ACCESS TO RECOVERY: IMPROVING PARTICIPATION AND ACCESS IN DRUG TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Hearing held on September 22, 2004	1
Statement of:	
Curie, Charles G., Administrator, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services	6
Heaps, Melody, president, Treatment Alternatives for Safe Communities; and Dr. Michael Passi, associate director, Department of Family and Community Services, city of Albuquerque, NM	22
Letters, statements, etc., submitted for the record by:	
Cummings, Hon. Elijah E., a Representative in Congress from the State of Maryland, prepared statement of	50
Curie, Charles G., Administrator, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, prepared statement of	9
Heaps, Melody, president, Treatment Alternatives for Safe Communities, prepared statement of	25
Passi, Dr. Michael, associate director, Department of Family and Community Services, city of Albuquerque, NM, prepared statement of	31
Souder, Hon. Mark E., a Representative in Congress from the State of Indiana, prepared statement of	4

ACCESS TO RECOVERY: IMPROVING PARTICIPATION AND ACCESS IN DRUG TREATMENT

WEDNESDAY, SEPTEMBER 22, 2004

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 2 p.m., in room 2247, Rayburn House Office Building, Hon. Mark Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder, Cummings, Norton and Ruppersberger.

Staff present: J. Marc Wheat, staff director; Roland Foster, professional staff member; Malia Holst, clerk; Tony Haywood, minority professional staff member; and Teresa Coufal; minority assistant clerk.

Mr. SOUDER. The subcommittee will now come to order.

Good afternoon and I thank you all for being here.

Today, we will continue the subcommittee's examination of drug addiction treatment or as President Bush refers to it in the National Drug Control Strategy, healing America's drug users. It is estimated that at least 7 million people in the United States need substance abuse treatment. Providing treatment is important because it improves the lives of individuals and reduces social problems associated with substance abuse.

Effective treatment, for example, reduces illegal drug use, criminal activity and other risky behaviors while improving physical and mental health. When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses such as diabetes, hypertension and asthma.

Last year, President Bush took what I believe to be a very significant step toward assisting the difficult problem of extending help to those suffering from substance abuse when he unveiled the Access to Recovery Initiative. Beginning this year the President's initiative will provide $100 million to the Substance Abuse and Mental Health Services Administration to supplement existing treatment programs. This is intended to pay for substance abuse treatment for Americans seeking help but can't get it, many of whom cannot afford the cost of treatment and don't have insurance that covers it.

If fully funded at $200 million per year as requested by the President, this program could help up to 100,000 or more suffering from addiction to receive treatment. The program also has enor-

mous potential to open up Federal assistance to a much broader range of treatment providers than currently available today.

The initiative will support and encourage a variety of treatment options and provide those seeking assistance a choice in treatment approaches and programs. Providing choices for those in need of assistance allows the individual to select the program that best addresses their personal needs. It has often been said that in order to help substance abusers, you need to meet them where they are. This approach goes a step further by allowing those seeking help to determine themselves where they want this meeting to occur and with whom.

This new approach to treatment will establish a State-managed program for substance abuse clinical treatment and recovery support services buildupon the following three principles.

Consumer choice. The process of recovery is a personal one. Achieving recovery can take many pathways, physical, mental, emotional or spiritual. Given a selection of options, people in need of treatment for addiction and recovery support will be able to choose the programs and providers that will help them most. Increased choice protects individuals and encourages quality.

Outcome oriented. Successfully measured by outcomes, principally abstinence from drugs and alcohol and including attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care and retention and services.

Increased capacity. The initial phase of the Access to Recovery will support treatment for approximately 50,000 people per year and expand the array of services available including medical detoxification, in-patient and out-patient treatment modalities, residential services, peer support, relapse prevention, haste management and other recovery support services. These funds will be awarded through a competitive grant process. States will have considerable flexibility in designing their approach and may target efforts to areas of greatest need to areas with a high degree of readiness or to specific populations including adolescents.

The key to implementing the grant program is a State's ability to ensure genuine, free and independent client choice of eligible providers. States are encouraged to support any mixture of clinical treatment and recovery support services that can be expected to achieve the program's goal of cost effective, successful outcomes for the largest number of people.

Today, we will learn more about the status and the goals of the Access to Recovery Initiative with the person most responsible for implementing it, my fellow Hoosier and friend, SAMHSA Administrator, Charles Curie. We will also hear from several experts who are on the front lines of substance abuse treatment. Melody Heaps is the president of Treatment Alternatives for Safe Communities in Chicago, IL, a recipient of Access to Recovery funding. Dr. Michael Passi is the associate director of the Department of Family and Community Services in Albuquerque, NM which was a pioneer in providing choices for those seeking substance abuse treatment.

Thank you again for being here today and I look forward to hearing more about the Access to Recovery from our experts who are with us today.

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

"Access to Recovery:
Improving Participation and Access in Drug Treatment"

Opening Statement of Chairman Mark Souder

Subcommittee on Criminal Justice, Drug Policy and Human Resources

September 22, 2004

Good afternoon and thank you all for being here.

Today we continue the Subcommittee's examination of drug addiction treatment or, as President Bush refers to it in the National Drug Control Strategy, "Healing America's Drug Users."

It is estimated that at least 7 million people in the U.S. need substance abuse treatment.

Providing treatment is important because it improves the lives of individuals and reduces social problems associated with substance abuse. Effective treatment, for example, reduces illegal drug use, criminal activity and other risky behaviors while improving physical and mental health.

When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses, such as diabetes, hypertension, and asthma.

Last year, President Bush took what I believe to be a very significant step towards assisting the difficult problem of extending help to those suffering from substance abuse when he unveiled the "Access To Recovery" initiative.

Beginning this year, the President's initiative will provide $100 million to the Substance Abuse and Mental Health Services Administration (SAMHSA) to supplement existing treatment programs. This is intended to pay for substance abuse treatment for Americans who are seeking help but can't get it, many of whom can't afford the cost of treatment and don't have insurance that covers it.

If fully funded at $200 million per year – as requested by the President – this program could help up to 100,000 more suffering from addiction receive treatment.

The program also has enormous potential to open up federal assistance to a much broader range of treatment providers than are currently available today.

The initiative will support and encourage a variety of treatment options and provide those seeking assistance a choice in treatment approaches and programs. Providing choices for those in need of assistance allows the individual to select the program that best addresses their personal needs.

It has often been said that in order to help substance abusers, you need to meet them where they are. This approach goes a step further by allowing those seeking help to determine themselves where they want this meeting to occur and with whom.

This new approach to treatment will establish a State-managed program for substance abuse clinical treatment and recovery support services built on the following three principles:

- Consumer Choice. The process of recovery is a personal one. Achieving recovery can take many pathways: physical, mental, emotional, or spiritual. Given a selection of options, people in need of addiction treatment and recovery support will be able to choose the programs and providers that will help them most. Increased choice protects individuals and encourages quality.

- Outcome Oriented. Success will be measured by outcomes such, principally abstinence from drugs and alcohol, and including attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services.

- Increased Capacity. The initial phase of Access to Recovery will support treatment for approximately 50,000 people per year and expand the array of services available including medical detoxification, inpatient and outpatient treatment modalities, residential services, peer support, relapse prevention, case management, and other recovery support services.

These funds will be awarded through a competitive grant process. States will have considerable flexibility in designing their approach and may target efforts to areas of greatest need, to areas with a high degree of readiness, or to specific populations including adolescents.

The key to implementing the grant program is the States' ability to ensure genuine, free, and independent client choice of eligible providers. States are encouraged to support any mixture of clinical treatment and recovery support services that can be expected to achieve the program's goal of cost-effective, successful outcomes for the largest number of people.

Today we will learn more about the status and goals of the Access to Recovery initiative with the person most responsible for implementing it, my fellow Hoosier, SAMHSA Administrator Charlie Currie.

We will also hear from several experts who are on the front lines of substance abuse treatment.

Melody Heaps is the President of Treatment Alternatives for Safe Communities in Chicago, Illinois, which is a recipient of Access to Recovery funding.

Dr. Michael Passi is the Associate Director of the Department of Family and Community Services in Albuquerque, New Mexico, which was a pioneer in providing choices for those seeking substance abuse treatment.

Thank you again for being here today. I look forward to hearing more about Access to Recovery from our experts who are with us today.

Mr. SOUDER. 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.

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

[Witnesses sworn.]

Mr. SOUDER. Once again, thank you for your patience and for your leadership not only here but in your previous State position in Pennsylvania in advocacy for those who often don't have advocates. You have been consistent for many years talking about co-occurring dependencies and creative ways to address these problems. Thank you for being here.

STATEMENT OF CHARLES G. CURIE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CURIE. Thank you so much, Mr. Chairman. It is great to see you again.

I appreciate the opportunity to testify today. I also request that my written testimony be submitted for the record.

Mr. SOUDER. So ordered.

Mr. CURIE. I am pleased, Mr. Chairman, that you and the committee have selected the President's Access to Recovery Substance Abuse Treatment Initiative as the topic of this hearing. Again, I am very pleased with your opening statement of support for the concept and for the program, Access to Recovery.

It is also a privilege for me today to be participating in the same session with Dr. Michael Passi from Albuquerque which did pave the way with a voucher type of program and New Mexico happens to be one of the recipients of Access to Recovery, so we have high hopes for the implementation there. Also, my friend and colleague for whom I have such regard, Melody Heaps who has done so much on behalf of individuals trapped in addiction in the criminal justice system, bringing hope in her career.

Expanding substance abuse treatment and capacity and recovery support services is a priority for this administration. There is a vast, unmet treatment need in America. Too many Americans who seek help for their substance abuse problem cannot find it. A recently released 2003 National Survey on Drug Use and Health, known as the Household Survey, provides the scope of the problem.

In 2003, there were an estimated 22 million Americans who were struggling with a serious drug or alcohol problem. The survey contains another remarkable finding. The overwhelming majority, almost 95 percent of people with substance use problems, do not recognize their problem. Of those who recognize their problem, 273,000 reported that they made an effort but were unable to get treatment.

To help those in need, SAMHSA supports and maintains State substance abuse treatment systems through the Substance Abuse Prevention and Treatment Block Grant. Our Targeted Capacity Ex-

pansion Grant Program continues to help us identify and address new and emerging trends in substance abuse treatment needs. Now, we also have Access to Recovery, ATR. It provides a third complementary grant mechanism to expand clinical treatment and recovery support service options to people in need.

ATR was proposed by President Bush in his 2003 State of the Union Address. It is designed to accomplish three main objectives long held by the field, policymakers and legislators. First, it allows recovery to be pursued through many different and personal pathways. Second, it requires grantees to manage performance based on outcomes that demonstrate patient successes. Third, it will expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

The program uses vouchers and coupled with State flexibility and executive discretion, they offer an unparalleled opportunity to create profound positive change in substance abuse treatment financing and service delivery across the Nation.

The uniqueness of ATR and its program is its direct empowerment of people, of consumers. Individuals will have the ability to choose the path best for them and the provider that best meets their needs whether physical, mental, emotional or spiritual. Recovery is a very personal process. If you were to ask 100 people about their story of recovery, people in recovery, you would get 100 different stories. There would be common elements but each would have their own pathway.

ATR ensures that a full range of clinical treatment and recovery support services are available, including the transforming powers of faith. I had the privilege of joining the President in Dallas when he announced that $100 million in Access to Recovery grants were being awarded to 14 States and 1 tribal organization. These first grantees were selected through a competitive grant review process that included 66 applications submitted by 44 States and 22 tribes and territories.

While all applicants had the opportunity to expand treatment options for different target population groups and utilized different treatment approaches, they all had to meet some specific common requirements, including the need to ensure genuine free and independent client choice of eligible providers and to report on common performance measures to illustrate effectiveness.

Key to achieving our goal of expanding clinical substance abuse treatment capacity and recovery support services and successfully implementing ATR is the ability to report on meaningful outcomes. We are asking grantees to report on only seven outcome measures. These measures are recovery-based and broader than simply reporting numbers of people served or beds occupied. They get at real outcomes for real people.

First and foremost is abstinence from drug use and alcohol abuse. Without that, recovery and a life in the community are impossible.

Two other outcomes are increased access to services and increased retention and treatment related directly to the treatment process itself. The remaining four outcomes focus on sustaining treatment and recovery, including increased employment, return to school, vocational and education pursuits, decreased criminal jus-

tice involvement, increased stabilized housing and living conditions and increased supports from and connectiveness to the community.

These measures are true measures of recovery. It is the first time we are striving to measure recovery in those terms. They measure whether our programs are helping people attain and sustain recovery. As a compassionate Nation, we cannot afford to lose this opportunity to offer hope to those fighting for their lives to attain and sustain recovery. Because the need is so great, the President has proposed in fiscal year 2005, to double the funding for Access to Recovery to $200 million and to also increase the Substance Abuse Prevention and Treatment Block Grant by $53 million for a total of $1.8 billion.

As you know, the President's fiscal year 2005 budget is before Congress right now. The President's proposed substance abuse treatment initiatives are good public policy and a great investment of Federal dollars. As the President said, and we all know, our Nation is blessed with recovery programs that do amazing work. Our common ground is a shared understanding that treatment works and recovery is real. Now, it is our job to see to it that the resources are made available to connect people in need with people who provide the services.

I also would like to recognize, in conclusion, Dr. Wesley Clark,who is with me today, who is the Director of the Center for Substance Abuse Treatment which is the center primarily responsible within SAMHSA for the implementation and carrying out of Access to Recovery.

Thank you and I would be most pleased to answer any questions you may have.

[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
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

on

ACCESS TO RECOVERY

before the

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

September 22, 2004

Mr. Chairman and Members of the Subcommittee, I am pleased you have selected the President's Access to Recovery substance abuse treatment initiative as the topic for this hearing. Expanding substance abuse treatment capacity and recovery support services is a challenging and complex issue. It is also an issue that is critical to the public health and safety of this nation.

At the Substance Abuse and Mental Health Services Administration (SAMHSA), we have a vision of "life in the community for everyone." Our vision is based on the precept that every American deserves the opportunity for a life that includes a job, a home, education, and meaningful relationships with family and friends. We accomplish our vision through our mission, "building resilience and facilitating recovery."

Our matrix of program priorities and crosscutting management principles helps ensure that we are focused on what needs to be done to accomplish our vision and mission and that we are doing it right. One of our Matrix priority areas is expanding substance abuse treatment capacity. It is a priority because there is a vast unmet treatment need in America and too many Americans who seek help for their substance abuse problem cannot find it.

Our recently released 2003 National Survey on Drug Use and Health provides the scope of the problem. In 2003, there were an estimated 22 million Americans who were struggling with a serious drug or alcohol problem. The toll of addiction on the individual, their family, and their community is cumulative. The devastation ripples outward leading to costly social and public health problems including HIV/AIDS, domestic violence, child abuse, and crime in general, as well as accidents and teenage pregnancies.

It has an impact on employers and on the economy in terms of lost productivity, lost wages, and injuries. Alcohol and drug abuse are serious problems in the workplace. More than three-quarters of adults who have serious drug and/or alcohol problems are employed. This amounts to over ten percent of the Nation's full-time workers and part-time workers.

Serious substance abuse problems often co-occur with serious mental illness. Adults who used illicit drugs were more than twice as likely to have serious mental illness as adults who did not use an illicit drug. In 2003, 18.1 percent of adult past-year illicit drug users had serious mental illness in that year, while the rate was 7.8 percent among adults who had not used an illicit drug. Concerning mortality, addiction also has a role here. Substance abuse increases not only the probability of a person with mental illness attempting suicide, but also increases the person's likelihood of succeeding.

When you start looking at the data, it becomes abundantly clear that many of our most pressing public health, public safety, and human services needs have a direct link to substance use disorders. This obvious link is why the Administration places such a great importance on increasing the Nation's substance abuse treatment capacity.

At SAMHSA, we support and maintain State substance abuse treatment systems through the Substance Abuse Prevention and Treatment Block Grant. Our Targeted Capacity Expansion

grant program continues to help us identify and address new and emerging trends in substance abuse treatment needs. Now, we also have Access to Recovery (ATR). It provides us a third complementary grant mechanism to expand clinical treatment and recovery support service options to people in need.

As you know, ATR was proposed by President Bush in his 2003 State of the Union address. It is designed to accomplish three main objectives, long-held by the field, policy makers, and legislators:

1. It allows recovery to be pursued through many different and personal pathways;
2. It requires grantees to manage performance, based on outcomes that demonstrate patient successes; and
3. It will expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services.

The program uses vouchers, coupled with State flexibility and executive discretion, to offer an unparalleled opportunity to create profound positive change in substance abuse treatment financing and service delivery across the Nation. The innovativeness and uniqueness of the ATR program is its direct empowerment of consumers. Consumers will have the ability to choose the path best for them and the provider that best meets their needs, whether physical, mental, emotional, or spiritual.

ATR dollars, administered through a State Governors' Office or a recognized Tribal Organization, engage eligible service providers from the faith-based, community-based, and clinical arenas. In particular, for many Americans, treatment services that build on spiritual resources are critical to recovery. ATR ensures that a full range of clinical treatment and recovery support services are available, including the transforming powers of faith. Denying these resources from people who want, choose, and need them denies them the opportunity for recovery.

To initiate the program SAMHSA announced in March 2004 it was seeking applications for ATR grant funds. The application deadline was June 2, 2004. During that timeframe, SAMHSA maintained a grant application help-line, convened five pre-application technical assistance workshops around the country, and conducted a national teleconference to help potential applicants. Additionally, an ATR website was maintained and included responses to frequently asked questions, information from a pre-application technical assistance meeting, and other information about this initiative. This website is still active.

The first 15 ATR grantees, 14 States and one Tribal Organization, were selected through a competitive grant review process that included 66 applications submitted by 44 states and 22 tribes and territories. The three-year grants were awarded to California, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington, Wisconsin, Wyoming, and the California Rural Indian Health Board.

Overall, the grant application provided broad discretion. Applicants had to design and implement a voucher program to pay for a broad range of effective, community-based substance

abuse clinical treatment and recovery support services. They could choose to implement the program through a State or sub-State agency, or implement some or all of the program in partnership with a private entity. Applicants could target the program to areas of greatest need, to areas with a high degree of readiness to implement such an effort, or to specific populations, including adolescents.

For example, in Louisiana the ATR grant will assist the state in closing identified gaps in treatment services for eligible Louisiana citizens with special emphasis on women, women with dependent children, and adolescents.

In Connecticut, the ATR grant will expand clinical substance abuse treatment services, including brief treatment interventions; intensive outpatient; ambulatory; detoxification; and methadone maintenance to those in the criminal justice system. Recovery support services will also be expanded, including case management; housing; vocational/educational programs; child care; transportation; and other recovery support, such as peer- and faith-based ancillary support services.

In New Mexico, the ATR project will enhance the City of Albuquerque's existing voucher system. Individuals will receive eligibility for voucher-funded services through a centralized intake, assessment, and eligibility process and will gain entry into a greatly expanded continuum of treatment and recovery services.

The Tribal Organization recipient, the California Rural Indian Health Board, will implement an approach for ATR that upholds the integrity of Indian self-determination by providing treatment opportunities through existing community-based programs. The program will allow patients to select among Indian and non-Indian providers of services; traditional native spiritual and mainstream faith-based services; restrictive or non-restrictive environments; and discrete or wrap-around services.

While all applicants had the opportunity to expand treatment options for different target population groups and utilize different treatment approaches, they all had to meet some specific common requirements. The first was to ensure genuine, free, and independent client choice of eligible providers. Second, they had to establish how clients will be assessed, given a voucher for identified services, and provided with a list of appropriate service providers from which to choose. Third, applicants were required to supplement, not supplant, current funding, thus expanding both capacity and available services. And finally, they will all report on common performance measures to illustrate effectiveness. In both program design and implementation, applicants delineated a process to monitor outcomes. These performance measures will be used to measure treatment success and the ultimate success of the voucher program itself.

Key to achieving our goal of expanding clinical substance abuse treatment capacity and recovery support services, and successfully implementing ATR, is the ability to report on meaningful outcomes. Through a SAMHSA data strategy workgroup and in collaboration with the States, we have identified a set of key "National Outcomes" and related "National Outcome Measures" for ATR. These outcome measures are concise, purposeful and useful. We changed the

emphasis from "How did you spend the money?" and "Did you spend the money according to the rules?" to "How did you put the dollars to work?" and "How did your consumers benefit?"

We are asking grantees to report on only 7 outcome measures. These measures are recovery based and broader than simply reporting numbers of people served or beds occupied. They get at real outcomes for real people.

First and foremost is abstinence from drug use and alcohol abuse. Without that, recovery and a life in the community are impossible.

Two other outcomes – increased access to services and increased retention and treatment – relate directly to the treatment process itself.

The remaining four outcomes focus on sustaining treatment and recovery: increased employment/return to school; decreased criminal justice involvement; increases in stabilized family and living conditions; and increases in support from and connectedness to the community.

These measures are true measures of recovery. They measure whether our programs are helping people attain and sustain recovery. They show that people are achieving a life in the community – a home, a job, and meaningful personal relationships.

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

Over the years we have convened over 30 State substance abuse agency meetings on performance measurement, and funded two "Treatment Outcome and Performance Pilot Studies". These studies have resulted in the careful identification of performance measures for substance abuse treatment.

As an illustration of our commitment to performance measurement and, because we know money is needed, especially in these tight times, SAMHSA will have invested just over $277 million in data infrastructure and related technical assistance to the States over five years, from $49 million in FY 2001 to a requested $66 million in FY 2005. These are all concrete examples of our steadfast commitment to build State data capacity to measure and manage performance.

Through performance measurement and management we open ourselves to accountability. The tighter our measures become, the more we can prove our effectiveness. The greater our effectiveness, the greater the number of people served, and the greater the chances for a life in the community for everyone.

As a compassionate Nation, we cannot afford to lose this opportunity to offer hope to those people fighting for their lives to attain and sustain recovery. Because the need is so great, the

President has proposed in FY 2005 to double the funding for Access to Recovery to $200 million and to increases the Substance Abuse Prevention and Treatment Block Grant by $53 million for a total of $1.8 billion. As you know, the President's FY 2005 budget is before Congress right now. The President's proposed substance abuse treatment initiatives are good public policy and a great investment of Federal dollars.

As the President said and we all know, "Our Nation is blessed with recovery programs that do amazing work." Our common ground is a shared understanding that treatment works and recovery is real. Now, it is our job to see too it that the resources are made available to connect people in need with people who provide the services.

Thank you.

Mr. SOUDER. Thank you very much.

In your testimony, you have four different ways you determined how people were going to get the grants: client choice, how clients will be assessed, acquire the supplement and no supplant, the poor, uncommon performance measurements. Were those all weighted equally? How did you sort through your applicants and if you can also add, did it matter whether they had prior experience with this, like you said Albuquerque did? And give us some feeling that this wasn't just darts at the board or something.

Mr. CURIE. That's a very good question. The peer review committee and the reviewers definitely took their jobs very seriously. We did give weighting according to what we expected with ATR. There was clear weighting given to the applicants who had to demonstrate and those who won awards had to demonstrate they did have an objective assessment process in place, that they did have the capacity to have an eligible provider list in a way of assuring that the providers were going to clearly increase capacity.

They also needed to indicate and show how they were going to assure there was not going to be fraud and abuse for using vouchers. Using electronic voucher approaches by using electronic forms of vouchers has been a way of doing that in other programs. I think most of the applicants who won were able to demonstrate they could do that.

Also, they had to demonstrate that the client would have choice based upon that assessment, that there was a clear link to the assessment and choice, that the assessment process was an objective one, that there was no conflict of interest in the assessment process and the providers they were able to select. They also then had to demonstrate and give competence to those reviewing, that they had the capacity to actually carry this out in a timely manner, in other words that they did have structures in place and would be able to implement this at least by early 2005 in terms of making the awards.

Previous experience was definitey a consideration because that would also show capacity to be able to carry this off successfully. It is clear though that this is a new way of financing and delivering services, so there were very few examples across the country of voucher programs. Wisconsin, which also happened to win a grant, also had a voucher program in Milwaukee and a track record as well.

Mr. SOUDER. They are 3 year grants?

Mr. CURIE. Three year grants, yes.

Mr. SOUDER. Are the outcomes reported annually and do you have a monitoring system for that?

Mr. CURIE. Yes. We are looking for the outcomes to be reported more frequently than annually. We will be looking and the States will need to demonstrate that they are beginning to collect outcome information within the first year. Yes, States need to demonstrate a capacity and that they would be able to glean the outcome measures from eligible providers. That would be one of the things we would expect in order for a provider to continue to be an eligible provider, that they respond to those seven domains.

Our role at SAMHSA through CSAT will be to monitor the States' overall performance and see to it that the States are holding those provides accountable.

Mr. SOUDER. One of the frustrations of any Congressman who works at all with grant requests, or at least supports those who do grant requests, has not known precisely how the measurements are done and particularly if this is going to expand to more than the 50,000 to 100,000. Did you review with the applicants that you didn't choose how to put together better programs or do they have a way to look at how to do that in the next round? Will you continue as you look at the outcomes that you are getting, do you have ways to communicate to people who didn't even apply the first round what you are looking for and how to make this program reflective of things that don't work and do work?

Mr. CURIE. I believe the answer to each of those questions is yes. We do have with all of our grant programs and discretionary grant programs the ability for an applicant who did not receive an award to ask for feedback in terms of where did they fall short and they can examine what their particular score was. We do offer ongoing technical assistance.

Just as we did in the very beginning with Access to Recovery, we held five technical assistance sessions and we had a great response to those TA sessions. One of those five was geared toward tribal organizations. I know we had over 100 tribal organizations participating as well. I think most if not all of the 50 States participated in those TA sections.

We would continue that process of outreach to encourage folks to apply. If we are in that position, it would be very good news because it means the $200 million was being appropriated but we would be prepared to do that to assue we are continuing to do outreach and expand.

Mr. SOUDER. There isn't any casual way to say this. As we move into areas that are say somewhat tinged with controversy such as voucher programs, faith-based programs, new ways of doing things, I think complete and total transparency and openness about this becomes more critical, even in our traditional way.

Normally we just respond when somebody asks for feedback. We need some sort of systematic way because this is big dollar business in drug treatment and many organizations are very concerned there is going to be a double standard for those of us who are conservative Republicans who have certain ideas about how this should be done, and may not hold quite the same rigid standards to some of the new groups coming in have been held to. I think it becomes critical to review with everybody maybe in a more systematic form like you did by targeting these different groups to also continue to do the reviews, make sure all the data becomes available.

Like you say, a lot of these are new providers. They aren't going to do it necessarily as efficiently in the beginning, but there are different types of groups. Drug cohorts don't work as much as we would like them to work but they still work a whole lot better than other types of systems and broaden to new approaches.

We have this in the Community Block Grant Initiatives under the bill that Congressman Portman and Sandra Levin did because

that was one of the ones where I sat through the first presentation, the grant applications and some of the reviews and this is even more difficult than those.

Do you have any comments on that? I know that is what you are driving toward but as you well know, doing this all the time, this is not without some stirring in the treatment community. We have to make sure they know how we are doing it and why and what is fair.

Mr. CURIE. I think your observations are accurate in this situation. Clearly, you always have with any grant process, especially when you are talking a total of $100 million and hopefully $200 million. It gains a lot of attention in the field, gains a lot of attention from the States and from tribal organizations. Just that in itself, there is a lot of emotion around because the field is, I think there is general agreement, underfunded. It is a lot of dollars, so people are very hopeful that they are able to apply and actually receive an award.

Second, you are exactly right about this particular program with the innovation of trying to bring to a systemic level vouchers and choice along with expanding the provider base to include recovery support services for the first time in a clear way which also includes expansion of faith-based providers is a change for the field as well. That becomes frought with concern and questions being raised. I think the solution of transparency is exactly the right course to take, that as we implement ATR that we are transparent about the outcomes? How it is going? Do we need to make any mid-course corrections? Are there things we are learning?

Also during the process of people who have applied, I heard you suggest perhaps we want to consider more of a global feedback overall that would not undercut the integrity of the competitive process of giving overall feedback of maybe where we saw applications of this type and things to keep in mind as we look ahead. We can certainly incorporate that into our technical assistance as we move forward.

Mr. SOUDER. Paticularly since in this category, when you hire what we call here without meaning it in a derogatory term, a "beltway bandit," in other words somebody who is trained in grants and works in a large organization, they will systematically do that. They will do that, go see who won, try to figure out how to do the exact adverb and adjective that got the grant of the winners.

But if you are out in a much broader group of people who aren't used to writing grants and you are trying to bring new people into the system, they aren't probably going to have the same hired people to do that for them in trying to figure out precisely where they are off becomes more critical and basically helps drive the program.

Also, I remember as one of the principles, batters learn by striking out. If a pitcher is going to throw them curve balls and they can't hit it, they had better learn how to hit a curve ball. Publishing what we learn from the first innovative people out there, what isn't working, is going to be important and to share that because it may be that your criteria from the first time may change but you have to be open in the process or you will have everybody gearing up to go in one direction and then find there is a shared learning experience.

We have done a series of faith-based hearings around the country. We didn't do a lot on drug treatment because we are treating this as a separate thing, but you can't deal with homelessness, with job development, with social services, child abuse without winding up with drugs and alcohol mixed in here and there. One of the things that was interesting because we always had representatives from both sides, both pro and against faith-based direct funding, was in drug and alcohol treatment, the questioning of licensed, traditional type providers versus this difficult question of drugs and alcohol which you alluded to is also a spiritual, in many cases, not necessarily in the sense of Christian, but a person has to make some kind of decision that they are going to be cooperative and that some of the failure rate in drug treatment programs isn't actually the providers not doing things right, it is people are mandated in, their family put them in, they didn't make the internal commitment and therefore they can go through an effective program and not be changed because they didn't change.

The irony here and one of the things we were hearing at the grassroots is sometimes the training may not be as high in some of these groups but the outcomes may be better because the person did a transforming or they were able to reach them in a different way, such that they dried out or got off of narcotics. Freddy Garcia is a classic example because he doesn't even do drug treatment but the people get off drugs. That clearly wouldn't be eligible under a Federal program but there are groups in between there that mix that and we heard that in at least three to four of the cities in which we did these hearings and the wide range of how to do this. It is an interesting thing when you are dealing with the psychology of drug treatment.

Mr. SOUDER. Absolutely. In fact, clearly we expected States as they look at eligible providers, because that is really I think the key of what we are talking about here, that they ensure the eligible providers met public safety standards if they are going to be receiving dollars through the vouchers. Also if you hang out your shingle and call yourself a particular kind of treatment program, if there is a license for that, you have to engage that; and also there is a range of recovery support services for which there may not be a specific State license but again, in terms of public accountability, the States needing to maintain the list of eligible providers.

Mr. CURIE. You are absolutely correct. Whenever you begin opening that, especially in a field that has really worked hard over the past 40 years to gain certification, to gain credibility along with the other health care fields, mental health and other types of primary health care, it does raise questions and concerns. I think the challenge is how do we operationalize recovery from a public policy and public finance standpoint. That is really what we are striving to do for the first time because there are many pathways to recovery. So we need to be thinking about this as a continuum because there are people whose lives wouldn't have been saved if it wasn't for that licensed, residential program, they went through a medical detox, licensed residence, they attained sustained recovery and now they are on their own personal recovery plan as a result of that.

There are others who have gone through a similar program and it wasn't until they engaged the faith-based program that recovery

took hold but also I would say probably each of those experiences added to that person being able to attain recovery some day. So I think it is clear we need a robust continuum that is available and when you have a qualified assessment and then a choice involved, I think you begin to open more of those pathways and the common denominator among all of those types of providers is holding them accountable to outcome. If they are held accountable to outcomes that reflect recovery, we think therein lies the key for public accountability that we have not seen before.

Mr. SOUDER. One of the problems we have in job training is cherry picking, for lack of a better word, that most people who go on unemployment, get off unemployment and the question is, those are the easy ones to do because probably they are going to get off anyway. What you are really dealing with is a temporary situation and you are trying to move it faster or at least claim credit as opposed to the long term dependency.

It is a little less clear to me how you would do that here but I can think of a couple types of things. Did you look in your grant system to see whether any of them were taking harder types of cases, in other words a program that specialized in taking people who failed four times?

Another thing would be in co-dependency, it is real interesting in Vancouver, British Columbia where we were looking at the heroin distribution, the needles and free heroin from the government, basically. One of the things that happened in downtown Vancouver is the areas where needles are distributed, people don't want to be and so the housing there tends to be the lowest income and people who used to be institutionalized are released in those areas. So all of a sudden they are exposed for the first time to illegal narcotics and you have this huge bump up in co-dependencies of people who have other problems and all of a sudden they are in a zone that becomes a drug zone.

I don't know whether this would be geographic, whether this would be different people who have co-dependencies, whether it would be people who failed multiple programs before, but looking for the real hard programs that really take up a lot of our drug money. I am not saying we don't need drug treatment for people the first time because if you can catch them early, you don't get them late. On the other hand, it can give you a false sense if you say we want to prove this program works, we are only going to take the people we think we can get at, first-time offenders, parents are there, wife is there, supportive, or husband. That won't give us a good read either.

Do you have a mix? Did you work to get that kind of mix?

Mr. CURIE. I am confident that we do have the mix. Again, we had another discretionary grant program we implemented over the past year or year and a half called Screening, Brief Intervention, Early Intervention Program, which is focused on those individuals who are considered the hard core, long term addict but catching them early. This program was not focused on that. In fact, this program is focused on individuals who have an addiction that is longer term. We are looking especially to hit that treatment gap with those people who are ready for service.

I think when it comes to cherry picking, the key thing to keep in mind here is this is the first time the client picks the provider. The provider doesn't pick the client. If someone is issued a voucher based upon the assessment and if a provider continually turns down people who bring vouchers, first of all, they are going to lose out on revenue but second, they have every reason to accept that client because they are going to get paid.

Second, that is what we are expecting the States to monitor in terms of provider performance. If a provider is consistently not working with the program, that would be reason not to keep them. I think there are some clear safeguards in there but I think fundamentally the objective assessment that is taking place without a conflict of interest, it is not the provider doing the assessing, and then a voucher being issued based on the client picking the provider. Again, the only way a provider could cherry pick is to refuse the client who comes with the voucher.

Mr. SOUDER. Here really it is you monitoring the States to make sure that they and their eligibility standards aren't taking the easiest ones first exposed, stable families, middle and upper income groups, no co-dependencies.

Mr. CURIE. Correct, and the other thing that is very good about the Access to Recovery, if you look at a profile and I believe we submitted that to you, of the grants that have been awarded, you see many of them are hooked into drug courts, the criminal justice system, vulnerable populations, adolescent treatment, some very tough and challenging cases just out of the shoot. So by virtue of the populations, the high risk populations that States were able to choose, again, you are not talking necessarily about an easy clientele out of the shoot.

Mr. SOUDER. I thank you for your testimony and willingness to come today. I wish I could say that the general public and Congress have become more sophisticated in this area but I think we are moving a little that way because after you put billions year after year and you hear numbers, it becomes a little bit like the old Vietnam days where you blow up the bridges and blow up more bridges and pretty soon you realize you blew up more bridges than there were to begin with. Sometimes in drug treatment and other things, it feels like you are pouring in all this money and yet the problem isn't going down or you put it into child abuse, put it into drug prevention in Colombia or wherever and we have to get more sophisticated in our measurement standards.

When groups come in and say, oh, if we can just put it into this, we will get $17 for every dollar returned and yet the Government is broke and if we did that, we would be 17 times more broke probably. We need to realize there aren't instant solutions here. This is going to be difficult. It is like a drug court but if you can get 25 percent of the people deterred or clean most of the time, it is much better than what we had before. We have kind of oversold a lot of these things and I think Congress in trying to analyze the spending, if we can show both success but reasonable success with the harder risk groups and people who weren't able to get it, it may be easier to get the money in the appropriations bills. I would hope at least that we are getting more sophisticated with that so we can avoid what good does it do to put the Government money in any-

way because we do it every year and the problem doesn't change. That is our challenge for those of us in oversight and your challenge in administration.

Mr. CURIE. Absolutely. I couldn't agree with you more. To be able to paint a picture of success that is based on real numbers I think will not only benefit us but benefit you in making those decisions, but most importantly, it is going to benefit those trapped in addiction.

Mr. SOUDER. Thank you very much for coming today.

Mr. CURIE. Thank you.

Mr. SOUDER. If our second panel could come forward: Melody Heaps, Treatment Alternatives for Safe Communities, Chicago, IL and Dr. Michael Passi, associate director, Department of Family and Community Services, city of Albuquerque, NM.

[Witnesses sworn.]

Mr. SOUDER. Thank you, Ms. Norton, for joining us. Would you like to do a statement before I start the second panel or wait until after they give their testimony?

Ms. NORTON. Mr. Chairman, the only statement I have is first to apologize that I have been delayed at another hearing and then to say how important I think this hearing is which is why I have run by. There is an introduction of a judge in the Senate I have to do.

All across the country, I think the link between access to drug treatment and elimination of crime is absolute. In the District of Columbia, we have people waiting in line for as far as the eye can see. Mr. Chairman, as you may know, there are some hard line jurisdictions that have decided to go way beyond where the Federal Government has dared venture. You have hard line jurisdictions like California, the three strikes and you are out State which inaugurate the notion of diversion to drug treatment for people caught with small amounts for the first time. I don't know how that is working out. All I know is they found their criminal justice system was so overcrowded, so costly with people who are not classic felons or classic criminals, that they have decided, for all their law and order concerns and innovations, to try something new.

I am interested in this hearing in particular and in what we in Federal Government can do to increase access to treatment, real tough treatment. There are all kinds of folks who claim to be able to treat addiction. I think treating addiction, Mr. Chairman, must be the most difficult thing in the world to do.

We all know something about addiction. Along about 10 p.m., I need grapes and it is all I can do to keep from going down to get some grapes. I have a sweet tooth and if I didn't exercise, I am not telling you I have real self control when it comes to the sweet tooth, but if I didn't exercise and do a lot of other stuff, I think the sweet tooth would have taken hold of my body by now.

Try then to analogize to somebody who, for whatever reason, has a tendency toward an addiction that is even more harmful and I think that, first of all, we can be more empathetic but then we know from our own experience that unless we fasten upon treatments that in fact say, there is something approaching carrot and stick that even the best treatment doesn't work, so I am here to be educated and thank you for this hearing, Mr. Chairman.

Mr. SOUDER. Thank you for coming.

We will start with Ms. Heaps.

STATEMENTS OF MELODY HEAPS, PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES; AND DR. MICHAEL PASSI, ASSOCIATE DIRECTOR, DEPARTMENT OF FAMILY AND COMMUNITY SERVICES, CITY OF ALBUQUERQUE, NM

Ms. HEAPS. Thank you, Mr. Chairman and members of the committee.

First of all, it is a real privilege to have been asked to testify on Access to Recovery. I particularly find it a privilege because I know the work that you, Mr. Chairman, have been doing to support treatment and particularly to look at the issues of reentry and the impact reentry for criminal justice clients is having on our communities. I applaud your work and applaud the work and interest of other members of the committee on this very, very serious, serious problem. Thank you so much.

I am Melody Heaps, the founder and president of TASC Inc. TASC is a statewide, not for profit organization headquartered in Chicago. Our primary span of services involves linking drug-involved individuals in the criminal justice system with community-based treatment and other services. In fact, by statute and administrative rule, we are the designated agent of the State to do so.

We provide the initial screening and assessment to the court, we facilitate admittance into substance abuse treatment and we incorporate a hands-on approach to providing case management services through the utilization of community resources that support clients and help them navigate through their regular social service system toward recovery. We also work with individuals involved in the juvenile justice system, the child welfare system and the TANF system.

I would like to talk to you today about Access to Recovery and how it is going in Illinois and how it is being applied, but I also want to talk more broadly about the implications of the program for people in recovery, for families and communities and for local, State and national drug policy. Like many States, Illinois continually grapples with the problems associated with drug use and crime. In our urban areas, we are among the worse in the Nation in terms of drug use by arrestees at between 70 and 80 percent. In addition, yesterday at a meeting with HIDA, we found out that Chicago ranks No. 1 in heroin deaths and in emergency admissions to hospitals for heroin. It is a ranking that does not bode well for our city.

Cocaine and heroin constantly emerge as problems and the Cook County system alone, the largest of its kind in the country, processes upwards of 55,000 felony cases each year. Most of these involve drugs or drug-related crime. Forty percent of new admissions to Illinois prisons are for felony drug possession cases. Even despite a recent attempt, the opening of a 1,000 bed Sheridan treatment and reentry prison, the large majority of our criminal justice population needs drug treatment but does not get it.

This is a population with a complex set of needs. In addition to drug use or addiction, some will have mental or physical health issues, some need housing, most need education and jobs, many

have children in our welfare system and most of them will not be eligible for Medicaid or any other kind of private insurance.

We know if we want to promote long term recovery, promote restoration of citizenship and productivity while at the same time reducing drug use and reducing crime, we have to address all of these issues. Addiction treatment may be core to the stability of individuals, but if any of these other concerns go unaddressed, their chances of returning to drug use and crime increases significantly.

It was with this in mind that the State of Illinois in partnership with TASC decided to apply for the Access to Recovery funds to support service delivery to individuals sentenced to probation with demonstrable drug problems. We already have a number of programs in Illinois that have been addressing this. There are the Statewide TASC services, drug courts, intensive drug probation but the sheer volume of probationers, over 125,000 at any given time, means that only a fraction of those needing services will have access to them.

Access to Recovery will predominantly target populations in Chicago and Cook County, two surrounding counties who aren't otherwise receiving services but we are also piloting it in some rural areas where the additional challenges like transportation, scarcity of providers are major barriers to successful service delivery. One of the key components of the Access to Recovery model is a comprehensive assessment and referral process. Any probationer that comes into our program will be assessed for needs in a wide array of behavioral and other social service areas. In fact, we are putting together what we call an assessment to develop a recovery capital index. What does the individual have in terms of his own capital? Does he have a home? Does he have a family? Do they have an education, so that we will be able to tell the degree of depletion of these resources in an individual?

Obviously substance abuse is one area. So is mental and physical health, housing, education, job training, family and life skills. Once the assessment is complete, we identify qualified providers in the client's community and make referrals.

From a service delivery perspective, Access to Recovery represents something that is rarely seen in publicly funded services of any kind. That is client choice. We know there are core services that a client in recovery will benefit from like individual and group counseling but we also know that every individual responds differently. If our goal is individual recovery, then our strategy must be to help the individual identify the programs and services in the community that will best help them achieve a place of stability.

Some will benefit from a mentor relationship, some will benefit from services in a faith-based context that addresses their spiritual needs as well as their clinical needs. Access to Recovery is truly a revolution in service delivery because it allows and empowers clients to do what works best for them.

In that regard, I do want to acknowledge the President, his vision, his promotion of and support for the expansion of treatment in our communities. I also want to acknowledge the leadership of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, particularly SAMHSA Administrator, Charles Curie, for taking hold of that vision, con-

ceptualizing recovery in the broadest and yet most personal sense and for pursuing innovative strategies like Access to Recovery.

This initiative has stimulated growth and challenge in our field that would not otherwise have occurred with a simple increase in funding. I also acknowledge the work that the Center for Substance Abuse Treatment has done in developing the proposal and in helping implement this very important program under the leadership of Dr. Wesley Clark.

Access to Recovery will bring funding to community organizations that might not otherwise have such. TASC has been operating in Illinois for over 30 years. One of the fundamental constructs of successful recovery has always been getting the community involved with the individual while the individual is getting involved in the community. Local providers understand local issues. They know strengths, weaknesses and potential challenges of reintegrating ex-offenders into their community. They are more culturally and socially aware and they understand the best circumstances that precipitated the drug use in the first place. When the client is involved in local programs, it creates a level of trust and comfort that may not exist if that same client were required to travel across town or in some instances, across the State.

From a policy perspective, Access to Recovery is important because it breaks down all the traditionally disparate funding streams and focuses funding on one thing, recovery. Success is measured by how well you assist an individual in achieving a place of clinical and social stability. This sounds like common sense but a program of this size, scope and complexity would have been almost impossible under any other previous funding mechanism. This move toward recovery focused and client focused funding started several years ago when many of the major Federal departments pooled resources for the Coming Home initiative. Access to Recovery represents the natural evolution of that strategy and I applaud the decisionmakers who were able to accomplish such a major sea change in funding and policy strategy in so short a time.

Additionally, because Access to Recovery is based on client choice, it will result in funding efficiencies we have never seen before. The right resources will be applied in the right intensity at the right time to the right people. The implications are huge. We will finally be able to start getting a handle on what we need as towns, States and as a Nation to turn the tide of drug use and drug crime.

I believe that Access to Recovery is the start of an innovative, new approach to funding and providing recovery services, an approach that focuses on what we have always been about, a full continuum of services supporting recovery which leads to the restoration of individuals, families and their communities. Right now there are 14 locations around the country that over the next 3 years will be redefining what it means to provide treatment and recovery services in an effective and efficient way. This is a critical time and a critical issue.

Thank you for your time and I would be happy to answer any questions.

[The prepared statement of Ms. Heaps follows:]

STATEMENT of

Melody M. Heaps, President
TASC, Inc.

On *Access to Recovery: Benefits and Potential to Illinois*

September 22, 2004

My name is Melody M. Heaps and I am the founder and President of TASC, Inc. TASC is a not-for-profit organization headquartered in Chicago. Our primary span of services involves linking drug-involved individuals in the criminal justice system with community-based treatment and other services. We provide the initial screening and assessment for the court, we facilitate admittance into substance abuse treatment, and we incorporate a hands-on approach to providing case management services through the utilization of community resources that support clients and help them navigate through the regular social service system toward recovery. We also work with individuals involved in the juvenile justice system, child welfare system and the TANF system in the same capacity.

I would like to thank the members of the committee for inviting me to testify on the Access to Recovery program and its potential for families, communities and social service systems. I would like to talk today about how Access to Recovery is going to be applied in Illinois and at the same time talk more broadly about the implications of the program for people in recovery, their families and communities, and for local, state and national drug policy.

Like many states, Illinois continually grapples with the problems associated with drug use and crime. In our urban areas, we are among the worst in the nation in terms of drug use by arrestees, at between 70 and 80 percent. Cocaine and heroin constantly emerge as problems in our emergency rooms and our courtrooms. The Cook County court system alone, the largest of its kind in the country, processes upwards of 55,000 felony cases each year. Most of these will involve drugs. 40 percent of new admissions to Illinois prisons are for felony drug possession crimes. And even despite recent innovations like the opening of the Sheridan treatment and reentry prison, the large majority of our criminal justice population needs drug treatment but does not get it.

This is a population with a complex set of needs. In addition to drug use or addiction, some will have mental or physical health issues. Some need housing. Most need education and jobs. Many have children in our child welfare system. And most of them will not be eligible for Medicaid and won't have private insurance.

We know that if we want to promote long-term recovery, promote restoration of citizenship and productivity, while at the same time reducing drug use and reducing crime, we have to address all of these issues. Addiction treatment may be core to the stability of these individuals, but if any of these other concerns go unaddressed, their chances of returning to drug use and crime increases significantly.

It was with this in mind that we decided to use Access to Recovery funds in Illinois to support service delivery to individuals sentenced to probation with demonstrable drug problems. We already have a number of programs in Illinois to address some of these

problems, such as statewide TASC services, drug courts and intensive drug probation, but the sheer volume of probationers – over 125,000 at any given time – means that only a fraction of those needing services will have access to them. Access to Recovery will predominantly target probationers in Chicago and Cook County who aren't otherwise receiving services, but we're also piloting it in some rural areas, where additional challenges like transportation and scarcity of providers are major barriers to successful service delivery.

One of the key components of our Access to Recovery model is a comprehensive assessment and referral process. Any probationer that comes into our program will be assessed for needs in a wide array of behavioral and social areas. Obviously substance use is one area. So is mental and physical health. So is housing, education and job training, and family and life skills. Once the assessment is complete, we identify qualified providers in the client's community and make referrals.

From a service delivery perspective, Access to Recovery represents something that is rarely seen in publicly-funded services of any kind – client choice. We know that there are core services that a client in recovery will benefit from, like individual and group counseling. But we also know that every individual responds differently. If our goal is individual recovery, then our strategy must be to help the individual identify the programs and services that will best help them achieve a place of stability. Some will benefit from a mentor relationship. Some will benefit from services in a faith-based context that addresses their spiritual needs as well as their clinical needs. Access to Recovery is truly a revolution in service delivery because it allows and empowers clients to do what works best for them.

In that regard, I would like to acknowledge President Bush, his vision, promotion of and support for the expansion of treatment in our communities. I also want to acknowledge the leadership of the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration, and particularly SAMHSA Administrator Charles Curie for taking hold of that vision, conceptualizing recovery in the broadest and yet most personal sense, and for pursuing innovative strategies like Access to Recovery. This initiative has stimulated growth and challenge in our field that would not have occurred with a simple increase in funding.

What Access to Recovery will do is bring funding to community organizations that might otherwise not have access. TASC has been operating in Illinois for almost 30 years, and one of the fundamental constructs of successful recovery has always been getting the community involved with the individual while the individual is getting involved with the community. Local providers understand local issues. They know the strengths, weaknesses and potential challenges of reintegrating an ex-offender into their community. They're more culturally and socially aware and they understand best the circumstances that precipitated the drug use in the first place. And when the client is involved in local programs, it creates a level of trust that may not exist if that same client were required to travel across town to receive services.

From a policy perspective, Access to Recovery is important because it breaks down all of the traditionally disparate funding streams and focuses funding on one thing – recovery. Success is measured by how well you assist an individual in achieving a place of clinical and social stability. This sounds like common sense, but a program of this size, scope and complexity would have been almost impossible under any previous

funding mechanism. This move toward recovery-focused and client-focused funding started several years ago, when many of the major federal Departments pooled resources for the Coming Home initiative. Access to Recovery represents the natural evolution of that strategy and I applaud the decision-makers who were able to accomplish such a major sea change in funding and policy strategy in so short of a time.

Additionally, because Access to Recovery is based on client choice, it will result in funding efficiencies we've never seen before. The right resources will be applied in the right intensity at the right time to the right people. The implications are huge, as we'll finally be able to start getting a handle on what we need as towns, states and as a nation to turn the tide of drug use and drug crime.

I believe that Access to Recovery is the start of an innovative new approach to funding and providing recovery services – an approach that focuses on what we've always been about – a full continuum of services supporting recovery which leads to the restoration of individuals, families and their communities. Right now there are 14 locations around the country that over the next three years will be redefining what it means to provide treatment and recovery services in an effective and efficient way. This is a critical time and a critical issue.

Thank you for your time. I would be happy to answer any questions.

Mr. SOUDER. Thank you.

Dr. Passi.

Dr. PASSI. Mr. Chairman, members of the committee, I am pleased to be here to speak on behalf of Access to Recovery. I am particularly pleased that CSAT found something worthy in what Albuquerque has been doing for the last several years and used our work to help shape the Access to Recovery program.

Needless to say, we believe in the approach articulated in Access to Recovery. Having built a system like it using local funds that will approximate $4 million a year during the current fiscal year, we will invest more money locally in this treatment system even while we welcome the resources that will come to us from the Federal Government. We speak here about something to which we have made a major investment and are happy to share our experiences with you.

The city of Albuquerque's system is based around two basic elements. First is unbiased assessment and referral using standardized instruments. The second is patient choice among qualified providers with subsidies available to those unable to meet the cost of care through a voucher system. Both these elements are tied together by an electronic management information system that facilitates assessment, referral, client tracking and billing and by treatment standards that assure quality treatment services.

To assure unbiased assessment and referral, the city has separated assessment from the provision of substance abuse treatment. Albuquerque Metropolitan Central Intake is a specialized agency that provides professional assessment of patients presenting for problems related to substance abuse. The primary tool used for assessment is the well known and standardized Addiction Severity Index. We administer ASI in both English and Spanish to patients in the system. For adolescents, AMCI uses the Modified Adolescent Drug Diagnosis instrument, another well known and standardized assessment instrument.

Based on the findings of the assessment, patients are referred to the treatment providers who are best able to meet their needs from within the city's provider network. This network currently consists of 20 different providers ranging from large public agencies to single sole practitioners. The network is open to any provider that wishes to join and agrees to comply with the city's clinical standards and reporting requirements. This means we welcome providers that are public and private, for profit and non-profit, secular and faith-based so long as they meet our clinical standards and are willing to accept our fees.

Income eligible patients are issued a voucher. It is not a piece of paper, it is an electronic account effectively established for them, to assist with the cost of their treatment, if they need such assistance. They are also given referrals to those providers in the network that could offer the services that meet their particular diagnosis. The value of their voucher is determined by the level of care the patient requires. For example, vouchers for early intervention, brief therapy and education, are principally for people who don't have severe substance abuse problems and many of those are first-time DWI offenders referred to us through the local courts. That

is capped at $390 per patient. For people with more severe problems, vouchers may reach $3,500.

What have we gained from this system? First, we think we have a better managed system. We have vigorous controls of treatment related expenses. Authorized units of treatment are based on objective assessments of needs and billed accordingly. We buy what is needed and pay only for what we buy.

This was not the case in our previous system built around cost reimbursement contracts with a small group of provider agencies that independently determined what a client needed. All too often in these cases, these were agencies whose principal tool was a hammer and for whom the clients' problems always looked like nails.

Beyond better management, we believe that opening the system to a broader range of practitioners has increased the likelihood of matching patients to the treatment approach and treatment setting that best meets their needs and preferences. Rather than narrow options to a handful of publicly supported providers, we now offer a broader range of treatment approaches and treatment settings that gives a system substantially greater flexibility in meeting different needs.

Most of the providers in the network moreover participate in the private market for treatment services and are not wholly dependent on the city for their financing. City-subsidized clients at a given agency in a recent 45 day period, I just picked one at random, ranged from one or two up to 165. The mean number of city-financed patients at an agency was 17.

Offering clients genuine choice in selection of a provider appears to affect the process of treatment in a couple of important ways. First, there is some element of market discipline. The patient is free to change providers if he or she does not believe that their needs are being met. We actually have had relatively few patients electing to change providers in midstream but they are empowered to do so if they want to and that appears in some way that I haven't been able to establish by research to better engage them in the treatment process.

Moreover, I think and more importantly, simply having choice from the outset makes the patient an active, empowered participant in the treatment process. They are not just routed there by government, they are required to commit at least that one initial act of choosing a provider.

How does this affect their outcomes? I can't say we are getting better outcomes now with a differently managed system than we were before. The only reason I can't say that is because our data from the way we operated before was so bad that I have nothing to compare what we are getting now against. We do have methodologically valid data, however, to show that we are getting positive outcomes, reduction in drug and alcohol use, reduction in binge drinking, reduction stress, reduction in depression, reduction in anxiety through the treatment process.

Shortly before ATR was launched, we in fact launched a similar initiative locally looking at domains of outcomes, establishing three at least that are similar to CSATs looking at sobriety, employment and criminal justice involvement. I don't have the data yet to report to you the results but initial outcome data looks positive for

us. I think it is important that we all recognize that outcomes aren't driven by the way in which the system is managed alone. It is also dependent on the quality of the treatment services that are out there.

Recognizing that, we have allocated about $200,000 a year in local general funds to support improving treatment to all of those 20 providers within the substance abuse system to try to increase their knowledge and skill in applying evidence-based treatment practices.

That, members of the committee, is the Albuquerque system. I would be happy to answer any questions you have.

[The prepared statement of Dr. Passi follows:]

A Summary of the Albuquerque Model for Substance Abuse Treatment Services Management

The City of Albuquerque's system is built around two basic elements. The first is the unbiased assessment and referral using standardized instruments. The second is patient choice among qualified providers with subsidies available for those unable to meet the costs of care through a voucher system. Both these elements are tied together by an electronic management information system that facilitates assessment, referral, client tracking and billing and by treatment standards that insure quality treatment services.

To assure unbiased assessment and referral, the City has separated assessment from the provision of substance abuse treatment. Albuquerque Metropolitan Central Intake (AMCI) is a specialized agency that provides professional assessment of patients presenting for problems related to substance abuse. The primary assessment tool is the well-known, standardized, Addiction Severity Index (ASI) which we administer in English and Spanish. For adolescents, AMCI uses the Modified Adolescent Drug Abuse Diagnosis (MADAD) instrument.

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Income eligible patients are issued a "voucher" to assist with the cost of their treatment along with a referral to appropriate providers within the network. The value of the voucher is determined by the level of care the patient requires. For example, vouchers for "Early Intervention" (brief therapy and education) which is principally for persons without severe abuse problems—many of them first time DWI offenders—is capped at $390. For Intensive Outpatient treatment with methadone, on the other hand, a voucher may reach $3,510.

A patient is issued a voucher following assessment which is activated when that patient is admitted to treatment with a network provider. The patient has up to one year from the time the voucher is issued to enter and complete voucher funded services. Providers may bill against the voucher for set rates for various services. The AMCI database automatically matches the services provided against what was originally authorized under the voucher and the patient's account is automatically debited until the funds are exhausted. If treatment needs to continue after the voucher is exhausted, the treatment providers are expected to transition the client to a sliding fee scale.

During the fiscal year beginning July 1, 2003, AMCI received service requests for 3,347 unduplicated patients. Of these, 3,306 were offered assessments, 3,296 completed assessments and were provided referrals for treatment (subsidized and unsubsidized),

2,870 were assisted with vouchers, and 2,631 were admitted to, and received, subsidized treatment services. The total amount of treatment billed through their vouchers was $1,463,100.

Alcohol abuse or dependency was the most frequent diagnosis, with 46% of the patients reporting these as their primary problem. This was followed by opioid abuse/dependence (17%), cocaine abuse/dependence (8%), and amphetamine abuse/dependence (5%). The primary source of referrals was the criminal justice system, which accounted for more than 58% of patients entering the system.

What have we gained from this system? First, we think that we have a better managed system with rigorous controls of treatment-related expenditures. Authorized units of treatment are based on objective assessments of needed services and billed accordingly. We buy what is needed and pay only for what we buy. This was not the case in our previous system built primarily around cost reimbursement contracts with a small group of provider agencies that independently determined what treatment the client's needed. To agencies whose principal tool was a hammer, most client problems looked like nails.

Beyond better management, we believe that opening the system to a broader range of practitioners, increased the likelihood of matching patients to the treatment approach and setting that best meets their assessed needs and preferences. Rather than narrow options to a handful of publicly-supported providers, we now offer a broad ranger of treatment approaches and treatment settings that gives the system substantially greater flexibility in meeting differing needs. Most of the providers in the network, moreover, participate in the private market for treatment services and are not wholly dependent on the City for their financing. City subsidized clients at a given agency in a recent 45 day period ranged from only one or two to 165, with a mean of 17.

Offering clients genuine choice in the selection of a provider, finally, appears to affect the process in a couple of important ways. First, there is some element of market discipline. The patient is free to change providers if she/he does not believe that their needs are being met. We actually have had relatively few patients electing to change providers even though they can take their voucher accounts with them. More important, perhaps, is that it makes the patient an active, empowered, participant in the process from the outset.

How has all of this affected treatment outcomes? This is a question about which we must be cautious, in substantial measure because we have no valid way of comparing the current voucher based system to the system of fixed, cost-reimbursement contracts that preceded it.

Still, the methodologically valid outcome data we do have is encouraging. Clients report a reduction in alcohol use, binge drinking, drug use, stress related to substance use, depression, and anxiety.

Mr. SOUDER. Thank you.

Let me make sure I understand precisely how this is working. Dr. Passi, you are in the city of Albuquerque and the State of New Mexico received a grant and then it went to your organization in the city of Albuquerque?

Dr. PASSI. Mr. Chairman, the Albuquerque system was developed using local funds prior to ATR. When CSAT was looking at designing ATR, our system was one that they looked at as a system that uses a voucher-based program in order to finance drug treatment. So we have been doing this for about 6 years, entirely with local funds.

Mr. SOUDER. Have you received any Federal funds from this new program at this point, Access to Recovery?

Dr. PASSI. We are a partner with the State of New Mexico. We have not yet received funds. The funds have not been released to us as yet.

Mr. SOUDER. Because New Mexico is listed as one of the recipients, when you say you are a partner, it means you will be one of the groups that most likely will receive funds from the State of New Mexico or are you designing the State of New Mexico program or a mix thereof?

Dr. PASSI. I think it is a mix thereof, Mr. Chairman.

Mr. SOUDER. Because you do have experience with it, you are unusual. I understand that. I am just trying to figure out how it works.

Dr. PASSI. I believe the New Mexico State proposal to CSAT was to expand treatment in Albuquerque using funds and particularly in our case, we want to expand and support recovery activities in relationship to treatment. Moreover, we would work with the State to help other communities, namely Santa Fe, Las Cruces and one of the Indian Pueblo groups implement a system comparable to ours using our methods and our electronic processing systems.

Mr. SOUDER. So the State grants can be used both for actual treatment for those who are addicted and for setting up programs?

Dr. PASSI. It will be necessary to do some work in setting up programs, I believe, in every one of these grants. In the case of New Mexico, I think we will be able to move more quickly because Albuquerque has a system in place with a web-based way in which screening and assessment can be done and communicated to providers, a billing system whereby accounts can be created for patients and billing done.

Mr. SOUDER. Ms. Heaps, the State of Illinois got a grant and then you were picked as one of their recipients?

Ms. HEAPS. The State of Illinois asked us to help them come together to design the program because we are a designated agent of the State working with the criminal justice system. The decision was made to target probationers within that system. So we sat down together to design the program.

The funds come to the State of Illinois, a portion of which will come to us for the work we do, the diagnostic assessment, the referral to treatment, the case management and the information technology that will trigger vouchers. The State retains the dollars for the treatment and will through the electronic management system be funding the programs that do take our clients.

Mr. SOUDER. And then in setting up the system, are you setting up predominantly for Chicago or for all of Illinois?

Ms. HEAPS. Because of the vast numbers we are dealing with and obviously limited resources, we targeted Cook County as the primary seat because of the vast numbers of probationers that are there. We also added two what is known as color counties which essentially are suburban/urban areas and then added some rural areas, two rural counties, so that we could see how this pilot would be were it to be expanded statewide.

Mr. SOUDER. In a metro area as big as Chicago, individuals have vouchers, but how many providers would you guess there are in Chicago?

Ms. HEAPS. Around the State, there are 140 providers with about 462 sites. Probably at least three-fourths of those are within the Chicago metro community. We, as TASC, have developed a provider network with actually every one of the 140 licensed treatment providers and also have been working in terms of recovery with many of the faith-based and other institutions job programs that would help our clients in the past. So we have a network already in existence but it has not been systematized, it has not been fully funded and this gives us an opportunity to do so.

Mr. SOUDER. In addition to those in the system trying to track new people, do you have a process for clearing them for approval to make sure they are adequately licensed?

Ms. HEAPS. Yes. We have a set of standards we developed with the State. They just be licensed and certified as treatment providers. If they are not direct treatment providers but perhaps recovery support people, do they have a license if they are treating people in terms of safe buildings, etc. Is it a corporation not an individual, do they have a sound fiscal mechanism, do they have a set of standards for providing the service they have, do they have experience in dealing with this population? In order to make sure of that, we will also have and are engaging now an orientation program, a training program for those providers that are not used to being more sophisticated perhaps as you were talking about earlier with Mr. Curie, in dealing with Federal funding. So we will have an ongoing training program actually facilitated by the addiction technology transfer centers that are a part of CSAT but are locally based.

Mr. SOUDER. Before I yield to Ms. Norton, let me see if I can make one more kind of global picture or sense out of something. The sheer volume of probationers, you said over 125,000 at any given time, not in the course of a year but at any given time?

Ms. HEAPS. Any given day, right.

Mr. SOUDER. That is Chicago and Cook County or statewide?

Ms. HEAPS. It is statewide but 80,000 I believe are in Cook County.

Mr. SOUDER. Of those 80,000 probationers, how many would you say are drug and alcohol related?

Ms. HEAPS. The research suggests that we are dealing with 60 to 70 percent that have some issues.

Mr. SOUDER. So 60,000, it looks like?

Ms. HEAPS. Exactly.

Mr. SOUDER. So you have 60,000 people there. Do you know how many of the percentage of the mix of 80,000 are juvenile adults?

Ms. HEAPS. We are dealing with the adult population in that number. We are not dealing with the juvenile population. We will only be focusing on adults courts.

Mr. SODER. So in your Chicago area program, you are only going to be dealing with adults?

Ms. HEAPS. Yes.

Mr. SODER. And only dealing with adults on probation?

Ms. HEAPS. Yes, that is right.

Mr. SODER. And only drug and alcohol?

Ms. HEAPS. That is right.

Mr. SODER. So we are probably at around the 60,000 number?

Ms. HEAPS. Yes, 50,000 or 60,000.

Mr. SODER. Do you have a criteria that the person has to have, as we talked about earlier, whether it is some risk or some ability to show an interest or is it that they are high risk? You are not going to have the dollars to do all 60,000?

Ms. HEAPS. No, we are not.

Mr. SODER. If we were looking at 50,000 in the whole Nation, it is unlikely that you are going to get 60,000 in Chicago?

Ms. HEAPS. That is quite clear. Again, because we have been working with probation for so long and have been working with them in terms of their screening mechanisms, we are going to take advantage of what they do in terms of screens. We are going to use the idea of people want to volunteer for treatment. We are also going to be looking at probation initial screens that suggest there is some activity perhaps in probation compliance, perhaps the hard cases you were talking about that indicate this individual may have a serious drug problem. He then would be referred to us for a full diagnostic assessment and if found drug or alcohol addicted or abusing, move into the treatment of their choice.

Mr. SOUDER. Thank you.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

Ms. Heaps, as I listened to you describe the licenses, I think I heard all kinds of licenses but I am not sure I heard any kind of license or certification for professional proficiency in treating people with drug or alcohol addiction. Is there any such certification of licensing in the State of Illinois attached to your program or to this particular program that is under review here today?

Ms. HEAPS. By administrative rule in the State of Illinois, all licensed programs must have certified addictions counselors and there is a certification training program and annual training they just comply with. So all licensed programs have individuals treating individuals who are certified in addictions counseling.

Ms. NORTON. Can programs that are not licensed get the funding that is under discussion today?

Ms. HEAPS. Absolutely. We estimate that programs that are not licensed, programs that will do the recovery support, whether it is the spiritual counseling or the jobs or education, who will not or may not be licensed as a treatment program will, through our program, be able to get support, will be able to get the voucher paid for their services. We will do so based on a set of standards that

I was talking about, bringing them in for training and orientation. In a mechanism, we are projecting that by the end of the second year, almost 40 to 50 percent of the dollars will be going to other recovery support service programs, not simply licensed treatment programs.

Ms. NORTON. I tell you what, Ms. Heaps, I am very fortunate with my children. If I had a son or a daughter who had an alcohol or drug problem, one of the first things I would look to would be to see the level of professional proficiency. I raise this only because I look at the series of things that HER uses, those are the things you look to, abstinence I don't know for how long, stable housing, social connectiveness. I am very troubled by programs that are unlicensed or uncertified, very frankly, because I see them all around. They hover around these communities. The communities that have the greatest drug addiction have all kinds of programs springing up with people who are just like me, they don't know anything except they claim to have the ability to treat people with what I regard as the hardest of all things to treat. Give me cancer or heart disease, the causal relationship I think has worked out there better than an addiction.

I just want to indicate my skepticism not of what you are doing but of the very idea and I speak from seeing the programs that abound. For example, if any religious program can get money, I happen to know that people who are most affiliated with a church are most likely to be able to be drug free. We have many ministers who have mentoring programs here quite unrelated to whether the Federal Government has dollars to hand out or not because they understand the relationship between faith and drawing people from addiction. Alcoholics Anonymous, for example, has often been faith-based.

I have been very troubled by some of these folks who claim to be able to meet standards like this, particularly since the standards see so amorphous. I just want to indicate that skepticism here because these programs have grown up so often in the African-American community and it is very easy, particularly if you are a religious-based program, to show a tiny group of folks who were affiliated with your church or who you can show in fact met these standards. So much for that.

The most of those affiliated with your two programs come out of the criminal justice system. Do most of them in one fashion or another have some contact with the criminal justice system?

Dr. PASSI. Representative Norton, about 60 percent of the patients that flow through Albuquerque Metropolitan Central Intake are referred to it from the criminal justice system.

Ms. NORTON. About 60 percent?

Dr. PASSI. The other 40 percent are self-referred or come from other referral sources.

Ms. HEAPS. Under our program, it will be 100 percent. They will be under the jurisdiction of the probation department coming to our program.

I concur with your concern that drug treatment be delivered by licensed professionals and I think the State of Illinois worked very hard to make sure and has a very rigorous licensure program in place. So we are using them for treatment but we also recognize

that we are dealing now with partnerships and that there are job programs, faith-based organizations out there that need to welcome these individuals in the community and surround them with support.

Ms. NORTON. That is very good if you are a job program but if you are in the business of helping people free themselves from addiction, you are in a very tough business and I think you have to be able to show some proficiency. The standard I use for the people in poor communities is the standard I use for my son and I don't see that as the standard if people can get government money who don't have that kind of professional proficiency.

Your 60 percent and your 100 percent also tells me that the best way, which I think is very typical, to get drug abuse or alcohol abuse treatment is to knock somebody in the head or commit a crime. I just think we have to face that. There are all kinds of folks waiting in line saying catch me before I kill. I know I am a crack head. In fact, if you are virtually possessed with this addiction, the notion of having to go to jail first is very troublesome. I don't know what to do with that except that they are waiting in line. We can get hold of them but we are not doing that.

I would like to know, finally, your evaluation of drug courts and what you know about drug courts. That is not a choice exactly. We have one here that is very successful. It is a kind of choice because you do choose to deal with your addiction and the crime that may be associated with it or you have made another choice, the choice to go through the traditional criminal justice system. I wonder what you think of that choice, the drug court or if there are drug courts in your jurisdiction with which you are familiar?

Ms. HEAPS. Yes, Representative Norton. In fact, we run six drug courts in the State of Illinois or are affiliated with them. TASC is a precursor to drug courts. It was set up in the early 1970's to be a sentencing alternative to incarceration for individuals involved with drugs. So much of the drug court protocols emerged from what had been TASC protocols but concentrated now on an individual courtroom where case processing of drug cases were to alleviate much of the overwhelming drug cases that were coming into the justice system practically shutting it down.

Our experience in the criminal justice system as a leverage for successful outcomes I think follows what research was done particularly by UCLA which because we know addiction is a disease of denial, when the choice is treatment or jail, and the individual not always, not always chooses treatment, I can't tell you the number of our clients who would rather go to jail knowing they will get out in 4 to 6 months or maybe a year rather than go into treatment where if they fail, the consequences will be severe. People are more likely to succeed, be retained in treatment if there is some jurisdictional hammer as it were over their head. So drug courts can be a very effective mechanism for moving people into recovery and retaining them in treatment. We know that the longer you can retain an individual in treatment, the better chances for recovery.

Dr. PASSI. Our experience in Albuquerque has been similar. We do have a drug court and in fact we worked closely with the local district court in establishing their treatment protocols. All evidence is as Ms. Heaps suggests that for a certain portion of the criminal

population, this is an effective way for us to get them into treatment and second, to retain them in treatment.

Ms. NORTON. I will just say in closing, Mr. Chairman, I think both of you have indeed targeted the group I am talking about. We can't get to most people ahead of time. It is naive to think when we don't get to people that all you have to do is arrest them and that will deal with it.

I have been very impressed by what judges have said about the effectiveness of drug courts. I very much endorse the notion of choice. I think the first choice you have to make in order to free yourself from addiction is that you want to do it. That is kind of the ABCs of how to proceed. That is why so many people don't make it time and time again. Of course if you make that decision and you have a choice and you find a particular program that suits you, that would be even better.

I suppose I am most concerned with the place, and Chicago would know all about this, where addiction almost comes naturally because you are in neighborhoods where people are surrounded by addicted people, by the selling of drugs, and if we know that is going to be the case, it does seem to me that we have to face the fact that once that first drug related crime is committed, we have a magic opportunity to get hold of that person in a carrot and stick way and therefore that the drug court may be one of the best approaches or devices that we have been able to use at least for those who are most likely to come in contact with the worse kind of addiction.

I do note and was fascinated, Dr. Passi, that you said alcohol addiction was more prevalent in your program than drug addiction. So all these things have to be very much tailored to the jurisdiction.

Thank you, Mr. Chairman.

Dr. PASSI. Multiple addictions really are increasingly the character of the patients that we see. They may be present for alcohol abuse but subsequent analysis I think shows that most people use a fair panoply of chemical substances from time to time or on an ongoing basis.

Ms. NORTON. Mr. Chairman, not only with grapes but grapes, ice cream and cookies. [Laughter.]

Mr. SOUDER. We have been joined by Mr. Ruppersberger as well as our distinguished ranking member, Mr. Cummings. I will yield next to Mr. Ruppersberger.

Mr. RUPPERSBERGER. Thank you.

Sorry, it seems we had a lot of hearings at the same time today, so if I ask a question that has already been asked, let me know.

First, if specific services are not available in one area, are patients allowed to be transferred to other areas or even other States under the program?

Ms. HEAPS. Not other States, but certainly in the city of Chicago, other areas and maybe in the instance of the color counties or the rural counties, we would be able to allow them to access services in another area, yes.

Mr. RUPPERSBERGER. As far as the actual patient, drug addiction is an ongoing battle. If a patient fails in one area or regimen of a treatment, does that mean that it is a one shot deal or can they

be involved and stay in the program until they get what they think they need?

Ms. HEAPS. I believe there will be different answers because of the nature of our population. In the instance of our population, which is under the jurisdiction of the probation department, if an individual fails in treatment, doesn't comply with what the court or probation order says, then through a case management conference with probation, TASC and treatment, we will look at the individual and say, can this person benefit from a different treatment, from a different placement? We may try that but if the probation office says we think this person is a threat to the community, we may not be able to offer them a second chance.

We at TASC have consistently tried to offer people second chances, particularly looking at their case and what may need to be modification of the initial treatment. We would hope to be able to give them a second chance as long as we are not jeopardizing community safety in doing so.

Dr. PASSI. In Albuquerque, we presume that substance abuse is a chronic and a recurring illness and that patients are highly likely to have one or more relapses in the course of their recovery. How that might affect their relationship with the criminal justice system has to be dealt with differently than how it affects the relationship to the treatment system. Rather like those cigarette ads you see on the Metro in Washington, DC, don't stop quitting, I believe that we would welcome patients back into the system again and again.

Mr. RUPPERSBERGER. I am going to get a little parochial and I know you are from different States. I represent, along with Congressman Cummings, the Baltimore metropolitan area and Baltimore City. We do have a serious problem as does Chicago and other areas. It is my understanding that our State has not either made application to get the moneys that are available for these programs. What suggestions would you have for the State of Maryland or any State that really hasn't taken advantage of this program to move forward and to get the benefits?

Ms. HEAPS. That is a very good question. Knowing a little bit about the work that Maryland has done. Maryland has a drug court, I believe, and you have had TASC programs. So obviously from my standpoint, the first thing is to look at the client population that does not now have access to treatment and decide where and how you will isolate that population and give them access. Do you want to move criminal clients into treatment, do you want to make it broader, what level of treatment do you have in the community if you do make it broader?

It seems to me that the State needs to partner with local or statewide private agencies as Illinois did with us to conceptualize the system and designing the system so that you might be able to apply next year. I am surprised, quite frankly, that Maryland did not apply. It would seem to me it is a classic case, much like Chicago is, and that some of the same decisionmaking processes would be potentially successful given your experience, given the breadth of your treatment, and given the fact that I know Baltimore has worked on this issue before. Hopefully you would be able to do so and I would be happy to talk with anyone in Maryland or the city.

Mr. RUPPERSBERGER. That is good and we might followup.

If you were to go somewhere to get involved in this program for the State of Maryland and Baltimore, if you were me, where would you go, to the Governor, to the Mayor? What I am trying to find out is how we get started because there are a lot of resources here that may be very useful.

Ms. HEAPS. The State must apply for these grants. So it is the State, the Governor's office that must do the application, submit the application. Obviously the Governor's office has to work with your single State agency for substance abuse and potentially with leading providers in the community and/or criminal justice system.

Mr. RUPPERSBERGER. So the mayor?

Ms. HEAPS. Yes.

Dr. PASSI. I would echo that and I would say the city of Albuquerque has had a fairly good relationship with the Baltimore substance abuse systems since the time we were both target cities under CSAT. I believe that Baltimore has in place the basic structure to make an ATR system work. I think it is a matter of getting the Governor together with the mayor and utilizing what I at least the last time I was looking at it was a very strong structure. It may have simply been a choice to wait as some States did.

Mr. RUPPERSBERGER. For what reason?

Dr. PASSI. That the commitment to just building one of these systems is fairly major and I know there are some States that have elected to wait for an additional round of funding to see what happens with the initial grantees. Indeed, the manager of our system could not be here today because she is in Utah working with the State of Utah to assist them in preparing an application for a future round.

Mr. RUPPERSBERGER. Just one more question because my time is up. It is my understanding that Maryland did apply, did not get the grant, so if that is the case, what happened, not Maryland but generally. When States are not given the grant, what is the reason?

Ms. HEAPS. I can answer that to some extent because I am a member of the Center for Substance Abuse Treatment Advisory Council. Because of this grant, all advisory council members must vote on applications that come into the center. Access to Recovery was one. Because we were part of an application, I had to recuse myself.

However, in the previous testimony by Mr. Curie and from what I understand, there was a peer review committee that ranked the proposals according to proficiency, identification of the population, the ability to develop an independent voucher system, information system, the ability to show you have a large network of providers out there, both licensed treatment providers and other recovery support providers. So there are a series of standards which I think are objective and you could easily obtain through the Center for Substance Abuse Treatment.

Mr. RUPPERSBERGER. Does the State put in the application or the city?

Ms. HEAPS. The State of Maryland would.

Mr. RUPPERSBERGER. Thank you.

Mr. SOUDER. Thank you.

I will now yield to our distinguished ranking member, Mr. Cummings.

Mr. CUMMINGS. First of all, thank you all for being here and thank you, Mr. Chairman, for calling the hearing. I am going to be very brief. Because of another meeting I did not get here earlier.

I am interested in data collection. One of the things Ms. Norton was alluding to was how these folks pop up and I just think whenever government has money to give out, there is going to always be some persons or entities that pop up and decide that they want to be a part of the process and sometimes they are not qualified.

I agree with Ms. Norton and I know you agree with her too that drug addiction is a very, very, very tough thing to deal with. I have seen in my district in Baltimore people who have been off for 15 years, clean, go back. I have also seen something that is of great concern and that is that the people who are out there, the recovering addicts, they know the good programs which is interesting. They will tell you in a minute which programs are I don't want to say fraudulent, but that aren't effective.

I am just wondering, is data collection a real challenge for you and how do you measure the progress? You may have answered this earlier but it is something that is very important to us because we spend a lot of time in this subcommittee trying to address the issue of effectiveness and efficiency with regard to treatment and of course, the spending of Federal dollars. What happens is I think it is criminal to put somebody through a program that is not a program that effectively deals with them, then they go through a process, they are not in a position for maximum potential for recovery and then they go back on the street. The next thing you know, they sometimes end up worse off than they would have been if they had never entered the program because they are so frustrated and they have been bamboozled. I am just wondering how do you address those issues?

Ms. HEAPS. Again, both of us probably have very similar and a little disparate ways of doing it. In the instance of our program, we have an information system and a hands-on case management system that will track a number of things. Did the client show up for treatment, does the client comply with treatment? We will be in the program checking the client files, meeting with the counselor, recording that and that then gets played into an information system data base which gets reported to the State and gets fed back to the treatment provider and the client, by the way. It is important that the client see what their record and compliance is.

There are on top of that the outcomes that have to be measured as a part both of the Federal program but even if the Federal program weren't there, there are outcomes we have always measured in terms of is the client complying with treatment, are they moving in treatment, are they drug free, is their status drug free, are they looking or is there a stable living arrangement, is there family or social engagement, do they have education or a job, are they crime free? So there are a series of outcomes which are frankly not rocket science. They are basic to what we know it means to be a citizen in our communities. Those outcomes are applied to every individual case, the data is collected, it is again transmitted to the various parties.

In addition, there are data required that look to do treatment providers open their doors, do the individuals have access to treat-

ment, what is the number of treatment providers, who is licensed to do the treatment versus who is a recovering support service in Illinois' system? The money that will go to licensed providers and to recovery support services will be tracked again with hands-on case management and data collection. So we will know very, very detailed, per case what is happening in that individual's recovery.

To the issue that has been raised and you raised again, it is true that money can bring a lot of folks to the table, many of whom really have a client's recovery in mind and many of whom do not but I think each of us has had to set up standards for participation in this program. I have a list here which I would be happy to provide for you, a faith-based organization that has had experience in the community, that is a legitimate organization that knows how to handle the population can offer the kinds of support and services that are critical to support recovery.

Dr. PASSI. We are getting pretty good at tracking process. Our system works really well at making sure we are getting what we pay for and we are paying for what we need according to an assessment instrument, but I think you are looking beyond that and that is where I think CSAT is making remarkable strides with the ATR program. That is to say, let us just stop measuring process, let us start measuring outcomes. I think the domains that they lay out, abstinence, employment, crime and criminal justice, family living conditions and social support are really the things that we have to start measuring and that we can measure. It is not real easy. There are some problems that we have run into in measuring criminal justice involvement. You can't rely solely on self report obviously and matching records from the criminal justice system with patients in the treatment system and confidentiality issues that get in the way but those issues are overcomeable.

I now believe we are making major strides toward being able to say is patient X abstinent for a month, a year, 5 years after treatment; are they not arrested; are they arrested once; are they arrested weekly; did they get a job, did they not get a job; did they get housing or are they on the street? Those are the things ultimately that I think the addiction treatment system is aiming to affect. We are not simply in the business of providing treatment, we are in the business of buying abstinence, of buying employability, of buying recovery, I think is the concept that goes with it. Those are objective things, things that can be measured and those are things that we should be measuring.

The city of Albuquerque started that before ATR in baby steps. We think ATR will push us to look at all of those domains, measure those domains and ultimately reward practitioners for their ability to produce positive outcomes in those domains.

Mr. CUMMINGS. Before I came to Congress, I was in the State Legislature and I also practiced law. A group of mainly gentlemen in my neighborhood, professional men, got together voluntarily and worked with a lot of people who were coming out of our boot camp program on Saturdays in a self help program, and didn't get a dime from the government. I looked at one of these evidence-based domains, social connectiveness. I don't know exactly what that means and I am sure you will tell me.

We did this program for about 3 years and we noticed there were people who were socially connected but they were connected to the same people that sent them to prison. I can tell you one of the things we noticed too was the people who found a whole new set of friends and/or reoriented themselves toward loving their family, it may have been a child, it may have been a wife, they may get married or something like that, those were the guys I see on the street today who never went back.

A lot of this was drug related, things they had been in boot camp for. They never went back and were living productive lives and almost everybody who went back to the social group they were from are back in prison and usually have committed much more serious offenses.

When we talk about social connectiveness, what does that mean? Does that mean going to church?

Ms. HEAPS. You actually, I think, defined it yourself. This idea of family, getting back with a child, reinvolvement with the family, going to church, going to peer support, AA, Winners Circle, a number of communities. We aren't talking about social connectiveness going back to the gang. We are talking about changing perhaps patterns of social connectiveness that are constructive, that are supportive, that are healthy. That we have to look at and there are ways to be doing that. That is where I think faith-based organizations have a huge role in this. In some of our communities, they are the only institutions, especially for people in some of our communities with huge reentry. I think the faith-based community has a wonderful role in helping develop social connectiveness.

Mr. CUMMINGS. You would agree, I am sure, with Ms. Norton, if you are going to do the faith-based, you also have to make sure you have the professional piece in there. As the son of two preachers, I have all faith but I also know you need to have some professionalism in there too.

Ms. HEAPS. Yes.

Mr. CUMMINGS. One of the things I know, I know about people who have been addicted. They are first of all, usually some of the best manipulators. I couldn't help but think about a good friend of mine who borrowed my lawnmower, said he was going to cut some grass and wanted to make a few dollars and I never got my lawnmower back but I did see it at a used lawnmower place about 3 weeks later, on sale for about one-tenth of what I paid for it.

I guess what I am trying to get to, I just think for people who may be naive with regard to recovery and there is another piece. One of the things I have noticed is that people will come to my office and say to me because they have been through a 12-step program and may have 6 or 7 years being clean, and will say, I want to start a program as if they now have become the experts because they have sat in the 12-step meetings, gone through the anniversaries with different people and for a lot of folks, it is a way to get into business.

They may have good intentions, but again, they may not have the support systems and all that. On the other hand, one of the things I have noticed is a lot of people who have come before us in this committee have had histories of drug addiction problems and have clearly made some tremendous strides and are being very

effective, or at least appear to be very effective and efficient in what they are doing.

How do you make sure you guard against all of that? That is tough.

Ms. HEAPS. I know the depth of concern here. I can hear it obviously and it is not the first time I have heard it. I don't mean to minimize it but it really isn't rocket science. It is called partnership. In Chicago, our licensed, certified treatment counselors at TASC go and work with the faith-based organizations or other organizations, go into their facilities, talk with them, orient them, try and orientate them, try and work with them, look at what resources they have to offer, construct a program that would make sense for the clients we see in a community that need to be reintegrated fully. So it is possible to do in partnership.

I agree with you, there has to be people who know the business of treating drug offenders or drug addicted individuals as a part of the process. What we have learned is when we just use that in terms of addiction and didn't deal with the other issues, people were falling away. They had finished the drug treatment and then they would reoffend and get back on their addiction patterns because we weren't using the other supports in the community, weren't dealing with the spiritual aspects, the job aspects and this program does in a unique way allow us to very effectively integrate both in an efficient manner.

Mr. CUMMINGS. Last but not least, Mr. Chairman, as you were talking, I could not help but think you know I am always fascinated by Starbucks and how Starbucks has become so popular. I think one of the reasons why Starbucks has become so popular is people need a social place to go. If they don't want to go to a bar, they need some place to go. I think you are right with regard to faith-based organizations. I think it is a great place for people to go. They go to church, they have all kinds of functions, dances, singles ministry and all this kind of thing, but I just want to make sure that we are very, very careful.

You may be listening to me and may be saying he is concerned about the money but I am concerned about something even more important than the money, the credibility of treatment because up here if people don't feel that treatment is working, then the money is not going to come from the Federal Government. That is the problem. When people believe that it is working and we have made some tremendous strides thanks to the chairman and many others, toward treatment. The more we know there is some accountability, the more we know it is working, I think the more Members of Congress are open to seeing those funds are flowing into those programs. It is just a win-win when we do have that accountability.

Dr. PASSI. If I might weigh in on that for just a second, Congressman. The first question you ask your oncologist if you have cancer is not are you a recovered cancer patient, you ask what is your training as an oncologist. If the oncologist happens to have recovered from cancer, that may make him a more sympathetic physician.

I think increasingly we have to ask the same kinds of questions of drug treatment providers and in the city of Albuquerque we certainly are doing that. We are first of all demanding the highest

standard of licensure that we can under State regulations. More than that, we are investing local funds to increase the level of skill of those practitioners in evidence-based treatment practices. Professor Bill Miller who is an outstanding substance abuse treatment researcher happens to be at the University of New Mexico and I think Bill estimates that something like 80 percent of the money we spend, not just public money but all of our money, is being spent on practices that we know don't work and 20 percent of our money is being spent on practices that we know work.

I think that the approach that we have adopted in Albuquerque, and I think the approach implicit in Access to Recovery, is going to try to shift that balance because this is not just about getting people into any treatment. It is getting people into the right treatment and the right treatment has to be those modalities that we know will succeed.

It ain't rocket science. We know a bunch of stuff that is out there that is working. We just have to start paying people for doing it.

Mr. CUMMINGS. I have to ask you this and then I am finished.

You said something that just hit me, just struck me. When we are talking about quality, do we have anything anywhere to your knowledge, like lawyers and teachers, you have to go back for certification if there is a new method. You need to know what is up to date. Do we have anything like that in Albuquerque, for example, so you keep the people who are doing the treatment right on the cutting edge of what it is that works and are constantly showing them these examples like you have a place right up the street which is extremely effective because they use this method and we believe this is the best practice? Are there actually mechanisms to do that?

When you say 80 percent of the money is being spent on things that don't work, if that program was being funded by the Federal Government, it would have some real problems, I am just telling you.

Dr. PASSI. I think there is a real slow knowledge transfer process that takes place and almost every State as a mechanism for doing training with its providers. We in Albuquerque believe that can happen more quickly, especially when we keep in mind that it is largely money provided by the Congress and by the taxpayers that is funding research that tells us what are the best ways to approach these.

Mr. CUMMINGS. The key is getting that research to the people who are doing the treatment.

Dr. PASSI. I agree.

Mr. CUMMINGS. Do you all have any recommendations on that?

Ms. HEAPS. There are two national bodies that I am aware of but forgive me, my brain being dead, I don't remember exactly the names but there are counselor certification boards that work with individual States to develop. Illinois, for instance, has a State certification board that requires counselors to get annual training, there are standards, there is a course of activity based on the research coming out of NIDA. I will be happy to get you that information so that you have some comfort level that there is certainly going on a new professionalism in this counseling arena.

Dr. PASSI. And I think CSAT has immense resources and knowledge on this that you can tap to find ways to bring best practices to providers in the field.

Mr. SOUDER. I want to ask a few more technical questions but I want to weigh in with a slightly different approach leading to a question. Both of you alluded to this and that is we in this country have to be careful we don't get so credential obsessed that we forget the point here is outcome. When I was a senior in high school, I took a program called exploratory teaching where we could go teach a class and because I had a lot of stuff going on, I couldn't get over to the elementary building and they put me in an eighth grade history class. It was clear that I loved history and all of a sudden the teacher disappeared and I had this class for the whole semester and I was just a senior in high school.

An amazing thing happened. Because I loved history, four of the kids who were getting an F turned to A students and the teacher suspected that they were cheating and she retested them and that they turned around. I didn't have any experience in teaching. What I did was I loved the subject. The question is, are we going to measure the outcomes or are we going to be obsessed in the credentialing?

If the credentialing is correct, presumably they will get better outcomes and much of this is medical in drug and alcohol treatment and therefore, it would be logical that the outcomes would reflect the training. But in this country to some degree, credentialing and I am going to make a statement that seems kind of role reversal but some of it is who you know and whether you have enough income to get the credential.

Some of our problem in some of our urban areas is minorities get excluded, lower income people get excluded and people who can often relate to the people are in the problem. I know there can be a street hustle part of this but you also have to be careful you don't get an elitism in the credentialed profession that is a disconnect with the actual problems the individuals are facing at the street and community level.

That leads to this question. How do you feel, because Director Walters has been here a number of times and we talked about this and some of the programs, that some of the funds wouldn't be delivered to the group that is providing the services until there is some feedback on the outcome, say they get 75 percent of the funds and there is a 3 or 6 month delay?

Dr. PASSI. Congressman, we are currently exploring ways in which to incentivize both outcomes and training. As to the question of credentialing, I think there has to be some base level of credentialing. There just are some things people have to know but it is less an issue of the credential of the practitioner than of the practice that they utilize, the overall approach to treatment. I think if we simply emphasize the credential, then we get the easy part rather than ensuring that what is happening in those clinicians' facilities reflects the cutting edge of treatment, what we in fact know works. If it does work, rewarding the outcomes is going to be in the long run the best incentive for getting people to find out how to do those things.

Mr. SOUDER. How did you feel about delaying some of the benefits, the funds?

Dr. PASSI. I think some form of incentivizing payments to practitioners based on outcomes is a direction in which we certainly want to proceed.

Mr. SOUDER. It really makes you focus on whether the outcomes are justified and balanced outcomes and will lead to tremendous manipulation of those outcomes. When I was in the graduate business program at Notre Dame and when you did case studies, I was the one who did the measurements because once I defined the measurements, then you start to define the problem, how you are going to address the problem and if those measurements have real dollar consequences, then indeed we will follow the outcomes. Otherwise, we will tend to stay at the process level.

Ms. HEAPS. I am very bad at analogies but for some reason this came into my head about that suggestion. It is as if we are building a plane and we decide we are only going to give you 70 percent of the cost to build the plane which may mean you don't get wings but the outcome will be can it fly. There is a caution here which is to say this is such a new endeavor that the need to build the system to not only treat the client and give the client choice, get the resources and the network there, develop the voucher system and move to assessing outcomes is such that you need to fund it, you need to get the plane built to see if it flies.

Having seen it and tested it and seeing it fly, the question is, how long a duration and how efficient. Now you can begin to look at perhaps funding in terms of providers and vouchers, individual providers who may not have outcomes as good for reasons having to do with quality of service, failure to integrate with others. There are standards you could set up but I think one has to be very cautious when one is building a new plane and a new system to make sure that you have everything you need and then begin to look at how we can incentivize.

Mr. SOUDER. We will exclude all small providers and there will only be big ones and the cash-flow.

Ms. HEAPS. Exactly.

Mr. SOUDER. At the same time, I believe that some incentives are appropriate and obviously not without the wings. In military contracting and so on because of the overruns we have seen and because of obsession with the lobbying and the contractors as opposed to making sure the weapons system can actually fire, that we have had to put outcome based things in.

I wanted to ask a couple technical questions to Dr. Passi since you have actually had a program. What percentage of your existing program was administrative versus actually cost of treatment? Do you know roughly?

Dr. PASSI. Our administrative costs are very low. I don't know that I can give you a figure.

Mr. SOUDER. Under 10 percent?

Dr. PASSI. I think it is under 10 percent. There is a fairly large cost in the assessment and in the system. Do you count the assessment itself as administrative? We don't, it is a clinical service and probably could be billed separately.

Mr. SOUDER. Is that 5 or 10 percent or is that higher?

Dr. PASSI. The assessment cost probably is running somewhere around $500 per assessment and I think that is about standard for clinicians everywhere. Our system is in fact administered by four people and it is about $4.5 million in treatment services.

Mr. SOUDER. You are saying each of you gets $1 million?

Dr. PASSI. We each get $1 million. In terms of the actual administrators of the program, we pay four people to do it and that might be probably $250,000.

Mr. SOUDER. Plus overhead of the office.

When you give out the vouchers, how many of those who you give these vouchers to don't redeem them?

Dr. PASSI. In fiscal year 2003, we actually gave out 2,870 vouchers. Of those, 2,631 were actually activated.

Mr. SOUDER. So less than 10 percent?

Dr. PASSI. So we lost a couple hundred.

Mr. SOUDER. Do you have a utilization review process to monitor whether they are actually spending the dollars in the vouchers? How do you determine the dollar of the voucher?

Dr. PASSI. The dollar amount of the voucher is based on the outcomes of the assessment. The assessment will say this person needs so much of this level of care.

Mr. SOUDER. And the voucher is then estimated for the full cost of that program?

Dr. PASSI. The voucher is then estimated for the full cost of that program. The patient is then given referrals to a practitioner who can provide those services. The voucher is activated when the patient engages in service. The provider bills then on a fee for service basis for services that are authorized under the voucher. One hour of counseling, actually counseling is in 15 minute units, but 1 hour of counseling will generate a unit of service payment that will then be deducted from the total amount of the voucher until the voucher is exhausted. It could be multiple units of different kinds of service. A heroin addict on methadone might get x units of service for counseling, x units of services for the actual dosing.

Mr. SOUDER. Does the dollar amount that you give them for the services calculate in whether they are eligible for Medicaid, have any insurance of their own and assure that the treatment provider doesn't in effect double bill?

Dr. PASSI. Generally we attempt to take care of that with the screening and assessment. Our assessment process doesn't say come in, get assessed and get a voucher. It says, come in and get assessed. So in that same fiscal year where we administered 2,800 vouchers, we actually did 3,300 assessments and about 200 of those assessments were for people who got referrals without a voucher. That is, they had some form of third party coverage or could afford to pay for the cost of their care individually.

The bulk of our patients are single, young males who in New Mexico are not eligible for Medicaid and therefore, billing to Medicaid is almost not an issue in our system, but several hundred patients a year probably do have some form of third party coverage through their employer that we then refer them to somebody who accepts that kind of insurance.

Mr. SOUDER. And you are balancing that so that there isn't, in effect, double billing?

Dr. PASSI. That person would not get a voucher until that third party coverage has exhausted.

Mr. SOUDER. The same on mental health coverage, is a voucher eligible for mental health coverage?

Dr. PASSI. No. At this point, this is for substance abuse treatment services only. If the assessment indicates a co-occurring disorder, the patient is referred to a local mental health provider to have those problems assessed and then a determination made about how that treatment will be financed.

Mr. SOUDER. Ms. Heaps, in Chicago, you are dealing with just adults on probation, so any nuisances different?

Ms. HEAPS. Slightly. Because the State of Illinois retains the dollars and the voucher payment, it will double check against Medicaid rolls and treatment provider rolls to see if indeed an individual has Medicaid as an insurer, so there won't be double payment. I think that is a pretty important thing that States have to guarantee against.

I am sorry I blanked on the last piece you talked about.

Mr. SOUDER. Mental health.

Ms. HEAPS. Yes, thank you. Many of our clients of course have co-morbid situations and we believe mental health has to be a part of the recovery process, so we will be using our voucher system where a treatment provider cannot provide both substance abuse and mental health to access mental health services as well.

Mr. SOUDER. I thank you for your efforts. I sure hope we can get the Portman bill moved through. At the very least, we have a marker out this time because long term, if we are going to hold people accountable and put them in prison, which is our highest risk population, we have to figure out as they are coming out that they don't come out more hardened criminals than they started and figure out how to deal with this. A lot of this as you pointed out and we hear hearing after hearing is drug and alcohol at least aggravated if not caused.

I appreciate your work in that field and will be very interested to see the probation results in Chicago, although our numbers will be small compared to the overall part of your problem. It is so frustrating as you see the juvenile probation officers with 260 people and can't possibly know their names let alone track them all. It is an overwhelming problem and I appreciate New Mexico's pioneering of this. We will continue to watch yours because you will be basically a step ahead of the rest of the country as we watch for the numbers.

Thank you very much for coming.

With that, the subcommittee hearing stands adjourned.

[Whereupon, at 4:15 p.m., the subcommittee was adjourned.]

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

Representative Elijah E. Cummings (MD-7)
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 "Access to Recovery: Increasing Participation and Access in Drug Treatment"

September 22, 2004

Mr. Chairman,

Thank you for holding today's hearing on "Access to Recovery: Increasing Participation and Access in Drug Treatment."

No subject is more important to me than the issue of drug treatment. Within my district in Maryland, Baltimore City alone has approximately 65 thousand people who are addicted to illegal drugs -- roughly a tenth of the city's population.

The illegal diversion and abuse of prescription drugs also represents a serious and growing problem for our health system and law enforcement, and I'm sad to report that, according to the Department of Justice, Maryland has become a magnet for people from neighboring states seeking illegal access to widely-abused prescription drugs such as Oxycontin.

Regardless of their drug of choice, people who are dependent or addicted are in dire need of effective treatment. Sadly, despite our efforts at the federal, state, and city levels of government and within the treatment community, the vast majority of people who need treatment are not receiving it and many who seek treatment are unsuccessful due to a lack of adequate capacity in our treatment system.

Baltimore City is not alone in suffering from the so-called "treatment gap." The 2003 National Survey on Drug Use and Health

estimates that, in 2003, 19.5 million Americans aged 12 or older (8% of the total population) were current users of illicit drugs. More than 6 million illicit drug users needed treatment but did not receive it.

Of the 22.2 million Americans (9.3% of the total population) who needed treatment for alcohol and/or illicit drug use, 20.5 million did not receive treatment. Regrettably, we have not seen this number decline, as it is slightly up from 20.3 million Americans the year before. The survey also notes a drop in the number of adults aged 26 and older who received treatment, from 1.7 million in 2002 to 1.2 million in 2003.

Mr. Chairman, we know that drug treatment can be effective in reducing not only abuse and dependency but also the range of social ills to which illegal substance abuse contributes, including criminal activity, mental illness, and risky health behaviors leading to HIV and hepatitis infection. Fortunately, there is a growing consensus that treatment does work and the Administration's Access to Recovery program reflects that view.

Originally dubbed "Recovery Now," Access to Recovery (ATR) was proposed in 2003 as a three-year $600 million drug treatment initiative designed to increase access to treatment, increase consumer choice, and expand the array of treatment providers who can participate in federally funded treatment programs. ATR is a key component of the President's broader pledge to commit $1.6 billion to drug treatment over five years, outlined in the President's 2002 National Drug Control Strategy.

The program establishes within SAMHSA's Center for Substance Abuse Treatment a new discretionary grant program, under which states compete for funds to establish a system of vouchers redeemable by patients for a range of drug treatment services. The voucher program is intended to complement, rather than supplant, the existing formula and discretionary grant programs within SAMHSA.

Under ATR, consumers seeking treatment will receive an assessment of their treatment needs and a list of providers who deliver services meeting those needs. Consumers will receive vouchers that they can use to pay for services at a range of appropriate community treatment programs. States that receive grants to establish voucher systems are required to create mechanisms to evaluate participating providers in terms of outcomes and costs.

ATR seeks to hold states accountable for delivering effective treatment by linking reimbursement to demonstrated effectiveness as indicated by seven evidence-based outcome measures or "domains." The seven domains are:

- Abstinence from drugs and alcohol;
- Attainment of employment or enrollment in school;
- Lack of criminal justice system involvement;
- Stable housing;
- Social connectedness;
- Access to care; and
- Retention in services

Reimbursement will be withheld from programs that prove ineffective over time.

The Bush Administration requested $200 million for ATR in FY04 and FY05. Congress appropriated $100 million for the program in FY04 and it appears that that funding level will be maintained in FY05. SAMHSA issued a request for applications (RFA) in March 2004 and conducted regional workshops around the country to assist states interested in applying for grants. In response to the first request for applications, 44 states and 22 tribal organizations and territories applied for ATR grants. In August, the President announced $100 million in three-year ATR grants going to fourteen states and one tribal organization. The Administration projects that the fourteen grants will

enable more than 100,000 individuals to be brought into the treatment system.

In announcing the new program, President Bush emphasized that ATR would increase the participation of pervasively sectarian faith-based organizations in the network of federally funded treatment providers. The standards to which these groups will be subject is an important issue for Members like myself who are deeply concerned about both the quality of treatment we fund with federal dollars *and* the implications of permitting the use of federal funds by programs that would discriminate against employees or people seeking treatment, or both.

With ATR in its early stages of implementation, this hearing provides an opportunity to learn how SAMHSA has addressed the aforementioned issues in the application process as well as what the agency has learned about how states plan to implement voucher programs.

I am pleased that we also will hear directly from providers in two states (Illinois and New Mexico) that will be implementing voucher programs under ATR and I look forward to hearing their perspectives concerning the challenges and the opportunities that this new program offers to states, providers, and those in need of effective treatment for substance abuse.

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

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