on Block Grant funded services to provide urgently needed drug and alcohol treatment, especially residential

care. Before approving the diversion of Block Grant funds, government should consider how that change would affect the treatment system that is already in place.

Allowing States to transfer Block Grant funding into a voucher program may harm many excellent drug and alcohol treatment providers. The voucher system is based on the idea that providers will receive referrals. If a drug treatment provider will not be able to predict a certain number of voucher referrals, it is potentially difficult for that provider to treat enough patients to cover her fixed costs. And without predictable funding, such as annual grants from the Block Grant, providers will be unable to pay for critical, fixed costs such as rent and staff. As a result, the diversion of Block Grant funds could reduce access to drug and alcohol treatment services as opposed to expand access to such services.

- **Ensuring that the new funding expands drug and alcohol treatment in as many states as possible.** Presently, the proposed voucher program is a competitive grant program that would not provide new funds to all 50 states. Given the budget crisis the states are facing and the funding cuts for these services in many states, it is imperative that new drug and alcohol treatment funding be shared with as many states as possible, preferably all 50 states.

Finally, I urge Congress to require that the Administration, while developing the program, and States, while implementing the program, set up advisory councils to guide them in these efforts. In Maryland, I have participated in the Maryland Drug and Alcohol Council and the Maryland Drug Treatment Task Force, which both have reshaped and guided Maryland's drug and alcohol treatment system by gathering expert advice as well as public input. Our system of care in Maryland has improved greatly as a result of this process, and such a process is a model for the nation that should be applied when developing new policies and programs.

Expanding alcohol and drug treatment and prevention is critical – so many lives depend on these services. I hope that Congress and the Administration will consider seriously the recommendations I have discussed today.

Thank you for hearing my testimony. I would be glad to answer any questions.

Mr. SOUDER. I thank you for your testimony, and you've raised a number of difficult questions we're going to sort through, but let me start with your example on the terminally ill cancer patients is absurd.

Dr. BOYER-PATRICK. No. I didn't say terminally ill cancer. I said hypertension and diabetic-type patients.

Mr. SOUDER. It says providers treating terminally ill cancer patients receive payment despite the fact that their patients will die. And the fact is, is that the fundamental question here is what is the point of drug treatment? In other words, if it is a curable—something that is curable, some of us would like to see that in other parts of health care as well, because we're very frustrated at the accountability in the bureaucracy. That's not to say individual programs haven't been effective, and we've all met people through them, but the fundamental fact that the industry has to look at is every single one of us on the street have met people who have been through seven, eight, nine programs, that the programs have reported—those same programs where I've talked to individuals have reported to us that based on science, that person is cured, and then they relapse.

Some of the nonscience-based programs where I've met people who have been off cocaine for 20 years after Johns Hopkins Hospital in particular told me they could not do it, and they went off overnight, and they're still clean 20 years later. There is a problem, in my opinion, you need a balance between our science fact-based things and things that have been erected around the process that protects the existing providers who don't want to be held accountable. And I think that you've raised some fundamental questions. We can't turn that into a big scam. We don't want to undermine the existing structure, many of which already works, and at the same time we have to have some kind of what I would say helpful input from the existing provider community rather than an overreaction in saying, look, we don't want to be subjected to accountability.

You're going to be subjected to accountability. The question is what is a fair way to do it? Some of it is process, and some of it is results, because like you pointed out, some people don't follow what you tell them to do. How can you lose all your funding if they don't follow what—on the other hand, there's got to be some measurement in a curable disease as opposed to an incurable disease, and it should be in other parts of health care as well. And I'd appreciate your response.

Dr. BOYER-PATRICK. I think that's a very complicated—thank you for sharing your thoughts, Mr. Chairman, and I guess working in the field for over 20 years, this is what I've noticed. And if I may use Mr. Cummings' reference to Cadillac versus Pinto. I think the big part of it is reaching a person when they're ready. As a provider, what I have noted—and I have to reference back to what you were talking about. This program is for people who do not have insurance, because those people with insurance usually get treatment, and that is not necessarily the case as we found in the State of Maryland. There are barriers to entry.

My concern is when a person is ready for treatment. There are many reasons why people seek treatment. A lot of times people

seek treatment because they're going to get kicked out of school, kicked out of home, their parents are tired of them, the boss is going to fire them, the wife is going to kick them out of the house. So there is a window of opportunity sometimes where a person wants to get that treatment and the treatment is not available because of lack of money for a majority of the people in the city of Baltimore or a lack of bed space. And the treatment facility that I worked at for 5 years, we had beds, and people had insurance, but they were not allowed to come in because of barriers to entry. And so we tried to make that more uniform.

So there is no way to know, Mr. Chairman, when a person walks in the door, be it the Cadillac or the Pinto, whether this is the one that is going to make it, but we don't change our strategy because this one looks like this one is the one that is going to make it because when they walk out of the door, they have a good family background, a network in place, they've been sent to a group home, they've been sent to a long-term residential.

There are a number of reasons that have to come into the pie as to why a person will make it and a person won't. We don't have a crystal ball to determine that, but I will let you know that there are many wonderful treatment programs out there that have licensed excellent staffs and do good work, and yet it's still 50/50. It's like guessing which is going to be—if it's going to be a boy or a girl without using an ultrasound. We don't know when the person walks in the door, and I just feel that to judge a program based on whether the 10 people come in and 2 make it versus 9 does not mean that that therapist is not a good therapist.

I guess that's sort of where I'm going with this.

Mr. SOUDER. But that's the way the world works. I had a retail furniture store, and each person could give me an excuse why they didn't sell as much that week, but ultimately part of the accountability is results. And, yes, the customers walk in with different qualifications. Some have more money. Some of them are more interested that day in buying. There's an accountability process, and with a number of programs that I've visited, quite frankly, they have a 90 percent success rate, and they have harder cases, in urban San Antonio, in urban Chicago and other places like that, than many of the programs who say that they only get 50 percent success rate. And that is partly what we're trying to address here is some of these programs that are grassroots-based, who live in the neighborhoods, who daily respond and who hardly get payment, and some of them—I've met some programs in Boston and in other places where they don't even have health insurance for their staff, but because they're invested in their community, they don't meet all of the great criteria, but they're getting people cured. And that's part of what we're trying to figure out how to address.

I don't mean to denigrate the advances of science or the passion and the commitment of the people in the existing system, but there's a mismatch here.

Dr. BOYER-PATRICK. Well, I would agree with you, Mr. Chairman, and if we could find out a way to make that match work, but at the same time you want outcomes, and you have to track outcomes, and you want everyone to be on the same playing field. I'm not saying that a program that is in the inner city or that is faith-based

would be better suited to do the work that you want to do at a lower cost than the Cadillac program, who probably has a good program as well, but has lesser outcomes for whatever the variable is. My issue is that if you're going to require tracking outcomes, it should be on the same playing field. You can't hold someone to a higher or lesser level or standard.

And so I'm not saying that the voucher program isn't a good program. I think it's a good way to meet the need for many people who do not have access to funds, but once they have that voucher, who is going to make that decision? Where are they going to go? To the Pinto, because it's better and cheaper? To the Cadillac, because there's a bed available? To long term because since my work is with children and adolescents, I know that with adolescents, because of their developmental level, they have no abstract thought, and they think that it's now or never, and it's not going to happen to me? Treatment for adolescents takes way longer than treatment for an adult who may have more hammers over their head, and they need to do it more. So we have less adolescent treatment. We don't have the time.

Now, the reason why people are in and out and in and out, because that's managed care. I can guarantee you that there are many times we'd like to keep them longer, but we cannot keep our doors open if we can't get paid, and the system that is in place right now will not allow us to do it. So we do the best we can with the time we have. It's not a perfect system. But I think there are a lot of other parameters that have to be looked at before this is all said and done.

Mr. SOUDER. And I think you've raised a very important question. There can be a double standard in accountability, and we have to work that through to be fair to all. Thank you.

Mr. Cummings.

Mr. CUMMINGS. The discussion that you all just had is an issue that has been raised in this committee before and is an extremely complicated issue. One thing that you will find that I think we all share, Democrats and Republicans, is that we want our tax dollars to be spent effectively and efficiently, and I'm sure you share that.

As I'm sitting here listening to your discussion with the chairman, I was thinking about how shaky drug addicts can be. I've often said that when I talk to—I've had relatives who were drug addicts, when I talk to them, I always would say to myself, I'm talking to a ghost of the person I knew. It's not the person I knew, because the person I knew wouldn't lie to me. The person I knew wouldn't cheat on me. The person I knew wouldn't take my lawn mower, say he's borrowing it, and then sell it to the nearest pawnshop.

And I would guess that when we're trying to measure treatment—and I guess this is a point you were trying to make—I guess there are a lot of reasons why people may not be successful. If a person is that shaky, then—and somebody said it—I think it was Dr. Barthwell who said it a little earlier. If a person is that shaky, almost anything can throw them out of treatment. In other words, they could have been faking it from the very beginning. They could have been. If a mother says, I'm going to throw you out of the house if you don't get treatment, the kid goes in, gets treatment,

something different happens in the household, the child feels that they can get out of the situation, then they may drop out of treatment. I don't know.

But I guess what I'm trying to get to is how do we make sure—going to what the chairman said, how do we make sure as best we can that we're not being treated—that people are not gaming the system, I've been a very strong proponent of making sure the treatment—that we don't have shams, but on the other hand, we have all of this shakiness with regard to the patient, with regard to the circumstances that a doctor cannot control or a provider cannot control, where's the middle ground there?

I read your statement. In the same paragraph it says, using—the last sentence, it says, using performance measures to evaluate past performance as a way to manage future investments in the drug and alcohol treatment system and its providers would be a better goal, but, I mean, what does that mean?

Dr. BOYER-PATRICK. Well, I'm trying to think of the best way to put it. I guess as a provider it's been difficult for me to address how do you know when it's for real. And it has been of great concern to me that the drug and alcohol problem is the only problem medically, and I think it's a medical problem, that is more held to you have one or two chances to get this right, or it's done. That's it. Two strikes, you're out; three strikes you're out. I've met people at Betty Ford who said it took nine times. When I said hypertension or diabetes, I look at substance abuse as a chronic illness, and sometimes you have your periods of crisis, and then you have a flare-up.

I also look at it as tools. You come to me for hypertension, I give you the medication. I have no control over whether you're going to do what you need to do. We have an obesity problem in our children and adolescents in this country, and we talk to parents, don't do this, don't do that. They do it anyway, because we're dealing with human beings.

But there seems to be so much more at stake, because there's a limited amount of money available, so what we say to a drug addict is, you've got this amount of time to get it right, and if you don't, then it's over.

Are you going to have people who beat the system? You bet you. That's where all the research has been going into over the years over recontemplation and contemplation and readiness for treatment. If we can get the person at the right time in the right program, then we can probably have 100 percent success, but we're dealing with human beings here with a very, very difficult disease to treat, and the only reason why we keep at it is because we win sometimes.

But there's no guarantee that we're going to win all the time, and I guess my concern is not that we try to help or give the opportunity to people who have never had it or to make beds available or payment available for someone on the first go-round, but when do we end? It seems to be not until they decide it's over or they drop dead or—I mean, we've lost kids. I've lost kids who have overdosed on heroin a week or two after they have left my treatment center, in a bathtub at a friend's house, but I also have kids who are still clean and sober today, and the ones we thought would

make it don't; and the ones we say don't have a chance do. There's no magic ball to it.

But I understand that there's a finite amount of money, and that's the dilemma, and all I'm saying is that there are good, well-meaning treatment providers who give good services, but when I talk about substance abuse, Mr. Chairman, what I say is if you're ready, it doesn't matter what treatment service you go to, and if you're not ready, it doesn't matter what treatment service you go to. That's it in a nutshell.

Mr. CUMMINGS. We're going to talk about faith-based at another time, and this is not necessarily a faith-based question, but I think about—when I think about faith-based, you said something about trying—when setting the standards, making sure that there's certain components of the treatment, I guess, and a lot of—let me just finish this.

My church has a drug treatment component, and we have some volunteers who do this in life. This is what they do. My church has 10,000 members, so we have some folks who can volunteer, come in and help out, but I think the main component of it is this self-help discussion. I don't know what you call that part of it, discussion piece. And then they also have the higher power element there.

Dr. BOYER-PATRICK. Twelve steps.

Mr. CUMMINGS. Right. And I take it that there is a clinical type of the treatment piece, and then there are other pieces that come to play with regard to that supportive—supporting each other, discussing the problem, situation.

Dr. BOYER-PATRICK. Mr. Cummings, there would be no way that a person in a community could even make it without those type of organizations.

Mr. CUMMINGS. Oh, I agree.

Dr. BOYER-PATRICK. Because, as a matter of fact, we highly recommend that if you go through a clinically based medical model-type treatment, that the people who have the greatest success are the ones who link up with those faith-based organizations. The very first Al-Anon meeting I attended 20 years ago was in a Presbyterian church in California.

Mr. CUMMINGS. And the issue for us is not faith-based. A lot of us believe in faith-based. We're just trying to make sure—our issue is more of whether the faith-based organization will discriminate, not that the faith-based program is not important and plays a significant role.

But this is what I want to get to. Do you see as you've read the material that you've read in regard to this effort, this recovery effort here that the drug czar was speaking about—what do you see the role of faith-based organizations being with regard to that voucher system? Are you following me?

Dr. BOYER-PATRICK. You know, I am, and I guess my concern was that this is a term that everyone is throwing out there, faith-based. I'm not always certain what that means. What I feel is if a person needs help—and not every person needs help on the same level. Some person might be using marijuana chronically, and we know that with some of the drugs, you don't need detox. But if a person walks in and needs detox and they get a voucher, if there

is a good program for detoxification that is run by a secular or a faith-based, wherever there is a bed, that's where they need to go. A person might just need long-term partial, residential. It may be run by a secular organization or faith-based organization. Wherever there is availability, if the staff is credentialed, licensed, and there is a way of tracking outcomes, and they have a good program, to be quite frank with you, it doesn't matter to me if it's faith-based or secular as long as the person needing the help gets the help they need.

Mr. CUMMINGS. The first part of what you just said is the piece I'm trying to get to. If it—and I'm trying to figure out, see, when I look at my church effort, I feel that that's more of a social——

Dr. BOYER-PATRICK. That is a support system.

Mr. CUMMINGS. Right. Right. On the other hand—but they do have some volunteer professional-type people.

Dr. BOYER-PATRICK. But if a person in Baltimore needs heroin detox, they're not going to go to your church first, because that's not where they're going to get the Buprenex. That's the point. So they still have to go someplace where they can get the detoxification services, and then you need the adjunctive services.

So the question is what is the voucher going to cover, the adjunctive services or the acute services? And it depends on if it's alcohol, cocaine. Certainly with crack cocaine, you may not need detox, or marijuana you're not going to need detox, but if someone who is coming off of alcohol withdrawal goes to a faith-based organization that does not have the credentials to do detox, that person will die. That's the issue.

Mr. CUMMINGS. The voucher system, as I understand it, there's sort of an entry—there's an entry point where somebody does an evaluation, and in that evaluation process I assume that some type of treatment plan is put together. That's what would normally be done for almost anybody; is that right?

Dr. BOYER-PATRICK. That is correct, but so often, as we know in the city of Baltimore, which is where there is a great problem, with the majority of people being uninsured and they need services, they end up in the emergency room, and they go to places like the psychiatric floor to get what they need. Then they come out, and they don't get put into the adjunctive type of services that is going to assure success of recovery. You're just putting a Band-Aid on what the problem is.

And so what is the voucher program going to do, just offer detox or offer a full continuum of care? And how much money are you going to spend for each time, and who's going to determine that?

Mr. CUMMINGS. Thank you.

Mr. SOUDER. I think that you've raised a number of things, but it's really important to understand that there is an irony to the debate that we're going through, and I want to share a couple thoughts as we wind up this hearing, because we're going to be evolving this over the next year as we debate these different programs.

Two friends of mine, Bob Whitson and Glen Lowery, got in an argument 15 years ago when I was a staffer on an elevator away from the general public, of which is probably the argument we're having here right now. Bob told Glen that he had become too estab-

lishment and was using data and science to masquerade a lot of the problems that were really human and psychological, and that Glen's approach was white establishment and he was buying into the way things did it, which excluded a lot of the grassroots programs which were actually most effective in the inner cities. Glen told Bob that he was too enamored of grassroots people who didn't necessarily want to have the same accountabilities as everybody else, and that while there was a truth to that, there needed to be some measurements.

The irony here is that with President Bush's program and people like myself advocating this, most of these programs aren't going to be in our Republican districts. Most of the people who are seeking these grants that we're defending right now are grassroots organizations who predominantly are Democrats, who are predominantly in Democratic districts.

I have looked at this for a long time, and I believe passionately that somewhere in here we've got to figure out this balance between people who come in and say, I can reach out and touch people and change their lives, but I don't know all of the science rigmarole, I don't have a college degree, but what I am is passionately involved with my neighbors, and I can get them off and move them, because you say a nonscientific thing, and that is when people want to get off, that's not scientific, and therefore some groups may be more effective than establishment centers at moving people to that first step.

Furthermore, while there may be some health points, I grant, where the detox or the addiction has gotten so great that there's a physical endangerment, the truth is much of this is psychological, and that, in fact, I have talked to multiple heroin dealers and—addicts and coke addicts who went straight off and didn't get through detox and have been off for 20 years. Now, the problem is that what makes some individuals able to do that and others not, and how do we have some kind of accountability standard that says, OK, you're able to do it here, but this person, when they try it, dies? And it's almost like what we've done is we have a risk-averse system that doesn't take some of the gambles with it, but we don't have some of the dramatic failures. But I feel, and many others, that we've missed these little grassroots organizations.

I don't know whether the ranking member wants to go in with me, but I have threatened that—this is Bob Whitson's idea. I've threatened to put this in when I worked for Dan Coats. We stuck it in a couple of model bills, and that is a ZIP code test, because, you know, one of the most effective things is that if one-third of these dollars went to people who actually lived in the ZIP code of the people they are serving, maybe two-thirds, because part of this is that we get out of the neighborhoods where people are. When we look at these dramatic urban center programs, it's because the people are there. The problems just don't occur 9 to 5. They occur at night. The followup programs are there. They see the people in their neighborhoods.

And the question is how do we get dollars into some of these programs that are in these areas that are people-based, that are active there, and much of which in the minority communities are oriented around the churches? How do we do that, and how do we meet the

scientific advances? How do we be fair to those programs that have been working before that reach large populations, and they have other assets and strong families, and at the same time reach our high-risk populations that need a different approach, because quite frankly, it's not working overall in the urban centers, and we have some zones that are in danger of being left behind in America while the rest of America deals with it.

And I don't believe there's some kind of malicious goal here to this treatment program or faith-based, that the goal here is to give it to Jerry Falwell and Pat Robertson. The goal here is to try to figure out how to advance the field. And it's not a political gimmick, because if it was, we'd be trying to give it to the suburbs, quite frankly, as Republicans, or rural areas. This is a different type of phenomenon, but it's going to be very difficult to work through, and I very much appreciate your passion and your years of dedication to it, and you've been a very articulate spokesman today, and I'm sure we'll hear from you in the future.

Anything else you want to say in conclusion?

Dr. BOYER-PATRICK. In conclusion, what I wanted to say was you are absolutely right about the grassroots, and many of the grassroots are nonfaith-based, and many of them are. And I think it would be a mistake to just make the faith-based issue a big political issue. I think that there are many programs in the churches that do outstanding work, without which we could not be where we are today.

So my only concern is that it was the drug czar who brought up the issue of measurement and outcomes, and a lot of these little faith-based programs that do good work don't have the money to do the measurement and outcomes, so how do you even know how good they are? And I'm saying if that's where you're going to go to determine who gets the money, make sure everyone is on the same playing field, because somebody might be doing good work, you just don't know about it. But I appreciate the opportunity to come here.

Mr. CUMMINGS. I just have one question, and I think the chairman raised a real excellent issue about how do you find in your field that faith-based organizations are often a major part of getting a person to that point, like he said, where they even want to do something about their problem? Do you find that to be the case?

Dr. BOYER-PATRICK. Yes. I find that to be the case, and not only that, but some of the faith-based organizations, some of them, because of the fact that they're not in the Federal loop or State loop, have private funders, and so there they might be able to offer more longer-term or different types of treatment that are not held to the same sort of standards. I think that the only concern is that you don't want a lot of people coming up just to try to get the money because they are faith-based, and I think that is what the big fear is, because we've had this problem before.

But, yes, there are many good, effective programs out there that are faith-based, and many times the minister is the first person that the wife will call and say, you know, we have a problem at home. And that's where the entree is. But the issue is once you have that entree, to make sure that person gets to the right place for treatment, and when they come out, they have that network of

services available to keep them clean and sober. There's no magic to it. It's hard work.

Mr. CUMMINGS. We really do appreciate you being here. Thank you.

Dr. BOYER-PATRICK. Thank you, Mr. Cummings.

Mr. SOUDER. Thank you very much to all our witnesses today and to the Members who participated, and with that, our hearing is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

[The prepared statements of Hon. Doug Ose and Hon. C.A. Dutch Ruppersberger, and additional information submitted for the hearing record follows:]

Honorable Doug Ose (CA)
Opening Statement
"Recovery Now: The President's Drug Treatment Initiative
Subcommittee on
Criminal Justice, Drug Policy and Human Resources
February 27, 2003

Mr. Chairman,

Thank you for holding this hearing and for your unwavering commitment to helping Americans fighting against the tide of drug use and abuse.

I would especially like to welcome two leaders in the Bush Administration in this fight, Drug Czar Walters and SAMHSA Administrator Curie. We appreciate your efforts and hard work on behalf of our constituents.

The President has taken an important step in the fight against substance abuse with his program.

I have seen first hand what substance abuse can do to individuals and even communities. In my hometown of Sacramento, we have seen problems from the growing popularity of methamphetamines, or meth.

People using meth in my community are responsible for a number of tragic incidents. Some of you may recall that a big-rig truck drove into our state capitol building causing serious damage a couple of years ago. The driver was on meth.

At a hearing of this subcommittee in my district in 2000, a local law enforcement official who works with children surrounded by meth use and production listed just a few of the many cases she sees on a regular basis.

She noted that press reports had given instances of a 15 month old child overdosing on meth in Rancho Cordova, a small town in my district, a 13 month old child who was raped, sodomized and killed by a meth addict, a 2 month old dying in San Jose with meth in the system passed on from the mother, a 2 year old found eating meth out of a baby food jar.

These are just a few of the heart-wrenching cases that she cited. It is evidence that meth abuse, and drug abuse in general, hurts even the most vulnerable members of our society – our children. Sadly, I hear more of these stories almost every day.

We have a responsibility to help those who want to escape the downward spiral of drug abuse.

I would like to highlight that the CLEAN-UP Meth Act, H.R. 834, includes $30 million for education and treatment of drug users and those harmed by their additiction. As the author of this bill, I would like to thank Chairman Souder and Ranking Member Cummings for joining me as original cosponsors of this bill in the 108th Congress.

I recognize that meth is just one of the many drugs that SAMHSA and the Office of National Drug Control Policy, as well as this subcommittee, needs to respond to. But I also know that the growth of meth, and related club drugs such as ecstasy, is one of the emerging threats that we need to attack early – before it becomes a true epidemic.

Again, I would like to thank you Chairman Souder for calling this hearing and I look forward to hearing the testimony of our distinguished witnesses.

Congressman C.A. Dutch Ruppersberger
Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources
Hearing on Bush Administration's "Recovery Now" Drug Treatment Initiatives
02.27.03

Thank you Mr. Chairman for holding this hearing the Bush Administration's "Recovery Now" drug treatment initiative.

I want to thank the Administration for testifying before the subcommittee and I want to send out a special thanks to Dr. Jude Boyer-Patrick from Maryland for being here to discuss this new initiative.

Drug abuse is one of the greatest problems facing our country. Drug abuse affects our families. It affects the workplace, and it ultimately destroys lives. The numbers on people who sought and actually received treatment is staggering. I believe the National Household Survey on Drug Abuse estimates that 6.1 million Americans need treatment, and of that only 17% actually sought out and received treatment. Worse yet are the numbers on people who do not recognize that they have a drug dependency problem or a staggering 66% of people in the survey.

We must find a way to get people to treatment facilities that work for them.

Today we are here to discuss the Bush Administration's new initiative on drug treatment, "Recovery Now." This new initiative is a competitive grant program where people seek out vouchers to gain access to treatment. The goal of this new initiative is to increase access to effective treatment.

I applaud the Administration's efforts and their willingness to address such a pressing national issue. However, we have to remember that our ultimately goal is getting more people to effective treatment and overcoming the "treatment gap." We should not and cannot limit access to treatment either through establishing preferred providers or forcing treatment facilities to shut down because of arbitrary performance standards.

I look forward to hearing the testimony and look forward to asking questions of the Administration.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, DC 20503

FOR IMMEDIATE RELEASE:
February 5, 2003

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SUBSTANCE ABUSE PREVENTION, TREATMENT EXPERTS APPLAUD PRESIDENT BUSH'S PLAN TO EXPAND TREATMENT ACCESS

(Washington, D.C.) - Treatment providers, researchers, and advocates nationwide are voicing support for President Bush's new treatment initiative. The initiative, part of the President's 2004 budget proposal submitted to Congress this week, seeks to provide effective services to people in need of treatment for drug or alcohol abuse through a voucher program. States will have flexibility to design the type of voucher that is appropriate for their systems, but the vouchers will allow treatment providers to seek reimbursement for their services and will have no face value to the client. The vouchers will be redeemed for care ranging in levels from brief interventions or counseling sessions, to intensive in-patient residential treatment by providers—including faith-based—designated by the individual states.

John P. Walters, Director of National Drug Control Policy, said the program will "bring new levels of access, choice, and accountability to a national treatment system that is currently challenged with meeting the needs of 5.7 million drug-dependent Americans."

The initiative's potential to facilitate recovery for 300,000 drug- and alcohol-dependent individuals is being heralded by prevention and treatment leaders from across the nation. In congratulating President Bush on the announcement of the new initiative, Joseph Califano, Chairman and President of the National Center on Addiction and Substance Abuse at Columbia University, said, "It is important to provide these funds to help close the gap between those who need treatment and the available treatment for them." Karen Freeman-Wilson, Executive Director of the National Association of Drug Court Professionals said, "The President's new voucher plan will allow those in and out of Drug Court to access treatment, and for that we commend him and his entire administration."

Acknowledging the plan's "no wrong door to treatment" approach, Ann Uhler, President of the Alcohol and Drug Problems Association of North America, said, "We support spiritual development as an essential component of treatment and recognize that social service branches of many faith-based groups have long met science-based standards." Dr. Lawrence Brown, President of the American Society of Addiction Medicine (ASAM), added that "ASAM appreciates the initiative and recognizes the importance of spirituality in recovery." Dr. Brown continued that the President's "leadership on this issue will have an enormous impact on people's attitudes toward addiction, as well as increasing access to treatment."

State and local advocates, as well as methadone treatment providers are highlighting the initiative's ability to direct resources where they are needed most. Judy Cushing, President of Oregon Partnership, said, "We know that treatment works. What we need is more of it, for

-MORE-

more people, through effective treatment providers. This initiative can help to meet the treatment gap in this country and here in Oregon." Mark Parrino, President of the American Association for the Treatment of Opioid Dependence, said, "President Bush's proposed three-year, $600 million plan to expand access to vitally-needed treatment services is critical. We are strongly encouraged that the initiative will provide greater access to opioid treatment. It builds on the principle of supporting evidence-based practices so that drug dependent individuals will gain access to care, leading to their recovery."

Summarizing the initiative's benefits for all Americans, Linda Hay Crawford, Executive Director of Therapeutic Communities of America said, "We are encouraged by the President's budget initiative to help addicted Americans find qualified treatment. By increasing access to evidence-based approached to alcohol and drug abuse treatment, we all stand to benefit by a decrease in emergency room visits, violence, job accidents, auto fatalities, workplace absenteeism, Medicaid and Medicare costs."

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More information about the President's new treatment initiative is available at:
www.whitehousedrugpolicy.gov and www.whitehouse.gov

adpa
alcohol & drug problems association of north america
370 N. Main, St. Charles, MO 63301 Tel 636.940.2283 Fax 636.940.2358

Alcohol and Drug Problems Association of North America (ADPA)
FOR IMMEDIATE RELEASE
February 5, 2003
Contact Ann S. Uhler, President, (636) 940-2283

In his State of the Union address, the President's underscoring of the miracle of recovery gives tribute to those who are in recovery as well as hope for those who still suffer from the devastating effects of this addictive disorder. For women who often feel terrible shame associated with the disease, the President's highlights were powerful testaments to the opportunity for recovery. ADPA and the treatment services field are grateful for the President's attention to this disease that can be deadly when left untreated, and that can be treated cost-effectively.

ADPA believes that it takes the commitment and a coalition of community resources to provide the comprehensive array of services needed to support a woman's recovery. ADPA also supports the National Treatment Plan's "no wrong door" approach to treatment. The core of this community service network for women — women's treatment providers — constitutes only a small proportion of treatment resources in most States and is significantly threatened by reductions in funds and other resources. Women and their children sometimes cannot access treatment at all due to lack of funding, transportation, or childcare. In those communities where treatment is available, women and their children often face barriers of access to treatment that is specific to their individual needs and inclusive of full wraparound services. The proposed voucher system offers a powerful opportunity to link a community's services with addicted women, to empower women and their children to seek recovery, and to bring recovery by integrating the consumer into the community setting.

Treatment for any individual, and especially women, should be holistic and so requires complex skills. Accordingly, ADPA supports use of the vouchers for treatment by programs that are certified and licensed by appropriate state agencies and that can meet requirements for accountability, quality assurance, and improved client outcomes. We also support spiritual development as an essential component of treatment and recognize that social-service branches of many faith-based groups have long met these same, science-based standards.

ADPA was established in 1949 and is the oldest professional trade organization in the field. Our purpose is to advocate for alcohol and other drug abuse prevention, intervention, and treatment services, particularly among special populations, such as women with dependent children, pregnant women, adolescents, and racial and ethnic minorities. ADPA has a tradition of advancing science to service, and for more than 14 years, has convened an annual Women's Issues Conference to disseminate research and knowledge-application strategies while providing skill-building and networking opportunities to women's service providers. Spirituality development has been a strong component in all the conferences.

For more information, please contact Ms. Ann S. Uhler at (636) 940-2283.

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- FOR IMMEDIATE RELEASE -

DRUG COURT PROFESSIONALS APPLAUD THE PRESIDENT'S NEW TREATMENT INITIATIVE

NATIONWIDE –
Karen Freeman Wilson, CEO of the National Association of Drug Court Professionals, applauded the White House treatment initiative announced on January 29, 2003 by the Office of National Drug Control Policy Director John Walters. "President Bush clearly understands both prevention and treatment. He understands the challenges that we face as professionals dedicated to assisting those on the road to recovery. While we appreciate the additional funding for Drug Courts, we also understand that our nation's drug problem is much larger than Drug Court." Freeman Wilson further stated, "Not all individuals who are evaluated for drug court can be admitted. A person should not have to get arrested to get treatment. The President's new voucher plan will allow those in and out of Drug Court to access treatment and for that we commend him and his entire administration." NADCP represents Drug Court Professionals all over the United States and welcomes the opportunity to continue working with Director Walters and ONDCP; Administrator Charles Curie and the Substance Abuse and Mental Health Services Administration; other federal agencies and other private entities dedicated to drug prevention and treatment.

If you would like more information, contact Karen Freeman-Wilson at 703-585-3619

NATIONAL TASC

Promoting Effective Case Management for Justice Populations

For release February 5, 2003

Contact: Sonya Brown
President, National TASC
(919) 733-0566

National Offender Case Management Association Supports President's Drug Treatment Initiative

(Washington, DC) -- The National TASC Association, which represents more than 220 offender case management programs across the U.S., today announced its support of President Bush's proposed *Recovery Now* program. The three-year, $600 million initiative will increase access and availability of treatment for persons with substance use disorders.

"More than two-thirds of offenders used illicit drugs prior to committing their crimes," says Sonya Brown, president of the board of directors of National TASC. "Courts and corrections systems across the country are burdened by the number of drug-involved offenders who cycle in and out of the system without having their addictions addressed. The lack of access to affordable treatment is a barrier to recovery for many, and the President's initiative is a welcome strategy for reducing that treatment gap."

Melody M. Heaps is president of TASC, Inc. in Illinois, a nonprofit recovery management organization that works with more than 20,000 criminal justice clients each year. She explains that recent science has demonstrated the effects of drug use and addiction on the brain, which has clear implications for treatment and recovery.

"Because of the chronic nature of addiction, studies show that successful outcomes require adequate lengths of treatment along with continuing recovery support. Most individuals in need of treatment lack the financial means to afford such care," says Heaps. "The President's initiative will help increase the capacity not only of traditional treatment services, but also of the continuing recovery support services that are so critical to lasting success."

Heaps notes that the *Recovery Now* initiative will allow more people to access treatment through criminal justice, primary care, and other systems that traditionally see large numbers of people with substance use disorders. "This initiative greatly supports treatment efforts that are currently in place," she says. "It allows for earlier intervention with individuals before their use becomes chronic and before they have embarked on a destructive cycle of addiction and criminal activity."

National TASC (Treatment Accountability for Safer Communities) is a membership association representing TASC programs across the United States. National TASC is dedicated to improved access and quality treatment and support services for substance-involved criminal justice and court populations through the professional delivery of clinical assessment and case management services.

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FOR IMMEDIATE RELEASE:
Contact: Christopher J. Curtis (503) 244–5211 x229
February 4, 2003

OREGON PARTNERSHIP WELCOMES
MORE FUNDING FOR DRUG TREATMENT

(PORTLAND, OR) – Oregon's only statewide non-profit organization dedicated to substance abuse prevention and treatment referral is lauding new plans for drug and alcohol treatment funding by the federal government. Oregon Partnership is supporting details of President Bush's new three-year, $600 million plan to expand access to drug treatment across America. The new initiative creates a voucher program that will complement existing alcohol and drug abuse treatment programs, increasing treatment capacity and access to effective treatment programs.

The program, called "Recovery Now," will allow up to 100,000 more people each year to receive treatment services. It allows providers to help people receive treatment tailored to their needs. States and partners will be held fully accountable and provide results to ensure quality services are being delivered.

"We know that treatment works," said Judy Cushing, President/CEO of the Oregon Partnership. "What we need is more of it, for more people through effective treatment providers. This initiative can help to meet the treatment gap in this country, and here in Oregon," she said.

According to Oregon Mental Health and Addiction Services, only about 60,000 of 375,000 Oregonians in need of some form of treatment are currently able to receive services – and those numbers were calculated prior to additional cuts to state services resulting from the defeat of Measure 28.

The new initiative will work by allowing individuals to utilize federal alcohol and drug abuse dollars at all effective treatment organizations. Those individuals will be assessed and receive a voucher to pay for an appropriate level of treatment. Individual states would be required to monitor the outcomes of the voucher program and to make adjustments based on the extent to which improved client outcomes are or are not achieved in a cost-effective manner.

The new initiative is designed to allow treatment providers, community organizations, workplaces, faith-based organizations and schools to help drug users receive the treatment and support services that are best suited to their individual needs. Combined with prior year requests, this increase in funding will meet the President's commitment to provide an additional $1.6 billion for treatment services over five years.

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John Robertson, Ph.D
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For Immediate Release

"NBAC Finds hope in the President's Speech"

(Washington, DC, February 5, 2003) The National Black Alcohol and Addictions Council, Inc. (NBAC) finds hope in the President's statement in the State of the Union Address supporting the involvement of faith-based organizations in the battle against alcohol and substance abuse. We believe that the President 'got it right' in proposing the allotment of $600 million for vouchers for treatment that would include faith-based organizations.

"*The vouchers have the potential for leveling the playing field and for including many organizations that for years have provided invaluable services to the African American Community in fighting the devastation of alcoholism and substance abuse*," said Peter Hayden, Chairperson of National Black Alcoholism and Addictions Council and President of Turning Point, a culture specific faith-based treatment program in Minneapolis, Minnesota. Hayden says, "*We have always known that faith in a 'higher power' was crucial in our culture and our efforts.*"

We believe that this initiative marks a beginning recognition of the unique strengths of faith institutions in the African American Community. These

institutions, often referred to as The Black Church, have served the community throughout the many years of struggle against a variety of problems. Examples of this strength can be found in the many members of our organization, NBAC who readily testify that without the hope, support, and inspiration that our Black Churches provided they would have been dead or disabled many years ago. As an organization, NBAC has always recognized in our 25 years of existence that the spiritual foundations on which our communities have survived are essential in the recovery process from alcoholism and other drug addictions.

Executive Director, John Robertson, Ph.D. states that our efforts in NBAC have always included collaborating with faith organizations. He cites NBAC in work with faith groups on a variety of issues including substance abuse prevention, drunk driving and HIV/AIDS.

NBAC is a voluntary non-profit organization dedicated to developing leadership in the prevention and treatment of alcoholism and substance abuse for African Americans. The organization operates a national training institute focused on alcoholism and substance abuse, holding workshops and conferences on these concerns, has developed models on interventions with children of alcohol and drug addicted parents, has conducted research and developed interventions on drinking and driving, and HIV/AIDS Community Capacity Building and Faith-based Capacity Building.
For information on NBAC please call 407-532-2774 or visit our website at www.nbacinc.org.

LEGAL ACTION CENTER

FOR IMMEDIATE RELEASE **February 4, 2003**

CONTACT: Jenny Collier, (202) 544-5478, x13

LEGAL ACTION CENTER PRAISES PRESIDENT BUSH'S EMPHASIS ON DRUG AND ALCOHOL TREATMENT AND RECOVERY

Washington, D.C. - The Legal Action Center praised President Bush for his strong statements in support of alcohol and drug treatment and recovery and announcement of a new treatment initiative during his State of the Union Address. Jenny Collier, Director of National Policy and State Strategy for the Legal Action Center, stated that, "Alcohol and drug treatment and prevention deserve this Administration's attention. Legal Action Center welcomes President Bush's statement that he and Drug Czar John Walters will carry out their promise to dramatically expand alcohol and drug treatment by investing an additional $600 million over three years. It is especially important to focus on wide dissemination of resources during these harsh economic times for the States – addiction treatment budgets are being slashed nationwide and federal resources are more precious than ever."

---more---

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Paul Samuels, Legal Action Center's President/Director, stated his hope that in addition to expanding treatment that, "The Administration will support protections for individuals in recovery who are reclaiming their lives and contributing to society. These protections encourage individuals to enter evidence-based alcohol and drug treatment, which has been proven time and again to reduce the human, social and financial costs of addiction."

The Legal Action Center is the only public interest law and policy organization in the United States whose sole mission is to fight discrimination against and protect the privacy of individuals in recovery from alcoholism or drug dependence, individuals living with HIV/AIDS, and individuals with criminal records. From its offices in New York City and Washington, D.C., the Center works to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center helps people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

# # #

ASAM AMERICAN SOCIETY OF ADDICTION MEDICINE

PRESS RELEASE

FOR IMMEDIATE RELEASE: **February 4, 2003**
Contact Eileen McGrath (301) 656-3920

AMERICAN SOCIETY OF ADDICTION MEDICINE PRESIDENT REACTS TO DRUG ABUSE TREATMENT VOUCHER INITIATIVE

Lawrence S. Brown, Jr., MD, MPH, FASAM, President, American Society of Addiction Medicine responded today to President Bush's $600 million plan to expand access to drug treatment by creating a voucher program to complement existing alcohol and drug treatment programs.

"ASAM and its members are profoundly encouraged by the prominence President Bush gave to treatment and recovery from addiction in his State of the Union Address. President Bush's confidence in the effectiveness of treatment for addiction is scientifically sound. His leadership on this issue will have an enormous impact on people's attitudes toward addiction, as well as increasing access to treatment." said Dr. Brown.

"ASAM appreciates the initiative and recognizes the importance of spirituality in recovery." Dr. Brown noted, "It is important that physicians be leaders of treatment teams. Clergy can often be on the front lines of treatment and many are trained and skilled. However, addiction is also a disease with complex physical and psychological ramifications that require evidence based medical assessment and treatment by qualified licensed professionals in a biopsychosocial multidisciplinary approach. The assessment and treatment of co-occurring psychiatric and medical disorders (such as HIV and hepatitis C virus infections) must also be an integral part of addiction treatment."

The determination of the need for and level of treatment must be a clinical judgment based on objective guidelines supported by clinical research literature and clinical consensus such as the guidelines in the *ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders (ASAM PPC-2R)*, which includes separate criteria for adults and children. The goals of these objective criteria are to match intensity of service to severity of illness in a continuum of care, prescribe a treatment level that can accomplish the objectives safely, and provide a framework in which clinical outcomes and cost benefit may be assessed. These goals and concepts have been required or recommended in over twenty states.

"ASAM recognizes that there is currently not enough funding to support treatment for all who need and want help with addictive diseases. ASAM strongly supports the intent of the voucher program to make treatment accessible to a larger proportion of those in need, and to their families."

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"ASAM's commitment to quality in treatment leads us to recommend that any system of vouchers be used only for treatment by programs that are accredited and licensed by the appropriate state agency, making them subject to quality assurance, regulation and inspection by the state."

The American Society of Addiction Medicine (ASAM) is a national medical specialty of 3,000 physicians engaged in research on and prevention and treatment of addiction to alcohol, nicotine and other psychoactive substances. The Society's mission is to educate physicians and other addictions caregivers and to improve access to treatment for individuals with addictions.

Johnny Allem <johnny_allem@yahoo.com>
02/04/2003 05:22:59 PM

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Subject: Statement

STATEMENT
By Johnny W. Allem
President, Johnson Institute

In Response to the President?s
State of the Union Speech
January, 2003

With grace, compassion and truth, the President of the United States last week pierced a major barrier for millions of Americans addicted or at risk for addiction to alcohol and other drugs. He broke the barrier of silence.

He said recovery is not just possible, but probable when the focus is on healing instead of fear.

There has been plenty of noise around the issue of chemical dependency.

It is said people who suffer from the consequences of addiction ?have it coming.? That is noise, not fact.

It is said treatment is a bad investment since many people have to repeat their treatment regime and some never enjoy complete recovery. More noise.

It is said it is a better investment to try and stop drugs at the border, or with helicopter raids in foreign lands, than to treat addiction and support recovery. Heavy metal noise!

What is not said in public is that addiction is an illness with proven treatments and highly valued survivors. The President said it, pointing to a single witness in the balcony. He could have pointed to many more, for recovery is everywhere ? even in Congress. Some wear their recovery like a badge of honor, including Rep. Jim Ramstad of Minnesota. Others react prudently to the conventional wisdom and reinforce the silence.

It is not news that faith increases healing. It is not news that money is required for appropriate professional response to illness. It is not news that standing institutions in local communities are in the

best position to recognize early symptoms of disease and assist in healing. It is not news that churches can serve people in secular as well as spiritual ways.

But we must not miss the significance of this major public step by President Bush: There is an experience of recovery that has been overlooked. That experience has been replicated. If that experienced was widely shared, America would experience wide healing.

For me, a person recovered from alcoholism with more than 20 years abstinence, the news is that the highest official in our land recognizes survivors, not chemicals; healing, not hopelessness; faith, not fear; action, not neglect; and truth, not silence.

How reassuring to my claim of first class citizenship, not the stigmatizing and ?guilty until proven innocent? condescension society maintains toward recovered as well as suffering alcoholics and addicts.

There are many hurdles to an appropriate response to chemical dependency in our society. For instance, we must not measure progress by the number of public dollars we can grasp, but by the merging of our health cause with America?s traditional and private health payment system. But the President has knocked down a major hurdle by bringing survivors to the table.

He has challenged America to focus on the solution, not the problem; to advance recovery, not curse the addicted.

Hear, hear.

Johnny W. Allem
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Message Sent To:

FROM : TCA FAX NO. : 2025185475 Feb. 03 2003 08:06PM P2

tca

Therapeutic Communities of America

PRESS RELEASE
For immediate release

For more information contact:

Linda Hay Crawford
(202) 413-3785

Therapeutic Communities of America Applauds the President's Support of Effective Substance Abuse Treatment Programs

Washington DC (February 3, 2003) Therapeutic Communities of America (TCA) applauds President George W. Bush for his recognition that treatment works. We are encouraged by the President's budget initiative to help addicted Americans find needed qualified treatment. Therapeutic Communities of America supports effective evidence-based sustained substance abuse treatment.

"Through the President's leadership in recognizing the efficacy of substance abuse treatment he can also help other social service and health objectives such as welfare to work and family reunification programs" said Linda Hay Crawford, Executive Director of Therapeutic Communities of America. The economic, medical, and societal costs of alcohol and drug abuse, places a burden on all of America's systems. Ms. Crawford continues "By increasing access to evidence based approaches to alcohol and drug abuse treatment we all stand to benefit by a decrease in emergency room visits, violence, job accidents, auto fatalities, crime, workplace absenteeism, Medicaid and Medicare costs."

" The therapeutic community methodology is one of the most effective forms of treatment that allows individuals to recover and live productive, safe, and sober lives," said Richard E. Steinberg, President of Therapeutic Communities of America and CEO of the WestCare Foundation. Length in treatment is key to the recovery of hard-core drug abusers.

Therapeutic Communities of America is a national non profit membership association based in Washington DC representing over 400 substance abuse treatment programs that serve over 100,000 clients per year. The member agencies provide services to substance abuse clients with a diversity of special needs, including HIV/AIDS, mothers with children, criminal justice clients, co-occurring adults including the chronic and persistently mentally ill, homeless, and adolescents. Therapeutic Communities of America's members provide a continuum of care including such services as assessment, detoxification, residential care, case management, outpatient, transitional housing, education, vocational, primary medical services and continuing care.

FEB-04-2003 15:49 FROM:MAGNA SYSTEMS 213-625-5796 TO:20 P.002/002

NAPAfASA ♦ National Asian Pacific American Families Against Substance Abuse
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February 4, 2003

The Honorable John P. Walters
Director
White House Office of National Drug Control Policy
750 17th Street, NW
Washington, D.C. 20503

RE: NAPAFASA Support for the Drug Treatment Initiative

Dear Director Walters,

This is to lend NAPAFASA's support to the Drug Treatment Initiative which will provide $600 million for three years to expand access to drug treatment for all Americans. The "voucher" program will hopefully make culturally competent substance abuse treatment services accessible to all who need these treatment programs including Asian American and Pacific Islanders.

We know that treatment provided in a culturally competent manner with a full continuum of high quality care can be extremely effective in the recovery process. It is also cost effective.

NAPAFASA looks forward to working with you and ONDCP in implementing this New Treatment Initiative.

Sincerely,

Ford H. Kuramoto, D.S.W.
National Director

cc: Andrea Barthwell
Darie Davis
Sandra Lawson
Emilie Dearing

National Association for Children of Alcoholics
... the advocate for children in families affected by alcohol and drug addictions

February 5, 2003

FOR IMMEDIATE RELEASE:

Contact: Sis Wenger
Executive Director
301-468-0985

NACoA Applauds President's Plans to Enhance Treatment and Recovery Options

The National Association for Children of Alcoholics (NACoA) applauds President Bush's proposals to make effective treatment more readily available for persons with substance use disorders. We also applaud his clear understanding that people can – and do – recover and go on to lead highly productive lives. Both the new initiative that creates a treatment voucher program and the proposed increase in treatment resources for Drug Court programs were hailed by NACoA leadership today.

The President's proposals promise not only bring recovery to many more addicted persons but they could help to bring relief and recovery to affected family members, including the children. Working together, we can break the cycle of this disease that permeates so many afflicted families.

"There is a growing body of evidence demonstrating that, when treatment programs provide services to the entire family, including the children, there are increased positive treatment outcomes for the client," according to Jerry Moe, M.A., national director of the Betty Ford Center Children's Programs. "We believe that the greatest gift addicted parents can give their children is the gift of their own recovery. The second greatest gift is providing for their children to begin their own healing."

NACoA recognizes that President Bush's leadership on issues of addiction treatment and recovery can increase both individual and family healing from alcoholism and drug addiction and can result in millions of affected children growing up in safer and healthier families.

The National Association for Children of Alcoholics is the national nonprofit membership and affiliate organization working on behalf of children of alcohol and drug dependent parents. Our mission is to advocate for all children and families affected by alcoholism and other drug dependencies. To learn more, visit www.nacoa.org

FOR IMMEDIATE RELEASE:
Contact: Molly Osendorf, (305)856-4886
February 4, 2003

INFORMED FAMILIES/THE FLORIDA FAMILY PARTNERSHIP SUPPORTS MORE FUNDING FOR DRUG TREATMENT

(Miami, FL) – Informed Families/The Florida Family, a statewide non-profit organization dedicated to substance abuse prevention and education is supporting new plans for drug and alcohol treatment funding by the federal government. Informed Families is supporting details of President Bush's new three-year, $600 million plan to expand access to drug treatment across America. The new initiative creates a voucher program that will complement existing alcohol and drug abuse treatment programs, increasing treatment capacity and access to effective treatment programs.

The program, called "Recovery Now," will allow up to 100,000 more people each year to receive treatment services. It allows providers to help people receive treatment tailored to their needs. States and partners will be held fully accountable and provide results to ensure quality services are being delivered.

"We are thrilled with this particular initiative because it will greatly help families and individuals to get the appropriate form of help they need when they need it," said Peggy Sapp, President of Informed Families.

According to The Florida Drug Control Strategy Report, issued by the Florida Office of Drug Control, Florida's treatment professionals estimate that they are only meeting about 20% of the treatment need. There are an estimated 722,198 adults and 247,000 children in need of substance abuse treatment services in Florida.

The new initiative will work by allowing individuals to utilize federal alcohol and drug abuse dollars at all effective treatment organizations. Those individuals will be assessed and receive a voucher to pay for an appropriate level of treatment. Individual states would be required to monitor the outcomes of the voucher program and to make adjustments based on the extent to which improved client outcomes are or are not achieved in a cost-effective manner.

The new initiative is designed to allow treatment providers, community organizations, workplaces, faith-based organizations and schools to help drug users receive the treatment and support services that are best suited to their individual needs. Combined with prior year requests, this increase in funding will meet the President's commitment to provide an additional $1.6 billion for treatment services over five years.

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FOR IMMEDIATE RELEASE

DATED: February 4, 2003

PRIDE Youth Programs, the world's largest youth drug prevention organization, today gave rave reviews to President Bush's new drug treatment initiative.

"Drug prevention and drug treatment provide the one-two punch needed to knock out drug abuse in our nation," said Mr. Jay DeWispelaere, President and CEO of PRIDE Youth Programs in Newaygo, Michigan.

"Operating in hundreds of communities throughout the U.S., PRIDE youth teams deliver a powerful prevention message. Now, youth already involved in drugs can get the help they need to get drug-free and join Pride's drug free peer groups to stay free," Mr. DeWispelaere, declared.

"Our youth provide international leadership in drug prevention. The unique treatment voucher system proposed is a landmark project for other nations follow," said Robert Peterson, PRIDE's Director of International Programs. "The power of "choice" is a concept valued by youth and parents throughout the world" Mr. Peterson further noted.

"When PRIDE youth teams present their positive prevention message, we encourage youth and others to offer a helping hand to those in need. Having wider treatment available enables us to point the way to where help can now be received," said Jennifer Kempen, PRIDE Youth Programs' International Trainer.

"When drug prevention, treatment, and law enforcement work together, communities are safer and healthier places to live. Those of us who work with youth, welcome this new drug initiative with open arms," Mr. DeWispelaere concluded.

Phoenix House

164 West 74th Street, New York, NY 10023 (212) 595-5810

For Immediate Release
February 5, 2003

Contact: Luci de Haan
212-595-5810, ext. 7854

LOOKING TO *RECOVERY NOW* TO HELP CLOSE THE DRUG ABUSE TREATMENT GAP

(New York, NY) – The United States will never bring drug abuse under control until adequate access to appropriate treatment is available for all who need it. But, in our nation today, there are nearly four million drug abusers who need treatment and for whom no treatment exists.

At Phoenix House, the nation's largest, non-profit substance abuse services agency, with more than 100 programs in nine states and a treatment population close to 6,000, we believe President Bush's three-year, $600 million *Recovery Now* program can go a long way toward meeting their needs. This initiative should make it possible for states to increase access to treatment, while extending the continuum of care, so that substance abusers will be able to find, in their communities, services that do not now exist there.

The program challenges the states, offering them a great opportunity for innovation and thoughtful design of voucher programs that will help substance abusers determine and participate in those treatment programs of proven quality that best facilitate their recovery. It is our hope that *Recovery Now* will open the way to recovery for thousands of Americans, empowering them and enabling them to start new, meaningful, productive, and drug-free lives.

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PRESS RELEASE

FOR IMMEDIATE RELEASE
Contact: The Lippin Group, 323.965.1990
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Entertainment Industries Council, Inc. 703.481.1414
Laura Baker

ENTERTAINMENT INDUSTRIES COUNCIL ATTENDS WHITE HOUSE DRUG CONTROL POLICY TREATMENT BRIEFING

EIC President Delivers Details Of President Bush's "Recovery Now" Initiative To Hollywood Community

WASHINGTON D.C., February 11, 2003 – Entertainment Industries Council, Inc. (EIC) President and CEO Brian Dyak represented the film and television industries at the White House's Office of National Drug Control Policy (ONDCP) Treatment Briefing last week in Washington. The meeting was held to bolster support and provide awareness for President George W. Bush's *Recovery Now* drug and alcohol addiction treatment initiative. ONDCP Director John Walters hosted the special briefing at which Substance Abuse and Mental Health Services Administrator, Charles Curie, M.A., A.C.S.W and other leaders from throughout the substance abuse and treatment community were present.

EIC will be providing Hollywood industry leaders with details of the President's new three-year, $600 million initiative.

"EIC applauds the President's *Recovery Now* initiative and the remarks made in his recent State of the Union address, during which he said that he plans to increase funding to help those addicted to drugs and alcohol," said Dyak. "We are glad that the White House is endorsing and supporting these programs, ensuring that everyone seeking treatment can get the help they need."

The goals of the *Recovery Now* initiative are:

- Providing effective services to people in need of treatment for drug or alcohol abuse through a voucher program.

- Allowing states the flexibility to design the type of voucher that is appropriate for their systems, but the vouchers will allow treatment providers to seek reimbursement for their services.
- Providing vouchers that will have no face value to the client.
- Establishing vouchers that can be redeemed for care ranging in levels from brief interventions or counseling sessions, to intensive in-patient residential treatment by providers (including faith-based) designated by the individual states.

"The President's initiative is a bold step towards addressing a problem that has plagued the Hollywood community," added Dyak. "Many Americans think that addiction within our industry only affects celebrities. Addiction runs much deeper than that, touching many who are behind the scenes of the entertainment we all enjoy. *Recovery Now* will provide all those in the entertainment industry access to services to begin the battle against addiction while establishing a viable road to recovery."

Dyak also believes that the entertainment industry can play a special role in the President's treatment push. Already, treatment and recovery are spotlighted at the annual *PRISM Awards*, produced by EIC in partnership with The Robert Wood Johnson Foundation (RWJF) and the National Institute on Drug Abuse (NIDA). This show, which recognizes accurate depictions of drug, alcohol and tobacco use and addiction in entertainment, is not only televised to a national audience, but also distributed in VHS format to over 4,000 treatment centers nationwide. By recognizing the efforts of productions such as *Blow*, *Sex and the City*, *ER*, *Third Watch*, *Traffic*, and the song *Junkie* by recording artist Ozzy Osbourne, the *PRISM Awards* express the support that the entertainment industry has for educating the public about substance abuse and supporting those in treatment. "The entertainment industry also has an awesome power to reduce stigma surrounding addiction, encouraging more people to seek treatment and find recovery," said Dyak.

EIC is a non-profit organization founded in 1983 by the entertainment industry to lead the industry in bringing its power and influence to bear on health and social issues by "encouraging the art of making a difference." Among the issues EIC addresses are: drug, alcohol, and tobacco use and addiction; gun violence, firearm safety and injury prevention; terrorism and narco-terrorism; mental health; safety belt and traffic safety awareness; and HIV/AIDS prevention, among others. Its website is located at www.eiconline.org. EIC is currently celebrating its 20th anniversary.

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FOR IMMEDIATE RELEASE
February 5, 2003

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COMMUNITY ANTI-DRUG COALITIONS OF AMERICA APPLAUDS PRESIDENT BUSH'S SUPPORT OF DRUG TREATMENT AND RECOVERY

ALEXANDRIA, VA—Community Anti-Drug Coalitions of America (CADCA) praised President Bush for being the first President to address drug abuse treatment and recovery before a joint session of Congress. In his State of the Union Address, Bush called for a total of $600 million over three years to enable 300,000 drug addicts to receive treatment.

"We believe the Bush plan will enable more addicts to receive treatment, and more providers to offer services specifically tailored to an individual's needs," said Arthur T. Dean, Chairman and CEO of CADCA.

CADCA is also pleased that the President recognizes drug addiction is a disease that can be treated and, in the President's words, "the miracle of recovery is possible."

"The plan proposed by the President is an important part of a comprehensive approach to the drug problem. Education, prevention, treatment and recovery are all critical to a successful effort," Dean added. "The Administration's support for increased funding for the Drug-Free Communities Support Program, coupled with more resources for treatment and recovery will help local anti-drug coalitions in their efforts to build safe, healthy and drug-free communities."

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Community Anti-Drug Coalitions of America (CADCA), home of the Drug-Free Kids Campaign, is the premier national membership organization representing more than 5000 community anti-drug coalitions nationwide, providing training, information and support. These coalitions are local partnerships between parents, teachers, young people, law enforcement, health providers, the faith community, business and civic leaders, elected officials and concerned citizens who unite and mobilize to make their communities safe, healthy and drug-free – one community at a time. For more information on CADCA, visit www.cadca.org. For more information on the Drug-Free Kids Campaign, visit www.drug-freekids.org