METHAMPHETAMINE TREATMENT: AVAILABILITY AND EFFECTIVENESS OF PROGRAMS TO TREAT VICTIMS OF THE METHAMPHETAMINE EPIDEMIC

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WEDNESDAY, JUNE 28, 2006

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

The committee met, pursuant to notice, at 2 p.m., in room 2154, Rayburn House Office Building, Hon. Mark E. Souder (chairman of the committee) presiding.

Present: Representatives Souder, McHenry, Cummings, and Foxx.

Staff present: J. Marc Wheat, staff director and chief counsel; Michelle Gress, counsel; Malia Holst, clerk; Tony Haywood, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. SOUDER. The subcommittee will come to order.

Good afternoon, and thank you all for being here. Today's hearing will examine methamphetamine treatment programs, their availability, effectiveness for addressing the needs of met victims and their communities.

I am very concerned about this issue. I feel there is currently a treatment vacuum when it comes to meth. Despite the fact that the meth epidemic has swept across the country, and especially devastated our Nation's western States and rural areas, I am worried that effective treatment for meth addiction is not available where the people need it the most, because the communities most affected are the least equipped in their treatment capabilities to handle the special needs presented by meth users.

An oft-repeated assertion is that meth addiction cannot be treated. That is incorrect. It can be treated. We will hear from successful treatment recipients. But the availability of effective programs across the Nation is difficult to measure. Moreover, without strong leadership from the White House Office of National Drug Control Policy and aggressively tackling this scourge of meth, Federal measures to address the treatment vacuum will languish, despite the tremendous toll this drug is having on our Nation.

The meth epidemic has touched every State in the country, draining resources, causing serious environmental damage and destroying lives. SAMHSA's Drug Abuse Warning Network [DAWN], showed that in the early to mid-1990's, methamphetamine use was

on the rise. The treatment episode data confirmed this: treatment admissions for meth use grew through the 1990's, increasing five-fold between 1992 and 2002.

The most recent treatment episode data show that 15 States have higher rates of admission for amphetamine use, largely meth, than for heroin or cocaine. In just those 15 States, there were over 102,000 admissions for amphetamine treatment, versus 73,000 combined admissions for heroin and cocaine. Nationwide, there were more than 151,000 admissions for amphetamine treatment.

To say that meth is highly addictive is an understatement, and it presents unique clinical challenges for treatment. Meth produces a short, intense rush, followed by a long-lasting sense of euphoria. Addiction to meth is caused by the way the drug alters the brain and leaves the users to compulsively seek more meth. Chronic use of the drug also leads to increased tolerance, prompting the user to take higher or more frequent doses of the drug to get the same effect.

Moreover, meth users may also develop severe psychotic and paranoid behavior. Meth users who do seek treatment often relapse and continue chronic meth use. There are currently no medications that demonstrate effectiveness in treating meth addiction. But intense behavioral interventions have proven effective. The largest controlled study of meth treatment conducted by the Center for Substance Abuse Treatment demonstrated positive post-treatment outcomes for 60 percent of the treatment sample, which reported no meth use and which had urine samples that tested negative for meth.

Nonetheless, traditional treatment programs for alcohol and marijuana are inadequate for dealing with the unique clinical challenges presented by this drug. Such treatment programs, sometimes the only treatment option available in communities hardest hit by the meth epidemic, result in very poor post-treatment outcomes for meth users. This represents our greatest challenge: how do we ensure that our Federal treatment efforts are addressing the meth epidemic in measurable ways in the areas hardest hit by the scourge, in many cases very rural areas?

I look forward to hearing from our witnesses today about the current state of meth treatment options: how prevalent, how effective, and by what measure. In the areas where we are falling short, I hope our witnesses are prepared to offer some solutions.

We have, by the way, had meth treatment witnesses at at least six field hearings with scattered reports of both effectiveness, the mix and availability in those areas. Oregon, Arkansas, Minnesota immediately come to mind where we have had meth treatment witnesses at our hearings.

I am particularly interested in the discussion with our administration witnesses who will present the information on Federal efforts for developing, supporting and measuring meth treatment systems and programs. The administration witnesses comprising our first panel are Dr. Bertha Madras, the Director for Demand Reduction at the White House Office of National Drug Control Policy; Dr. Nora Volkow, Director of the National Institute on Drug Abuse [NIDA], National Institutes of Health; and Charles Curie, Administrator of the Substance Abuse and Mental Health Services Admin-

istration [SAMHSA], and I am most pleased to say a fellow Hoosier, one of two Hoosiers testifying today.

Dr. Clark, are you with Mr. Curie? I wanted to make sure I introduced you as well. I didn't see you on my list.

Witnesses on our second panel will present on-the-ground perspectives of treatment, both from the treatment provider side and the recovered meth user side. This includes a second Hoosier witness, Leah Heaston, director for Noble County in Indiana of the Otis R. Bowen Center for Human Services; Richard Rawson, associate director of integrated substance abuse programs at UCLA; Russell Cronkhite, a recovered meth addict; Darren and Aaronette Noble, also recovered addicts, and their son Joey Binkley; Mr. Michael Harle, president and CEO of Gaudenzia, Inc., and Mr. Pat Fleming, director of Salt Lake County Substance Abuse Services.

We welcome all of you.

I also want to say for the record that Malia Holst has been our subcommittee's clerk, and today is her last hearing. She has been our clerk since April 5, 2004, and has cheerfully endured the countless schedule and witness changes during the time for hearings here in Washington and throughout the United States.

She is exchanging her time here on the subcommittee for much better things. She is getting married later this summer, and then she and her husband will be attending Dallas Theological Seminary. I want to salute her diligent work and consistent Christian witness in the time we have had with her on the subcommittee. She has been a tremendous asset.

Now I would like to yield to Mr. Cummings.

Mr. CUMMINGS. Thank you very much, and I too extend my best wishes to Malia. I want to thank her for her service to our committee and to this great country of ours.

Mr. Chairman, I want to thank you for calling this hearing. But I want to start off by saying that I am concerned about the title of the hearing. The chairman and I get along very, very well. We are very good friends and we do just about 99 percent of the things we do in a bipartisan manner.

But when we say the availability and effectiveness of programs to treat victims of the meth epidemic, I have never heard that word used with regard to the people from my district who suffer from cocaine addiction, heroin addiction, crack cocaine addiction. They are all victims. I think we have to be very careful with the use of words. Because there is no one in this Congress who will fight harder to make sure that those who have been victimized by any drug are properly treated.

The second thing I want to say before I forget, I want to thank you, Mr. Curie, for your service. I understand you will be leaving your position. You have indeed been a breath of fresh air. Wherever your journey may take you, I feel that we have been so blessed as a Nation to have you at the helm of your agency. I just wanted to take this moment to salute you and thank you.

Mr. Chairman, again, I want to thank you for this hearing. The National Institute on Drug Abuse [NIDA], defines drug addiction generally as a chronic relapsing disease, characterized by compulsive drug-seeking and drug use, and by neurochemical and molecular changes in the brain. Numerous studies demonstrate the effi-

cacy of drug treatment in reducing drug use and related problems and behaviors, including criminal activity, unemployment, poor health and engagement in risky sexual or drug consumption behaviors that may result in infection with HIV, hepatitis and other dangerous communicable diseases.

Unfortunately, limited public funding for drug treatment puts the benefits of treatment out of reach for many individuals who need and seek treatment but cannot afford to pay the cost out of pocket. Of the 22 million Americans with substance use disorders in 2003, approximately 3 million people received treatment, leaving an estimated 19 million Americans without treatment services.

Closing the so-called treatment gap should be a leading priority of our national drug control strategy. And nowhere, absolutely nowhere, is the need for expanded access to treatment more clear or more compelling than in the context of what has been described as a national meth epidemic.

Methamphetamine is a very potent and highly addictive stimulant drug. It has very limited medical use, and as a Schedule II controlled substance, it can be obtained legally only by prescription. Meth can be snorted, swallowed, injected or smoked, and it is frequently taken in combination with other drugs.

In contrast to cocaine, which is quickly removed and almost completely metabolized in the body, methamphetamine has a much longer duration of action and a larger percentage of the drug remains unchanged in the body. This results in prolonged stimulant effects.

Some meth users experience psychoses that persist months after the drug has been stopped. Also because methamphetamine affects the contraction of blood vessels, it can result in heart attacks and strokes in relatively young patients. Meth use is also linked to risky sexual behaviors, increasing the risk for transmission of infectious diseases, including HIV. Like other intravenous drug users, those who inject the drug risk contracting HIV when they share contaminated equipment, and methamphetamine's psychological effects may also increase the likelihood of HIV transmission and accelerate its progression.

According to the 2004 National Survey on Drug Use and Health, nearly 12 million Americans have used methamphetamine at least once. NIDA has characterized the abuse of methamphetamine as an extremely serious and growing problem. Once concentrated in a few western States, meth use has expanded geographically and it is moving to more diverse populations. The fact that meth can be manufactured from chemical derived from retail products has contributed to the spread of small, clandestine labs. And these labs contribute to a set of additional problems, including costly environmental damage and child endangerment and neglect.

The resulting burden on State and local law enforcement and social services agencies has been enormous. According to NIDA, methamphetamine addiction can be treated successfully using currently available behavior treatments. NIDA is currently investing in the development of new medications for methamphetamine addiction.

NIDA also is pursuing the development of an immunization strategy for the treatment of methamphetamine overdose. In gen-

eral, studies show that clinically appropriate treatment, provided by qualified and trained staff, is effective in stopping methamphetamine use and that outcomes from meth users are comparable to outcomes for cocaine and heroin users.

It is vitally important that we expand funding for programs that support effective treatment services for meth addiction. These programs include the Substance Abuse Prevention and Treatment block grant, the foundation of our public treatment funding infrastructure, and programs of regional and national significance, such as targeted capacity expansion.

It is important to note that States have achieved commendable results in block grant funds. According to the National Association of State Alcohol and Drug Abuse Directors, in Colorado 80 percent of methamphetamine users were abstinent at discharge in fiscal year 2003. In Iowa, a 2003 study found that 71.2 percent of methamphetamine users were abstinent 6 months after treatment. And in Tennessee, over 65 percent of methamphetamine users were abstinent 6 months after treatment.

Mr. Chairman, we must also provide adequate funding to support the vital research efforts of NIDA, which has devoted an increasing amount of funding to meth research. Unfortunately, as I have noted previously, the administration has chosen to devote a declining percentage of drug control funding to demand reduction programs over the past 6 years. I hope that today's hearing will increase the recognition of the importance of treatment in addressing addiction and related problems and in turn, to a reversal of the trend toward de-emphasizing domestic prevention and treatment relative to supply reduction efforts abroad.

I anxiously look forward to the testimony of our witnesses, and with that, Mr. Chairman, I yield back.

Mr. SOUDER. I thank the gentleman.

Mr. McHenry, the vice chairman of the subcommittee.

Mr. MCHENRY. Thank you, Mr. Chairman.

Thank you, Mr. Chairman and ranking member, for putting together this important hearing. I am so glad we have a distinguished panel before us today.

In my part of the country, in western North Carolina, we have been severely affected by methamphetamine use. And now, now that State law and Federal law is curbing the availability of it, we are still dealing with the ongoing repercussions of how to treat people that have been addicted to it. It is such a harmful, destructive and nasty drug that we as a society and as Government policymakers, we have to make sure that we have the right policies in place, and make sure that our treatment dollars are going in the right direction, and that there are treatment dollars available to effect change.

So it is important that as a committee we actually look at the availability of and effectiveness of these treatment programs. Current treatment initiatives in western North Carolina have shown strong results. Actually, in a recent study from 2002 to 2005, in my region alone, meth admissions to treatment programs have doubled, just in 3 short years. It seems, now that is being experienced around this country, largely in rural areas.

So it is important that we look at the best way to treat these meth addicts. One example in my district is through the Matrix Model. From what I understand, it is the only evidence-based program for attacking meth addiction. And it has been effective. I don't think it has been largely understood in the community, but I look forward to hearing your testimony today about what we should be doing here in Washington and in our communities to make sure that the treatment programs are available.

I appreciate your taking the time to be here to make your voices heard here in Washington, DC, with this important committee which we serve on. Thank you again, Mr. Chairman, for holding this hearing, and for your ongoing fight to make sure that we have effective drug control and elimination, as well as treatment programs throughout this country.

Thank you, Mr. Chairman.

Mr. SOUDER. Thank you. I want to clarify briefly Mr. Cummings' point, because I think he raised a very fair point. There is a certain amount of sensitivity that we treat methamphetamine differently right now because it is predominantly white users and different than urban areas. I think it is very important.

In the title here, I would refer to the crack epidemic that hit Fort Wayne as an epidemic with victims. At the same time, this isn't like a hurricane where individuals just get hit. They also choose to participate. So you are simultaneously a victim and somebody who made a personal decision to do this.

I absolutely believe that any distinctions that we would have that would be artificially different, we shouldn't refer to one group as being overwhelmed by a tide and another group bringing it upon themselves. In my hometown, there is very little meth in my hometown of Fort Wayne. It is around us, but it is crack, it is heroin, and it is marijuana and occasionally oxycontin. And we need to make sure that we treat everybody, regardless of their racial background, regardless of their income, the same way, whether it is in treatment or what.

We argue that in fact the administration has been less responsive to rural areas in the meth thing, and we focused on that here. But this committee will continue long term to make sure that we focus on all the different narcotics.

Mr. CUMMINGS. Will the chairman yield?

Mr. SOUDER. Yes.

Mr. CUMMINGS. Mr. Chairman, I just want to take a moment to thank you for saying what you just said. That means a lot to me personally, and I am sure it means a lot to anybody who is listening to this hearing. Thank you.

Mr. SOUDER. We have seen our urban areas ravaged, and we need to work together on how to rebuild this, and suburban families destroyed and rural areas. All these things need to be a focus of this committee.

I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record, and that any answers to written questions provided by the witnesses also be included in the record. Without objection, it is 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.

Our first panel is composed of the Honorable Bertha Madras, Deputy Director for Demand Reduction of ONDCP; the Honorable Dr. Nora Volkow, Director of the National Institute for Drug Abuse, National Institutes of Health; and the Honorable Charles Curie, Administrator of the Substance and Mental Health Services Administration, Department of Health and Human Services. Mr. Curie will also be joined by Dr. Westley Clark, Director of the Center for Substance Abuse Treatment at SAMHSA.

Would each of you stand and raise your right hands, and I will swear you in?

[Witnesses sworn.]

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

Thank you for being with us today, again. I think this might be your first time, Ms. Madras. We met in my office, but welcome to our committee, and Dr. Volkow and Mr. Curie have been here many times. We very much appreciate your leadership in this issue, as well as Dr. Clark has been here numerous times.

Ms. Madras.

STATEMENTS OF BERTHA MADRAS, DEPUTY DIRECTOR, OFFICE OF DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY; NORA D. VOLKOW, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND 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, ACCOMPANIED BY H. WESTLEY CLARK, M.D., J.D., M.P.H., CAS, FASAM, DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT

STATEMENT OF BERTHA MADRAS

Ms. MADRAS. Chairman Souder, Ranking Member Cummings and distinguished members of the subcommittee, thank you for the opportunity to appear before you today to discuss the Federal response to treatment needs of populations affected by methamphetamine.

As a chemical, meth is a serious, unique national problem. It is one of the few drugs that can be synthesized with little expertise or equipment. Its production can result in significant personal and environmental contamination.

As a drug, meth is one of our greatest public health challenges. It is highly addictive, it can promote brain damage, its heavy medical and psychological toll on individuals can impact their children, families, communities and the criminal justice system at a national level.

With cooperative efforts of the administration and Congress, there is a historic 19 percent reduction in teenage drug use over the past 4 years. Of specific reference to methamphetamine, there

is at least a 30 percent reduction in the number of meth lab incidents, in meth-positive workplace tests, in lifetime meth use among youths over the past 2 years. There is also a significant increase in 12th graders who disapprove of using amphetamines.

The administration's recently released Synthetic Drug Control Strategy outlines key meth treatment initiatives. A 15 percent reduction in meth use, a 15 percent reduction in prescription drug use and a 25 percent reduction in domestic meth labs over the next 3 years are the stated goals.

What are the meth treatment programs that are available? In general, 25 percent of the Federal budget is targeted to treatment. Four major programs can impact meth abuse and addiction treatment. The first is the Substance Abuse Prevention and Treatment block grants. The 2007 budget requests $1.7 billion for the block grant. The funds are for treatment providers, many of whom provide treatment for abuse and dependence on meth. States that elect to prioritize meth treatment can target the money for this population.

A second initiative are programs of regional and national significance. The 2007 budget requests $375 million for effective screening and treatment programs, which include Access to Recovery and Screening, Brief Intervention and Referral to Treatment. These discretionary grants provide flexibility and services for regional and rural needs.

Access to Recovery, the 2007 budget requests $98 million. There is a 25 percent setaside specifically for ATR meth initiative, and $5.4 million targets programs in rural areas. ATR funds essential recovery support services, not generally reimbursable through conventional Federal treatment resources. For example, meth addicts require intensive relapse prevention training, which is covered by ATR.

The third program is Screening, Brief Intervention and Referral to Treatment. The 2007 budget requests $31.2 million. This program provides grants for effective early detection and intervention in general medical settings. It is positioned to identify meth users that enter hospital or clinical environments, seeking treatment for reasons other than for meth abuse.

The fourth program are drug courts. The 2007 budget request $69 million for drug court programs, a $59 million increase over the 2006 enacted level. Drug courts effectively divert non-violent, low-level offenders away from prison into supervised treatment and reduce re-arrest rates by over 50 percent.

Of the 2005 adult drug court planning initiatives, the National Drug Court Institute estimated that 92 percent were rural. Of these, a significant proportion of offenses that they will treat are meth-related. This cohort can be steered into treatment by the drug courts.

In conclusion, I would like to state that substance abuse treatment works, and so effectively stated by Ranking Member Cummings, treatment and recovery for meth addiction are feasible and possible. Treatment programs are flexible and adaptable to meth. The Screening, Brief Intervention and Referral to Treatment and Drug Courts identify and help meth abusers or addicts who do not come forward for treatment, but come forward for other rea-

sons, medical and/or legal, and then they are steered into treatment. And the Access to Recovery and block grants provide the treatment.

The President's drug control policy is characterized by vigilance, flexibility, adaptability and innovative strategies to address emerging drug threats. Our ultimate objective is to eradicate meth use and provide meth users the opportunity for a renaissance in their lives.

Thank you, and I welcome questions from the subcommittee.

Mr. SOUDER. Thank you.

Dr. Volkow.

STATEMENT OF NORA D. VOLKOW, M.D.

Dr. VOLKOW. Good afternoon. It is a privilege for me to be here, and to be given the opportunity to present how science can help us combat the problem of drug addiction.

As Director of the National Institute of Drug Abuse, that funds 85 percent of all of the research related to drugs, we have long recognized the problem of methamphetamine. We recognize it not just because it is a very potent stimulant drug, but because of the data showing that it is one of the most toxic of illicit drugs.

So as the Director of this Institute, I see it as our responsibility to develop the science and the knowledge that will allow us to combat this problem.

What do we know about methamphetamine? We have learned significantly over the past 5 years, actually past 20 years. As Mr. Cummings was mentioning, we recognize it as one of the most potent of the stimulant drugs, probably it is the most potent. We know that methamphetamine can be taken by smoke, snort, injection. And what we have seen is that over the past years, we have seen a shift from the use of methamphetamine through the routes of administration that are not just the most toxic, but also the most addictive, that is smoking and injection. And this in turn may account in part for the increase in the numbers of medical emergencies, as well as treatment-seeking addiction from the use of methamphetamine.

We know that methamphetamine, like other drugs of abuse, predominantly affects dopamine cells, increasing the concentration of this chemical in the brain, this chemical that is crucial in allowing us to perceive pleasure, regulate and motivate our behavior. This chemical is also crucial in allowing us to think properly.

It is believed that the effects of drugs of abuse, all of them, to increase dopamine is the reason why they can produce addiction. Of all the drugs of abuse that we know, methamphetamine is the one that is most potent in increasing dopamine in the brain. Indeed, it is at least three times more effective than cocaine in increasing dopamine in the brain. And it is believed that this may be one of the reasons about why it is also so addictive.

Indeed, from human studies, we know that people that get exposed to methamphetamine may become addicted even faster than when they take cocaine. In the case of methamphetamine, addiction has been reported to occur 1 to 2 years after initiation of use, in contrast to an average of 3 years for the case of cocaine.

The large increases in dopamine induced by methamphetamine are not only linked to its highly addictive potential, but also its toxic properties. These large increases in dopamine damage the dopamine cells themselves, and the consequences of course relate to the function of dopamine. These individuals are less able to experience pleasure from natural reinforcers. But they also affect their ability to exert cognitive control and the ability to think clearly.

However, one of the good news in this is that some of these changes appear to be reverted with protracted detoxification. This is extraordinarily important, because it further highlights the importance of initiating treatment and of initiating treatment at early stages, so that we can maximize the recovery of that individual.

As mentioned by Mr. Cummings, there are many other toxic effects of methamphetamine. Methamphetamine does not just go into your brain, it does damage to the blood vessels, so you can just end up with a stroke and be paralyzed. But it also affects other organs. One of the ones that has attracted a lot of attention is seeing young individuals with myocardial infection because of the toxic effects of methamphetamine to the myocardium.

Because of these adverse effects, as was mentioned, many people believe that methamphetamine cannot be treated, or that it is extremely difficult to treat. And yet, we know, as has been mentioned before, that it can be treated. And in fact, the comparisons with cocaine show similar rates of success.

There are several programs, behavioral interventions, that have been shown to be effective in the treatment of methamphetamine addiction. You are going to be hearing specifically from Dr. Rawson on the Matrix Model, which has been very successful. There are other interventions, motivational incentive interventions, prevention of relapse, that have also shown very positive results.

However, one of the things that we need to recognize in order to be successful in the treatment of methamphetamine, as is the case for all other drugs of abuse, is that addiction is a chronic disease, which means that treatment is not going to be a one shot and you are going to be cured. It will require repeated treatments, and relapse does not necessarily mean failure of treatment. It needs that treatment needs to be reinstituted. But it highlights the importance of continued interventions.

At NIDA, as I say, we feel an obligation to develop also not just better behavioral interventions, but also medications that can help those afflicted with addiction. In the case of methamphetamine, we have some very promising compounds, both from the results in the laboratory animals, but also from pilot studies in humans. This includes, for example, anti-epileptic medications, such as GVG or topiramate, which has been actually showing very promising results in clinical studies on methamphetamine abusers.

Certain anti-depressant medications, such as Welbutrin, which is currently also used for the treatment of nicotine addiction, also has shown positive signals in methamphetamine treatment. And finally, we are also evaluating the use of medications that can improve alertness and cognitive performance, such as modafinil.

As mentioned by Mr. Cummings, we are also developing immunization strategies, such as monoclonal antibodies, that can be used

for those that are suffering from overdose, and thus can be acutely saved. But we are also investigating the feasibility of developing a vaccine for methamphetamine that can prevent relapse, using similar strategies as those used for the vaccine for cocaine and for nicotine, which also are showing some very promising results.

NIDA indeed has long recognized the danger of methamphetamine abuse and has actively supported research on these and related drugs. This research continues to help us elucidate the effects of these drugs in the brain, which is very important, because of course this leads us to new targets for medication and treatment. At the same time, we can never, never under-emphasize the importance of this knowledge to develop better prevention strategies.

Thank you for allowing me to share this information with you, and I will be happy to answer any questions you may have.

Mr. SOUDER. Thank you very much.

The last statement of this panel is from Mr. Charles Curie. I also want to commend you for your years of service in Pennsylvania and then at the national level for the last 5 years. I look forward to working with you as you move on to other endeavors. I am sure you will continue to stay involved in this field, but we thank you very much for your leadership.

STATEMENT OF CHARLES G. CURIE

Mr. CURIE. Thank you, Mr. Chairman, for those kind words, and also Ranking Member Cummings, for your words earlier. They mean quite a bit. The partnership that we have had has been invaluable. I appreciate this opportunity to testify one last time in my current capacity to this very important subcommittee.

Mr. Chairman and Ranking Member Cummings, Mr. McHenry, I am Charles Curie, the Administrator of the Substance Abuse and Mental Health Services Administration [SAMHSA], within the U.S. Department of Health and Human Services. I am pleased to say accompanying me today is Dr. Westley Clark, the Director for our Center for Substance Abuse Treatment, the able Director, very able Director, within SAMHSA.

And I am pleased to be able to present, with my colleagues Dr. Madras and my long-term colleague and friend, Dr. Nora Volkow, SAMHSA's role in addressing the methamphetamine addiction crisis that this country faces. First, I also would ask that my written testimony be placed in the record, which is much more detailed than my oral testimony. What I would like to focus on in my oral testimony is our role to more effectively address this issue.

To efficiently align and focus our prevention resources, and I would like to begin with prevention, SAMHSA launched the Strategic Prevention Framework in 2004. The Framework advances community efforts to prevent drug use, using a risk and protective factor approach. Whether we speak about abstinence or rejecting drugs, including meth, tobacco, alcohol, or promoting exercise and a healthy diet, we are really working toward the same objective: reducing risk factors that exist in a community and exist in an individual's life and promoting protective factors.

By the end of this fiscal year, nearly 40 States will be implementing this new approach. I am pleased to say that there are many States that have taken SPF and have definitely aligned it in

addressing the methamphetamine issue. Indiana is one State that I would point out. In presenting the award to Governor Daniels in Indianapolis, on the Strategic Prevention Framework, he made it a point to say that this was going to be a central element in addressing the meth issue in Indiana. Again, we shaped Strategic Prevention Framework so that it will address the local needs and work in partnership to address those priority needs that are identified locally and by States.

The success of the Framework rests in large part on the tremendous work that comes from grass roots community anti-drug coalitions. The anti-drug coalition effort is very much tied to, and we view it as part and parcel of Strategic Prevention Framework. That is why we will continue to work with ONDCP to administer the Drug-Free Communities Program, and this program currently supports approximately 765 community coalitions across the country.

In terms of treatment, SAMHSA supports treatment, and you heard Dr. Madras highlight several of those efforts. Again, primarily our substance abuse prevention and treatment block grant is a major vehicle, and is foundational, as has been mentioned here before. Appropriated at nearly $1.8 billion, the block grant provides 40 percent of all State funding for public substance abuse services.

We also support treatment through competitive grants. Public and non-private entities apply directly to SAMHSA for targeted treatment funds. Since the subcommittee is well acquainted with both the block grant and our discretionary grant portfolio, let me discuss one program in particular. In his 2003 State of the Union address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery [ATR], a new consumer-driven approach for attaining and obtaining treatment and sustaining recovery through a State-run voucher program.

State interest in Access to Recovery was overwhelming. Sixty-six States, territories and tribal organizations applied, and competed for $99 million in grants in fiscal year 2004. We funded grants to 14 States and one tribal organization in August 2004. I am pleased to say that again, there were States who identified methamphetamine as their No. 1 growing problem, Tennessee and Wyoming, and they targeted their Access to Recovery funds to address that issue.

Because the need for treatment is great, as methamphetamine treatment need alone has demonstrated, President Bush proposed $100 million for a new cycle of Access to Recovery grants in the 2007 request. Of that, $25 million will be focused exclusively on methamphetamine. ATR's use of vouchers, coupled with the State flexibility and executive discretion to target emerging drug trends such as meth, is creating profound positive change in substance abuse treatment financing and service delivery across the Nation. In short, the ATR initiative has helped all of us operationalize recovery in both public policy and public financing.

I am also pleased to point out that while in fiscal year 2006 we had $19 million in our budget targeted exclusively toward methamphetamine in terms of treatment and prevention, in our proposed 2007 budget that number is $34 million, in terms of increased emphasis and effort toward methamphetamine.

To help ensure the latest science-based services are being provided to people with substance abuse disorders, a true partnership has emerged between SAMHSA and the National Institute on Drug Abuse [NIDA]. The result of this collaboration was the result of a development of a treatment strategy for methamphetamine addiction. The Matrix Model, which Congressman McHenry mentioned earlier, and you will be hearing more about from Dr. Rawson, and other cognitive behavioral approaches, are available in a set of two DVDs produced by our Pacific Southwest Addiction Technology Transfer Center. Dr. Clark has them. They are on sale in the lobby after the hearing. [Laughter.]

And our treatment improvement protocol [TIP] No. 33, the treatment for stimulant use disorders, again, giving direction on methamphetamine.

Our national network of Addiction Technology Transfer Centers also are critical in our efforts to provide training, workshops and conferences to the field regarding methamphetamine. I want to stress that these entities are available to States, to treatment providers in their region, to have the resources and technical assistance necessary in order to gain the expertise and the knowledge around address methamphetamine.

Recently, SAMHSA financed two conferences on methamphetamine for States. SAMHSA paid for States to bring 15 people each, including State and local officials and providers, to hear experts in the field of methamphetamine treatment and research, and a well-received and much-needed opportunity to learn and share information about methamphetamine.

In conclusion, we are striving to do our part at SAMHSA to make methamphetamine and continue to make it the priority it needs to be, especially in areas of this country where, as you say, Mr. Chairman, the intensity of the consequences of methamphetamine are overwhelming. We have been building systemic change also, so that no matter what drug trend emerges in the future, because we don't know what is going to emerge as we go along, and we need to be agile, we need to be flexible, we need to be ready, that States and communities will be equipped to address it immediately and effectively. Our goal is always to try to reach it before it hits a crisis level.

Mr. Chairman, Mr. Cummings, Mr. McHenry, Ms. Foxx, as has been mentioned before, I would like to ask, if I have a few additional moments, to discuss this being my last appearance in this capacity before you. As you know, I have submitted my resignation to the President and will be leaving my current post in SAMHSA on August 5th. I want to express my appreciation to the dedication of all of you. Mr. Chairman, Mr. Cummings, we have been in many hearings together, field hearings. And I have definitely appreciated your ongoing leadership and unwavering support for those people who have addictive disease in their life and who are looking to attain and sustain recovery in the pathways you give.

This committee has stood strong in terms of assuring that addiction is addressed in this country. At times when the public interest in addiction has faded and comes in waves, you have been unwavering. You have kept it at the top of the list of priorities. In my 10 years as Administrator of SAMHSA, I have also found this sub-

committee to be both supportive of what we are doing and at the same time appreciate your keeping our feet to the fire, appreciate you in terms of bringing, based on the data, what we need to be addressing. I think that is true partnership, and I think it has been invaluable to us, as one would expect from Congress.

So it has been an honor working for you and with you. And it has been the highest privilege for me to be in this position. Your subcommittee has been one of the very, very great highlights of my tenure here. Thank you very much.

Mr. SOUDER. Thank you very much for your comments. That is the best praise we have gotten from the executive branch and—it is because you are leaving, I guess. [Laughter.]

Nevertheless, it is appreciated.

Let me ask a technical question first, and maybe Dr. Volkow or Dr. Clark and Ms. Madras, Mr. Curie, if any of you have any further comments on this. Are there medical differences between, in methamphetamine, it is really unusual, because we have two simultaneous tracks going on in the United States, the mom and pop labs where people are home cooking with their own chemicals, and the crystal meth that is the bulk of the users. The chaos it has caused and the political problem is greatest in the areas where it is doing environmental damage, they are blowing up families, they are tying up drug task forces all day long while they wait for somebody to come in. And the political pressure is on those individuals, and those individuals tend to be more predominantly rural.

The crystal meth moves, some into some cities, particularly if it moves into cities like Minneapolis-St. Paul, Omaha, Portland, but we haven't seen massive intrusion into cities. But does the crystal meth behave on the brain differently than the home-cooked, and are the chemicals substantially different? Or does the same treatment process basically work for everybody who uses some form of methamphetamine?

Dr. VOLKOW. One of the things, methamphetamine is a racemic mixture. A racemic mixture is when the compounds have a mirror image one to the other. The "d" version of it is the most potent. The methamphetamine that you get from home cooking, it has mostly d-methamphetamine, but there is a little bit of the l-methamphetamine, very small amounts, 5, 6 percent. Whereas the methamphetamine that is coming from abroad is 100 percent pure.

Does this make a difference? I don't think it does. Actually, we are funding imaging studies to document the differences between these two compounds and we really don't see a difference.

So based on the pharmacology itself, it is unlikely to have much of a difference. Your concern, of course, has to do more with impurities that may come in the manufacturing of the methamphetamine. That is where my concern would come in terms of treating these patients, or what I would expect would happen to them.

Mr. SOUDER. Do you expect, and if anybody else has any comment, you can pick it up in the followup here, do you expect, the States took the lead and started to control pseudoephedrine, which has been the fundamental ingredient in the home cooking. That partly pushed people over to crystal meth, as we have seen in Oklahoma, started to see in Oregon, some degree pushing people to the Internet.

We have heard rumors, one I believe was in the hearing in North Carolina, that people have looked for, obviously, and the question is, are they finding substitute ingredients, things other than pseudoephedrine that they can mix in and emulate methamphetamine? Do you believe that is possible, or do you believe that by controlling the pseudoephedrine we in fact will shut down the home cooking?

Dr. VOLKOW. There is no doubt that control of the pseudoephedrine has had a dramatic impact on the number of small laboratories. Unfortunately, that has been taken over by the importation of methamphetamine from abroad, including Mexico. Could there be other sources for producing methamphetamine? To my knowledge, right now, I do not know of any.

But I am not a chemist, and chemists can be incredibly creative. So I do not know. My colleague, Dr. Madras, who is very much a chemist, may be able to shed some light on that.

Ms. MADRAS. With regard to the precursors, ephedrine well could serve as a precursor. So could another compound called phenethylamine. I do think, I certainly agree with my colleague, Dr. Volkow, that creativity is one of the major problems we face in the chemical world. Because the creativity, for example, with regard to cocaine, is what created crack cocaine versus cocaine hydrochloride. And there was an enormous difference. The basic molecule cocaine was the same. But crack cocaine enabled cocaine to be smoked. And that enabled a rapid bolus of cocaine to enter the brain. Whereas cocaine hydrochloride, which is just a different salt form, was not smokeable, because if you heated it up, the entire molecule fell apart.

So creative chemistry is what we always have to worry about. And I don't mean creative in a very positive sense.

Mr. SOUDER. Dr. Clark, did you have a comment?

Dr. CLARK. Not only must we deal with the issue of the precursors, you also have to deal with the issues of unscrupulous dealers, if you will. We recently had an episode of phentenyl added to heroin, dealers may choose to add unrelated substances to products and use that to advance their economic interests.

So what Dr. Volkow and Dr. Madras said is of critical importance, and we also need to look at some recent behavior in terms of what drug gangs have done. The importation issue is a major issue, but also unscrupulous behavior is also an evolving issue.

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. When I talk to young women who are crack addicts, they tell me that the addiction is very quick. And one of you mentioned, I think it may have been you, Mr. Curie, how fast it is, how long it takes for one type of drug, for you to become addicted, and then how slow it may be for others. I was just wondering, when you compare crack cocaine to methamphetamine, is that a rapid addiction situation? Because I hear that a lot, young women who say they tried crack cocaine and thought it would just be a one-time thing, next thing you know, they are on it. Particularly from women. I am just curious.

Dr. VOLKOW. I had mentioned that, and indeed, there was a story that specifically compared the course from occasional use to compulsive use between cocaine abusers and methamphetamine abus-

ers. That story did not distinguish between those subjects that were taking cocaine, as cocaine, whether it is hydrochloride snorted or injected, versus those that took it smoked. Effectively, as I mentioned, the routes of administration that are the most dangerous are the smoked and the injected. The smoked is the crack cocaine. But injected cocaine is also highly addictive.

And what you are saying is absolutely correct, and the transition from snorting to smoking is what is actually associated with the fast development into the addictive process. So to address the question correctly, one would have to compare the transition from smoking occasionally. But once you start to smoke occasionally cocaine, you become very fast regular. And that I do not have knowledge of any data. I was actually trying to find out if there was. So I do not know of a study that specifically has addressed that.

Mr. CUMMINGS. Mr. Curie, let me ask you this. You had talked about, you said you were talking about risk factors in communities, and you said you had worked closely, it was important to have a close relationship with the anti-drug coalitions with regard to methamphetamine. This is what we are talking about, of course.

What is it that they do that helps so much with regard to methamphetamine, and is that any different than other drugs? In other words, what they do? Because we have been very strong proponents of the anti-drug coalitions. We have been fighting pretty big time. And I just wanted to know how that affects it.

Mr. CURIE. I think methamphetamine is the classic example of why a community anti-drug coalition is so essential. Because the coalition gives an opportunity to form leadership and focus on the particular substance abuse, drug issues that are existing in that particular community. Strategic Prevention Framework, the reason that it fits so well with the anti-drug coalitions, is what we expect communities to do is to first assess all the resources that community already has going toward drug prevention efforts, then embark upon the process of assessing what are the risk factors in that community, is it a transient community, is it a community that doesn't have a sense of neighborhood, of connectedness. All those things add to risk factors that could promote substance abuse. There is a list of many others.

Once they have embarked upon a process of assessing their risk factors that exist, as well as protective factors that can be existing in that community, they can then make collective decisions. And again, the ideal coalition not only brings together concerned parents and school systems, but city government, brings together a range of non-profit organizations, brings together Boys and Girls Club and all those entities that work together.

They can make informed decisions. And we have a list of a registry of effective programs. Communities that Care has a list of evidence-based programs for prevention, and they can actually begin to make decisions to invest their prevention dollars into addressing those risk factors. If methamphetamine is really the emerging problem in a community or is a problem and it is overwhelming the resources, they can really put an emphasis on that locally, and we have again technical assistance and resources to help them do that.

But the coalitions really give leadership and life and voice and focus to combating and give that consistent voice to combating the drug problem in the community.

Mr. CUMMINGS. You also gave some stats on Access to Recovery. I think you said something like 66 States and jurisdictions requested funding, 14 of them got it. I just like the block grant situation so much better. When you tell me that 66 entities applied and 14 got it, that doesn't, I mean, that means we have quite a few folks, 52, to be exact, out there saying, what about us? And then I think you mentioned too Iowa and another State that was geared toward methamphetamine, Tennessee, I think you said.

Mr. CURIE. Right.

Mr. CUMMINGS. So would you consider that kind of competition to get 14 out of 66, when people are having all these problems, if you had to have a choice, would you rather see that in block grant or see that in that competitive grant?

Mr. CURIE. That is a great question. I think that first of all——

Mr. CUMMINGS. Since you are leaving, I guess it is safe for you to answer that. [Laughter.]

Mr. CURIE. I can say anything I want.

Mr. CUMMINGS. I wouldn't have asked you that if you weren't leaving.

Mr. CURIE. I support the President's proposed budget. And I do.

I think the question you are asking is, where can we get the most value for our dollar in terms of addressing this issue.

Mr. CUMMINGS. That is right.

Mr. CURIE. If you go back to the original Access to Recovery proposal, the first time the President proposed it, it was for $200 million. So I think clearly we would say, we would agree, $100 million wasn't enough, $100 million is what was appropriated. If we would have had $200 million we probably could be in up to 30 States during that first cycle, which could have made a more tremendous difference.

As we moved ahead, we proposed $200 million the second year, got $100 million. It has been staying at pretty much $100 million. So clearly, I think the administration would be in agreement that you need to more, especially in that interest. You are exactly right, 66 States and territories were clamoring for it, and we were only able to make those awards.

I think we would have been hopeful by now with the original Access to Recovery plan that we would have perhaps up to $300 million to $400 million if you recall, I think our goal was to add significant amounts of additional dollars to the treatment budget, if you go back to the first year, the first term.

Mr. CUMMINGS. Right.

Mr. CURIE. I think that we could make a tremendous impact in an Access to Recovery approach, because a State would get an award of somewhere around $7 million to $8 million per year. If we put that same amount of money into the block grant, that gets dispersed, if we put like $100 million in the block grant, that gets dispersed over 50 States and the territories, so it makes less of an impact in States.

So if we want to target particular problems and a State wants to make a case, that we want to use Access to Recovery dollars to

battle methamphetamine, because in Indiana, for example, or as they did in Tennessee and Wyoming, meth is undercutting so many things in the lives of our people, we need to address it, they could make much of an impact with the $7.5 million grant than if they end up getting an extra half a million in their block grant.

So I think those are the types of issues that have to be under consideration in assessing.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. SOUDER. Mr. McHenry.

Mr. MCHENRY. Thank you, Mr. Chairman.

A couple of things are happening in my State. First of all, we passed an effective meth bill in North Carolina at about the same time we passed Federal legislation here. And that has had an enormous effect on eliminating the small lapse in these rural communities in western North Carolina.

Now, we certainly have a problem still because Tennessee doesn't have as strict of a law about pseudoephedrine as does North Carolina. So you have some traveling over the mountain across the lines. You also have those coming from South Carolina and Tennessee over into my district to buy Sudafed because of some of the restrictions and having it behind the counter. They are able to go to a half dozen CVS stores and buy three boxes of Sudafed.

I talked to a police officer this weekend who deals with this, and he said that they treat Sudafed now like you would treat cocaine or marijuana. They hide it in their automobiles. It is a drug in and of itself and an enormous commodity for them to trade in.

But having said all that, the issue that we are dealing with, because we have cut down on these labs so much, it is not the expense of the labs now, and the dealing with the property damage and the chemicals you have left. The expenses have migrated over to these meth addicts, who the law enforcement continually has to deal with. Because you can throw them in jail, and once they get back on the street, they are back on it.

So that leads to the opening question for this hearing, which is treatment. So my question to the whole panel is, what type of partnerships do we need with law enforcement and with treatment facilities? Because it seems like there is a disconnect. Law enforcement wants to stem the demand. But I would like to hear your feedback on what we can do to stimulate that partnership.

Ms. MADRAS. With pleasure. I think that drug courts offer a very ideal solution to some of the issues that you have raised. Drug courts offer a choice of treatment or prison for low level criminal offenders and certainly, this can be applied to methamphetamine addicts as well.

What they do is partner the legal system with the treatment community and treatment providers. They have been extremely effective, and the interesting thing is that the re-arrest rate for people who have gone through the drug courts is much lower, considerably lower. A comparison figure is 54 to 60 percent re-arrest rate for those who have not been treated compared with 16 percent for those who have.

Mr. MCHENRY. My State courts in North Carolina, we have a drug court. I have visited a drug court, and it is an amazing result that they have had in the community where this exists. The dif-

ficulty is actually getting what is pilot project in essence in North Carolina State courts and spreading that.

The other issue is that all law enforcement now in my State wants Federal charges. And the Federal courts have not been as equipped as that drug court is. So beyond that, what else can you say? I would say that to all the panelists.

Ms. MADRAS. In terms of the extending drug courts, the President's proposal is to increase the budget by more than $50 million for drug courts because of proven efficacy——

Mr. MCHENRY. Beyond drug courts.

Ms. MADRAS. Beyond drug courts, I think the second issue is that screening people through medical systems is a very effective way of identifying people who have methamphetamine addictions and yet do not show up in any other venue. They do not appear for treatment, they do not appear in the criminal justice system.

Mr. MCHENRY. My time is limited. Dr. Volkow, would you address that?

Dr. VOLKOW. I am glad you are asking that question, because I think that we have an extraordinary opportunity through the criminal justice system to touch a very, very large range of drug-addicted people, including those on methamphetamine. The problem is that it is almost ubiquitous by its absence. So from day one when I took over, I started to recognize that there are very few prisons and jail systems in this country that institute treatment for drug addiction.

Well, we have two different cultures, and you are picking them up. One of them is to protect and punish, and the other one is to treat and to rehabilitate. So the challenge is to bring it together. So we have a large initiative at NIDA, which we call NIDA Goes to Jail. It has a multi-pronged approach, which one of them is to start educating the judges about the problems of drug addiction, the effects as a disease, but very important, about the treatment and the treatment outcomes from the different perspectives.

The other approach to it is how do you bring these treatments inside of this system that has been rejecting them. And it is not automatic. So we created a network of prison systems that combines the criminal justice system with the academicians to develop these treatments and apply them into the prison system, and very important, to follow these individuals once they leave the criminal systems. Because what research is showing is if you do not do the followup, then a lot of these benefits are lost.

This is of course the only close partnership with the SAMHSA and the criminal justice system. But it is an extraordinary opportunity that if we don't use, not only is it going to be increasingly costing our Nation, but we are actually missing the opportunity of helping those that are afflicted, that unfortunately end up with criminal behavior and in prison.

Mr. CURIE. I might just quickly mention, I endorse everything that was just said. I think if you look at Cook County in Illinois, there is a clear belief there, I recommend the committee take a look at what is occurring there, if you haven't already. There is a philosophy emerging that every court needs to be a drug court. Eighty to 90 percent of the individuals in the criminal justice system, and this is why NIDA's project is so critical, have a drug and/

or alcohol problem. Over 50 percent of the individuals who are arrested are under the influence at the time of arrest.

And what we find is, and drug courts have demonstrated this, but what we find is that if people are engaged in treatment when they are in prison, then you have literally a captive audience, so you can force treatment there. And the continuity, which Nora stressed, is so critical for attaining recovery. Recidivism goes down.

So I think again there is a lot we can do in growing drug courts, but I think the point you are making is we also need to do some urgent things now in the current justice system. I want to commend what I am finding in the justice system to be a real enlightenment in terms of more and more understanding, more and more reaching out for help and support. We have had Governors' summits on methamphetamine in which we had law enforcement, the judicial system, the community-based system of care, faith-based community together. And those summits, I can give you a list of all the States where they have been held, and again, that heightens the awareness as well.

So I think it is an ongoing process. I think it is bringing the models of what is working and making it more the norm in our prison and court system.

Mr. MCHENRY. Thank you.

Mr. SOUDER. Judge Kramer from Noble County, IN told me over the weekend that he was just going to convert to a drug court. It is not like the Federal Government has to all the time fund it. It is nice to have the extra Federal funding, but this is something that can be done, and the process is implemented if the people are committed.

I wanted to ask a couple of other medically related questions. In looking at treatment for meth, does the reason the individual has chosen to take meth make a difference if the solutions are largely behavioral? For example, in some areas we have learned that meth usage is often driven for weight loss, particularly among women, it seems to be more prevalent there. In other areas, it may be truck drivers who are trying to stay awake. Others may be people working on a factory assembly line, trying to increase their piece work. Others may be just looking for a high of some sort.

Does why you got involved in meth impact the treatment process?

Dr. VOLKOW. Definitely. You are very perceptive here, because in general a lot of the community has always waited for the magic bullet that would cure the disease. They have been terribly disappointed.

Well, it is not surprising, because if you do not address the issue that led a person to take the drug, that as you pointed out, in many instances is not just to get high, you are very unlikely to succeed in getting that person rehabilitated properly. Particularly cogent, for example, is those situations where a person may be driven to taking drugs as an attempt to auto-medicate an unrecognized psychiatric disorder.

In the case of stimulants, for example, that may occur if you are depressed, or for example, also if you have a problem with attention deficit disorder. Why? Because when you take these drugs, you will temporarily feel better and perform better. However, with re-

peated administration, the problem gets compounded, because your mental disorder is not treated and can deteriorate. But you start to become addicted.

So it is extraordinarily important. That is one of the things that research has shown about treatment, that it is a multi-pronged approach. Clearly, SAMHSA has followed that. You cannot just address this person is taking methamphetamine. You have to evaluate the uniqueness of the effects of methamphetamine in that person in each context and what drove them there.

So what you are saying is extraordinarily important vis-a-vis our ability to have a successful therapeutic intervention.

Dr. CLARK. That is one of the first things we do in a clinical situation, having treated methamphetamine addicts and others, you need to make sure you identify what the underlying issue is. One of the reasons we have a work release program at SAMHSA is because indeed, if the employer's environment, and we work with the DOT on workplace drug testing, which has proven to be very effective, if the employer's environment encourages the mis-use, in this case, of stimulants, then the person is being rewarded for misusing stimulants.

I had a patient who said, "My job was to do emergency work when things fell. And I had to sometimes stay up for 72 hours. Nobody asked me how I could stay up for 72 hours." He was doing cocaine, in this case. But the fact of the matter is, the job provided incentives for the mis-use of a stimulant. And you are correct, truck drivers have that. If I get rewarded for long hours behind the wheel, then I am going to look for ways to do long hours behind the wheel. So the employers have to play a role in it. The vectors of value in a community have to be tied to recovery in order for recovery to have meaning.

Ms. MADRAS. I would like to add, in terms of the causes, in the surveys that were done, not recently, but a while ago, more than 60 percent of the people who used methamphetamine took it initially because it was available. And that is a very important factor.

The second issue that I think is important with regard to treatment outcomes is that the age of onset and the amount of use can have an enormous influence on whether or not treatment is successful, so that the earlier a child or an adolescent or a young adult is identified with regard to methamphetamine, a far higher probability that they will be successfully treated. And that is why I think that being able to identify people who don't show up with the methamphetamine problem, but show up sporadically in emergency rooms and trauma centers, or even in college screening, such as what our administration is planning with regard to the SBIRT Program, is going to have an enormous influence on catching people before they progress to addiction.

Mr. SOUDER. One of the things that became apparent in major league baseball as we did the hearings in this room is that steroids, while a serious problem, amphetamines are more common. In fact, some baseball teams actually had the pills available in the locker rooms, not necessarily authorized by the team itself, but certainly hadn't shut it down through their training, and called them different names. We have been trying to address this question.

Could you describe a little bit of the medical differences between amphetamines and methamphetamine and some of the range? Historically this has been called crank, it has had different names in its lifetime. Right now, everybody refers to it as methamphetamine. In the opening testimony we talked about the category of methamphetamine and a little bit of the medical differences that we are dealing with.

Dr. VOLKOW. All of these drugs are considered stimulants, because they activate the sympathetic system, which is one that allows you do the fight-flight response. Within the stimulants, there are two categories, one represented by cocaine, and the other represented by amphetamine and methamphetamine. What is fascinating is in each one of these categories, you have a medication that is used extensively in treatment on children with attention deficit disorder.

So what are the differences and the similarities? Amphetamine has been abused and continues to be a significant abuse problem in several countries of the world, such as Japan. So there is an epidemic of amphetamine abuse. It can be very addictive, and it also can be very toxic. And just like methamphetamine, it can produce psychosis.

Now, how does amphetamine compare with methamphetamine, and why is it that we can still use amphetamine properly to treat children with attention deficit disorder? Well, to start with, when we treat, we use a route of administration that is much less addictive. We use oral administration and we regulate and titrate the doses. You never will administer an amphetamine for any other route than oral.

Having said that, as I said, when you inject amphetamine, the same amphetamine that you give to children to treat attention deficit disorder, you can crush and inject. It can produce a very intense high, and it definitely is associated with addiction.

Now, if you compare amphetamine and methamphetamine in terms, for example, they are quite similar pharmacologically. Methamphetamine is more potent than amphetamine itself, in its ability to increase dopamine as well, and its ability to increase noradrenaline, which is the other property that is associated with enhanced alertness that they were referring to. You need to stay awake for many hours, what are our kids doing in college? They are taking an amphetamine to study for their exams without having to read, and they are going to perform better. Why? Because it has neuradrenergic effects.

Will methamphetamine do the same thing? Yes, it will. But it will be doing it for a longer period of time. So it is an issue of potency between methamphetamine and amphetamine. Both of them are highly dangerous. When abused inappropriately, amphetamine can be highly dangerous.

Cocaine, on the other hand, is less potent than the amphetamines. But because it is very unique, it goes in and out of the brain very rapidly, it can lead to a repeated administration that can be incredibly dangerous. Also, cocaine, different from amphetamine and methamphetamine, has local anaesthetic effects. And that is particularly problematic vis-a-vis toxicity, because it can

lead much more easily to seizures. This is one of the reasons associated with medical emergencies with cocaine.

So while they are similar, there are unique characteristics. And on top of them in terms of potency lies methamphetamine. And as Dr. Madras stated, one of the things that makes it also so incredibly problematic is that it is very easy to synthesize. That is where the move about pseudoephedrine becomes so very important, because as Dr. Madras said, and we have known that for many, many years, availability is one of the most important variables driving drug experimentation, which is of course the first step toward the path of addiction.

Mr. SOUDER. One other question here that often have heard, well, let me ask two questions. One is that methamphetamine, more than we hear in other drugs, the users tend to be paranoic and behave differently as law enforcement approaches, more likely to be violent.

As you were describing this with the different potentially co-occurring dependencies and masking other things, is it the drug that is causing the paranoia, or to some degree they were already paranoic, and it got exaggerated? In other words, a person who is more paranoic may be attracted to use this drug if they had a co-occurring dependency, such as ADD or other types of things.

Dr. VOLKOW. You know, it is a fascinating question, but there is clear-cut evidence that amphetamines can produce psychosis. You can actually do it, they have done it in the past where they were doing experiments of giving some of these pharmacological agents to normal individuals. This was reported, high doses of amphetamine, not just methamphetamine, can produce psychosis. So to the question, if you are paranoid, are you more likely to take this stimulant drug, in fact, you are not. Because it can make you really, really sick.

So when you have someone, for example, that has a vulnerability for psychosis and they take one of these drugs, they get very, very sick. So it becomes subversive. So the drug itself, what do we know about why that drug can produce psychosis and why is it so much more frequent than with cocaine? Because it can increase dopamine so much more than cocaine. That is one of the elements.

The other element that is unique to amphetamine that does not happen with cocaine is that the target, that is, where the drug binds, which is a protein that is involved in recycling dopamine, so dopamine is liberated, but it is immediately removed. Cocaine and amphetamine and methamphetamine block it. But methamphetamine and amphetamine, cocaine does not do that, bring this protein inside the cell, decreasing its availability. And that appears to be long lasting.

So what you have is, the protein is no longer there, even though the drug may not be there, and there is no recycling process, so dopamine stays longer. And that is really one of the reasons why it is also so much more frequent to see psychosis with methamphetamine than with cocaine.

Mr. SOUDER. Ms. Madras, did you have a comment?

Ms. MADRAS. Just to add to Dr. Volkow's excellent comments, in schizophrenia, which is the ultimate form of psychosis, a blockade of dopamine targets is what produces therapeutic benefit. So schiz-

ophrenia is characterized by psychosis with, in many cases, paranoia. The underlying theory is that schizophrenia is a disease where there is too much dopamine not necessarily being produced, but there is too much dopamine activity in the brain. And amphetamines parallel that effect by producing excess dopamine.

So there is a very clear parallel between the two. In fact, emergency room physicians, if someone comes in with psychosis and they want to diagnose a person as being schizophrenic, they have to wait and make sure that they have not taken amphetamines in order to make the diagnosis.

Mr. SOUDER. My last question is a direct followup on this, Mr. Curie has made his whole career on co-occurring dependencies. And this is the first hearing in all the hearings we have on meth, I think we have had 10 now, or more, in this subcommittee, where the subject of the co-occurring dependency may have led to somebody using. In other words, it isn't just that they want to get a faster piece rate or stay awake or get high, that some individuals may have actually kind of self-prescribed this, because it masks their other symptoms, it may have actually made it worse.

Is there a study to this effect? Is this common? Is it in certain areas of the country more? What are we looking at here? Because in fact, if it makes disease more severe, this is a potential, another type of the problem that we are tackling.

Mr. CURIE. I will make just a couple of general remarks and let the scientists go into more detail with that. I think first of all, stressing the fact that an addictive disease is its own disease, as well as mental illnesses, and there is a range of mental illnesses. And I think the key is the term co-occurring. Sometimes they do co-occur, and we have the data to demonstrate that. Many times when they do co-occur, what we have found in our systems is that we have failed those individuals, because we are either treating one or the other disorder instead of both, in a particular sort of way or acknowledging it. And many times, the disorders get worse if you are not treating both.

So again, we know more today than ever before about that. I think in general, you do have situations where people may have an underlying bipolar disorder, schizophrenia that has been undiagnosed. And the use of drugs or substances has been a form of self-medication. You see that. And they may be treated for addiction. If that goes undiagnosed, it is likely that they are going to be going back with the medications.

I think you just heard excellent explanations too that many people do not have an underlying mental illness, but because of the impact of the substances, psychosis did occur. So all those things need to be sorted out, but the key is I think us having an understanding in primary health care settings, in mental health settings and substance abuse settings, that we need to do an assessment around the co-occurring issue, and make sure any door is the right door to assure people are receiving the appropriate treatment at the appropriate level, depending on the nature of the co-occurring disorder.

Mr. SOUDER. In any additional comment on that, could you also address if the drug can actually cause another psychosis, for example, will that last, even if they give up the drug? And then we have

crossed the other direction? In other words, you had co-occurring, but then could actually the drug create a co-occurring instance?

Dr. VOLKOW. The question that you are asking is one that has been challenging the whole research community. For some there are some clearer answers than for others. It is clear evidence that certain drugs can induce an anxiety disorder, given an individual that otherwise would not develop it. The same thing with a conduct disorder.

With respect to schizophrenia, this has been very controversial. There is evidence, this has been for many years, particularly from the European literature, showing that early exposure to cannabis can indeed increase the risk of schizophrenia. There is an elegant study that showed that it could actually trigger it in those individuals that have the genetic risk, that may or may not have gotten it if they had not smoked.

So the consensus right now is that by itself, the drug has not been shown to produce a schizophrenia or a psychosis that is irreversible. That doesn't mean it doesn't happen. The overall consensus is that it is likely to produce it in those that may have the vulnerability, because of your genes.

But again, what genes confer, what we know is the gene is not going to be a death sentence that you are going to get schizophrenia. What a gene gives you is a vulnerability that when, combined with the environmental factors, can determine whether you will develop the schizophrenia or not.

One of the most important environmental factors contributing on whether you will develop the mental illness or not is the exposure to drugs. Dr. Madras made a comment that is extremely salient, which is the notion that early exposure to drugs in an vulnerable individual is particularly problematic. So if you have the vulnerability and get exposed, that increases your risk of developing depression, of developing anxiety, of developing psychosis.

Ms. MADRAS. I think some of our best evidence in linking the use of drugs with ultimate consequences is with regard to alcohol. In a study that began in the 1940's and persists to this day, of a cohort of Harvard graduates, as compared with other workers in the Boston area, it was found that people who initiated alcohol use during their youth and adolescence and subsequently had a much higher incidence of depression consequently, than people who did not. That was true whether or not you graduated college or whether or not you did not go to college.

So there are clear links. But some of the others with regard to amphetamine and methamphetamine, as Dr. Volkow said, they are more controversial. There is no question that acutely, drugs can induce a psychosis. But whether or not it is reversible I think remains to be determined.

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. Dr. Volkow, you earlier invoked the term "magic bullet." This Sunday's New York Times Magazine ran an article entitled "An Anti-Addiction Pill." The article discusses Prometa, a drug treatment protocol for cocaine, alcohol and meth addiction, that is being marketed aggressively by a Los Angeles-based health care services management company called Hythiam. Some addiction medicine physicians who have administered this drug protocol

have reported encouraging results in reducing anxiety and drug craving. But some scientists have expressed concerns about the aggressive marketing of the protocol without clinical investigation.

Can you comment on that for a moment?

Dr. VOLKOW. Yes, certainly, I will be happy to comment on it. In the field of drug addiction, it has been very, very difficult to change the culture to accept drug addiction as a disease. As you know, we are treated differently. The insurance, private insurance, do not cover for the treatment. Why? Because they say drug addiction treatment does not work.

So it has become extraordinarily important for us to provide objective evidence of the effectiveness of treatment interventions. And it is harmful to the field to promote a treatment without that evidence, because it serves to propagate, if the treatment, when the studies are done properly, does not show effectiveness, it serves to propagate the sense that treatment does not work.

So to my knowledge, and I have looked into the literature, there is no randomized study that has proven the efficacy of Prometa. There was a study that was recently reported last week in the committee on Problems of Drug Dependence meeting, where they showed positive results. However, that is an open trial, and where the placebo effect is likely to confound the results of that study.

So as of now, there is not yet evidence of a randomized study that can attest for the efficacy of the treatment.

Do I support the utilization of treatments that are not evidence-based? No, I do not.

Mr. CUMMINGS. What are the possibilities or probabilities of a pharmaceutical treatment for meth addiction analogous, say, to methadone? What is the situation there?

Dr. VOLKOW. I am very confident, and I am not one of those people that just sort of says, to make a good feeling, that we will have——

Mr. CUMMINGS. I kind of got that impression. [Laughter.]

Dr. VOLKOW. That we have some very promising compounds, if only we could accelerate it faster into the clinics, that we will be seeing a shift in the way of the treatments that we can offer to people that are addicted to methamphetamine.

For many years, we were very much married to the concept of emulating the success with methadone, and now with buprenorphine for heroin. And as of now, that type of strategy, which is to provide a medication that actually accesses the same targets as the drug that is being abused, but with different properties, which has been so successful in heroin, as of yet have not yielded success for the treatment of methamphetamine overall.

That doesn't mean it doesn't work. But what we are doing in the meantime, rather than just concentrating on that approach, we are in parallel checking other types of strategies that for example address, can we interfere with the memories that are formed when you become addicted to the drug, such that you do not desire the drug when you are exposed to it. The notion of the vaccine that will actually change and interfere with the ability of the drug to get into your brain as a mechanism of protecting you against relapsing, medications that can interfere with the responses of our body when we are stressed, which is one of the factors that lead people to re-

lapse. Why? Because stress activates the same circuits that are activated by drugs. So it primes them, wanting you to want the drug.

So that is the other medication strategies that we are looking for, while at the same time still keeping an eye on the possibility that perhaps a molecule may work. But as of now, I cannot tell you of any success in that particular type of strategy.

Mr. CUMMINGS. One of the things that I wonder about, and we have touched on it a bit here, is what causes one population to use a certain drug and another—these are all people that are trying to get high. And so I look and I see, and one thing may be access, in other words, if it is there and available. But it seems as if, and I am just wondering, is it something unique about methamphetamine, its nature, that draws people to it from the beginning, as opposed to cocaine? In other words, in the urban areas, I don't hear too much about methamphetamine in Baltimore. I am not saying it is not on its way or not nearby.

But on the other hand, you go into the rural areas, and there it is. A lot of very, very good people come up with great backgrounds, the next thing you know, they are addicted. But it is almost like you can put a wall between one drug and another. I am just wondering, is there any particular person that is prone to use methamphetamine as opposed to cocaine or crack cocaine?

Dr. VOLKOW. The reason why I jumped at your question is that you touched on something I have been obsessing now for several years. Because I think it is very important, to me, an opportunity to understand what may be protecting a certain population, specifically in the case of methamphetamine. What has been intriguing me is why there are such low rates in the African-American community.

Now, you could say, and these are the responses that I got from people in the field, that it is perhaps of the market and the accessibility, that the urban territories are predominantly, they have strong markets to deal with cocaine. And so there is a pressure and an availability. Or there may be a culture that makes it negative, not acceptable.

Yet at the same time, I cannot forget what we know from other sources of drug addiction. For example, smoking is also much less prevalent in the African-American population. And the question for many years, people said, well, it has to do with the way that kids are brought up in their families. But recently, for example, we have known that African-Americans have a gene that encodes for the protein that destroys nicotine, that does not do it very properly. And as a result of that, they cannot metabolize nicotine properly. And as a result of that, when they smoke, nicotine concentrations are much higher and become aversive.

So this is a protection that helps decrease the number of people that become addicted, that will smoke cigarettes, but also the amount of cigarettes that they smoke. So I have always been very intrigued about that possibility. There is no data, so this is purely speculative. That yes, while environmental factors are extraordinarily important in addressing the question why one may favor one, not the other, there may be other biological factors, such as how do you excrete or metabolize the drug. And we know for example, that in African-Americans, kids treated with amphetamines for

attention deficit disorder require much lower doses. Why? Because they excrete is less.

So it is plausible that it is a combination of factors, environmental and biological, that can determine the differences as we are seeing right now, specifically with the methamphetamine, that we are seeing very low rates of abuse.

Mr. SOUDER. I need to do a followup with that, because that came up at one of our other hearings, where you made a similar reference. And in our field hearings, the home cookers clearly are in rural areas, partly because it can't be smelled as easily. That is why they are in the national forests and elsewhere, they can find the ingredients.

But neither crystal meth nor the home-cooked meth has been very prevalent in the big cities. But in our hearing in Minneapolis, and you need to look at Minneapolis, because in Hennepin County, we have testimony from the drug court and I think it was the head of the State drug treatment, that in one neighborhood in Minneapolis, an African-American distribution organization switched to crystal meth, and all of a sudden, 60 percent of the people hitting the emergency room and in the drug court were African-American.

It isn't clear whether that sustained itself, whether it was a brief spurt because a distribution group changed. But that is the only hearing we have had in the country where we saw it hit an urban area and the distribution change all of a sudden in the whole city, one neighborhood took over the drug addiction problem in the whole city of Minneapolis.

Now, the question is, is this going to repeat itself? There has been a little bit in New Orleans, a little bit in Detroit. My understanding is Omaha and Portland have started to see it in the minority community, too. But there should be starting to get enough of a sample to be able to test the theory. Because we have our first urban exposures.

Even in my home district, Fort Wayne has no meth. Elkhart has crack. South Bend is still cocaine and heroin. Even in Kosciusko County, where the whole area around the city of Warsaw-Winona Lake, which maybe had 20,000 people, there is no meth in the town, in the bigger city. It isn't a question of minority-majority populations. To some degree there seems to be an urban-rural phenomenon to this, even on crystal meth.

But this is the big challenge, because in anticipating where this drug is going to move, if there is indeed a biological difference, then that makes a big difference where the drug is going to move. If there is not a biological difference but just a distribution difference, then we have a different strategy toward trying to work it.

Mr. CUMMINGS. That is what I was trying to get to.

Dr. Clark.

Dr. CLARK. I think it is a combination of all the factors, that is, what Dr. Madras and Dr. Volkow were stressing, that indeed you are dealing with multi-factorial issues. The data shows that African-American people who present for people, only 0.1 percent are users. But that still is 0.1 percent, it is not zero. I think that is the key issue.

So what Mr. Souder pointed out, the chairman pointed out, is in fact an issue. There is an access issue. The northeast does not have

a major methamphetamine problem. So you go to Maine, it does not have a major methamphetamine problem. The African-American population in Maine is still really quite low.

So there is access, there are drug gangs, there are importation routes, there are manufacturing routes, there are a host of issues associated with this. Communities of color, African-American communities should not assume that this is not going to be a problem because it hasn't been a problem. The fact is, if the African-American community has been spared the problem, it should recognize that the problem can come. And as other communities, Asian communities, Hispanic and Latino community. The American Indian and Alaska Native communities, very high prevalence rate compared to other ethnic groups, other than Native Hawaiians and Pacific Islanders, 2.2 percent, which is the largest among Native Hawaiians and other Pacific Islanders.

So what we are dealing with here is a combination of access, biology in terms of genetics, preference, gang activity, importation, routes, etc.

Mr. CUMMINGS. Mr. Chairman, I know we have to get to our other panelists, and I am going to be very brief. But let me say this, that in my district, and I have literally seen this many times, where 100, 150 people, you can be riding down the street, and all of a sudden you see people coming from everywhere. And then if you hang around long enough, you see them lined up, straight in a row. And sometimes it is on a main thoroughfare.

And if you watch long enough, what will happen is a drug dealer, along with his comrades, will come and give them samples. And everybody stands there, and it is almost like somebody says at 1 o'clock at North and Monroe, this is going to happen, and they are there on time, they are disciplined, they stand straight in a line. It is well organized, they have lookouts everywhere. And I am talking about in broad daylight.

Now, what am I getting to? Drug salespeople are very sophisticated. They are some of the most brilliant people probably out there. They can actually operate an enterprise under the nose of the DEA, the FBI, the local police, the State police. And they do it very effectively. And what are they trying to get? Money.

So it says to me that if they can come up with, and by the way, what they do, the reason why they are giving out these samples, of course, is to say my product is better than your product. So come back tomorrow and you can buy it, today it is free.

So it seems to me, that somewhere in this country, somebody would say, you know, over there in Indiana, they have this stuff called meth, it is working, and it is making people high. And guess what? It stays in your system a long time. So maybe you can get a bigger bang for your buck. I mean, it is just logical. These people are out to make money.

So I wonder what it is that would keep that person from coming over and at least, if they can do this in the inner city, under the eyes of the police, it seems like they would be doing it, we would be seeing even more Minneapolis-type incidents, like the chairman talked about, all over the country. And that is a concern, because it does tell us what we have to deal with.

I just can't believe, the reason why all of it, what Dr. Volkow was saying, and you, Mr. Curie, it makes a lot of sense. But I have to tell you, a lot of people don't think it is going to get to the cities. I do. I do. Just because of the profit.

Ms. MADRAS. Just to add on to this, if one gives animals access to methamphetamine, or amphetamine, or any of the emerging drugs, they will self-administer it as robustly as humans, if not more so. In fact, some of them will kill themselves with unlimited access. So this is a biological property of our human brains as well as our colleagues in the mammalian kingdom.

Mr. CUMMINGS. Last but not least, drug courts. Do drug courts have more effect—I think you were talking about this, Mr. Curie—do we find that drug courts are more effective with regard to methamphetamine, or is it about the same as with other drugs?

Mr. CURIE. I know that Dr. Madras discussed that. I think in terms of, I mean absolutely in terms of the impact overall with substance abuse we see drug courts being very effective, and we have seen them be effective with methamphetamine in terms of getting people in treatment. We know treatment works. I don't know if we have the actual data in terms of separating the meth—I guess the Matrix study would have that, yes.

Mr. CLARK. In the SAMHSA research project, one project that works as well as the Matrix Model was drug courts.

Mr. CUMMINGS. OK.

Ms. MADRAS. And in the Vigo County drug court system in Indiana, the recidivism rate was only 16 percent for meth users, which means very, very high efficacy.

Mr. CUMMINGS. The reason why I asked that is you all talked about how long it stays in the system. I think somebody used the term "intense relapse." And I was just wondering whether, when you have intense relapse, when you have a cocaine addict in drug court, as compared to a methamphetamine user, if the relapse is less intense for the cocaine user, more intense for, of course, the methamphetamine user. I just wondered how drug court affects that.

Ms. MADRAS. One of the things the drug courts have that a voluntary admission into treatment does not is both the coercive aspect as well as the treatment aspect. So there are adverse consequences to failing. And what is so interesting in a number of areas in our society, such as the medical community, the Department of Defense community, is that when you impose adverse consequences on relapse, you get a much higher treatment rate.

For example, physicians who are treated because of impairment, their relapse rate is much lower, because the consequence is the loss of their medical license. And in the Department of Defense, mandatory drug testing leads to 1 to 2 percent positives, compared to the rest of society. So the drug courts have a certain measure of coercion with adverse consequences that has an added benefit, compared with voluntary treatment.

Mr. CUMMINGS. I often say, and I will close with this, Mr. Chairman, that people do things for one of two reasons or a combination of both: to gain pleasure or avoid pain. And it goes to what you just said.

Mr. SOUDER. I thank you. We have had different people testify at our meth hearings on drug courts. One of the things is, the sample size is really relatively small yet in the United States. By the time you separate out mandatory entrance, in Arkansas it was mandatory going into the drug court, in other States it is voluntary to go into the drug court. Also the number of drugs you are dealing with, also a critical question is, did you catch them early or catch them late.

Even in some of our counties, the drug court judge tends to get them earlier in meth than some of the other judges. We have one judge in one of my counties who has, the person is coming up for the third offense of cooking meth, and they haven't been prosecuted yet on the first one. That makes the measurement difficult, very difficult.

But as we get more experience, the drug courts, the emergency rooms are the great mines for information to try to do this. We appreciate the service of all of you. Thank you for being patient with our questions today. Thank you for making it in a form that we can understand. It was very informative to each of us. We thank you for that.

If the second panel could come forward and remain standing so that I can give you each the oath. Our second panel is Russell Cronkhite, recovered meth addict; Darren and Aaronette Noble, recovered meth addicts, with their son, Joey Binkley; Dr. Richard A. Rawson, associate director of the Integrated Substance Abuse Programs at UCLA; Leah Heaston, Noble County director of the Otis R. Bowen Center for Human Services in Indiana; Mr. Michael Harle, president and CEO of Gaudenzia, Inc.; and Pat Fleming, director of the Salt Lake County Substance Abuse Services.

If you will each remaining standing so we can give you the oath.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that each of the witnesses have responded in the affirmative. We thank you for coming today and we will start with Mr. Cronkhite.

STATEMENTS OF RUSSELL CRONKHITE, RECOVERED METH ADDICT; DARREN AND AARONETTE NOBLE, RECOVERED METH ADDICTS, ACCOMPANIED BY JOSEPH BINKLEY; RICHARD A. RAWSON, PH.D, ASSOCIATED DIRECTOR, INTEGRATED SUBSTANCE ABUSE PROGRAMS, UCLA; LEAH C. HEASTON, MSW, LCSW, ACSW, SAP, NOBLE COUNTY DIRECTOR, OTIS R. BOWEN CENTER FOR HUMAN SERVICES, INC.; MICHAEL B. HARLE, MHS, GAUDENZIA, INC.; AND PAT FLEMING, DIRECTOR, SALT LAKE COUNTY SUBSTANCE ABUSE SERVICES

STATEMENT OF RUSSELL CRONKHITE

Mr. CRONKHITE. Thank you, Mr. Chairman.

Actually, I am very encouraged at some of the things I have heard today, especially for the progress in the drug courts.

For nearly 12 years, I had the honor to serve our Nation as the executive chef of Blair House, the President's guest house. In my tour of duty, I served Presidents Ronald Reagan, George H.W.

Bush and Bill Clinton, as well as nearly every world leader of this era.

Today I am the author of two successful cookbooks. My work has appeared in several top food magazines. I continue to contribute food-related articles to publications like the Washington Post. Rather than write the latest celebrity chef trend cookbook, I have chosen to write cookbooks that encourage quality family time, promote a sense of community and foster traditional American family values, like A Return to Sunday Dinner and A Return to Family Picnics. I continue today with my career as a public speaker and working with faith-based organizations, community organizations for the purpose of encouraging families and family values and a sense of community.

My family value message is not a marketing plan. In August, my wife and I will celebrate our 34th anniversary. She works for the Fairfax County school system here. We are the parents of three grown, adult children.

But the one subject I have not spoken about publicly and something that I generally do not talk about at all is that I was addicted to methamphetamine, or speed, crystal meth, during my adolescent years. Indeed, you will be hard pressed to find anyone that I worked with in Washington, DC, or worked with in the hospitality industry over the last 30 years who would even believe that such a past struggle was even possible.

I find no pleasure in telling or even recalling this self-imposed hell that is so far removed from my life, but the epidemic sweeping our country has compelled me to come forward and tell my story. It is a story of restoration and redemption. I come here today as a private citizen with no connection to any party, political organization or advocacy group.

My spiral into the drug culture began in 1965 and soon my life became a shattered mess that reflected the chaos of the turbulent times. By 1967, just after my 14th birthday, while looking for a better thrill, I fell into the frightening world of methamphetamine into a desperate addiction that continued over the next 3 years.

Methamphetamine is different than other drugs. Using methamphetamine is not about escapism. Staying up for days and weeks on end without sleep is no escape from reality. Meth addiction is self-destructive. It is a slow suicide and is also a visible call for help. I knew full well the risks and down side of methamphetamine use. We used to say "speed kills, speed thrills." It was a catch phrase. My spiral into this hell of meth addiction was severe. Self-mutilation, chaos, psychotic episodes and frightening and violent hallucinations and dementia. I came very close to pulling the trigger to end the madness that my life had become. I know those who did, and I know those who died by the needle.

We were not the children of unfortunate circumstances. The Los Angeles community where I grew up was similar to the local communities surrounding Washington, DC, like Arlington and Falls Church. We were middle class and upper middle class families. My parents' friends were real estate brokers, doctors, contractors, school teachers, dentists, business owners, executives and engineers for companies like Douglass, Northrop and Hughes.

I am not one who believes that drug addiction is a disease, per se. It is an illness, yes. It is not something that you can catch, like a communicable disease, like measles or chicken pox. There is a certain self-inflicted part to this disease, to this illness. I do understand the idea and the desire to sort of let people off the hook in counseling and provide an emotional, short-term, feel-better fix. But those who have such a low self-image that they are willing to engage in this kind of deadly behavior do not need to have additional guilt dumped on them.

But the loss of personal responsibility, while attractive in the short term, can also take away the impetus for change. If we are simply creatures of our genetic makeup, predisposed to some disposition or some unfair twist of fate, we are sadly condemned and unable to rise above our very circumstances.

Equally, I am concerned, as has been expressed here today, that some might suggest that methamphetamine addiction cannot be effectively treated. Clearly, my life is evidence to the contrary. The years between 1965 and 1970 found me in and out the juvenile court systems, and eventually the California Youth Authority. I owe a lot to some very dedicated counselors and to a parole officer who was more concerned about seeing me delivered than keeping me locked up.

My road to recovery began with a very simple, act, though. An uncle, finding me dazed, my body reduced to that of some sort of holocaust survivor, simply put his arms around me and invited me in to have something to eat. There was no scolding, no lecture, no condemnation, just loving concern, served with a bowl of peaches. Today I applaud groups like CASA, who foster the values found around the family table and the quality companies that support their efforts.

It does take a village. An effective drug treatment program, especially for the highly addictive methamphetamine, must be comprehensive. Faith in God, the support of my church, my family, dedicated school teachers and community organizations like the YMCA, coupled with a viable, quality psychological counseling and a State-run system that worked, brought me to a place of transformation and renewal in 1970.

One of the first jobs I took as I rebuilt my life was that of a prep cook. You have to start somewhere. Still, without a high school diploma, a little consistent work experience and a troubled adolescence, I faced many challenges. People were not eager to hire me. But it only takes one exception. The first chef that I worked for had a policy of hiring the worst applicants. His thought was that if you gave someone a second chance, as someone had given him, the person would rise to that opportunity, work harder than someone with other choices. His views carried over throughout my career.

Being an executive chef, like any business manager, is part babysitter, part marriage counselor, part drug counselor, part cop, part coach and part psychologist. Working with lower income employees here in the Washington, DC area, before I joined Blair House, who had limited training, limited educations and limited opportunities was a challenge. I met those challenges by listening and recognizing that outside influences faced by employees also affected their performances.

When I was in the hospitality industry, I found that many of my employees were affected by the social plagues like domestic violence and substance abuse. Many of the employees that I had working for me in hotels in Washington, DC, and in Atlanta became involved in methamphetamine and amphetamines because they were working two jobs to support their families. I personally paid an employee's rent and covered their time off for treatment to compensate for the limited resources that were available, rather than lose an otherwise good employee.

The social fabric of America has changed. Too often teachers are no longer part of the communities where they work. Most cannot afford to be. The lack of affordable health care means a family whose children struggle with addictive behavior often have few outlets for professional treatment.

I know families who have mortgaged their lives, lost their homes and spent their life savings to save a child. I know families who have seen their children relapse into the frightening hell of drug addiction, simply because the 30 day maximum for mental health treatment and the 20 allowable followup counseling sessions have run out. These are the ones with health care. To my knowledge, Fairfax County, one of the country's most affluent communities, has only one facility available for these kinds of programs.

According to a recent Washington Post article, Americans feel more and more isolated and have fewer people that they feel they can confide in in times of difficulty. Robert Putnam has chronicled these alarming social trends in a monumental work, Bowling Alone: The Decline and Revival of American Community.

I am concerned about the mixed messages that we seem to be sending out. Today we have a lock them up and throw away the key mentality too often. I am especially concerned about this when it comes to juvenile justice: 14, 15 and 16 year olds are not adults.

I do believe we should have little tolerance for those who manufacturer and distribute dangerous drugs for profit. In this, truly the love of money is the root of all evil. Those who market their witches brew of toxic chemicals for the sake of profit are a pariah on society and should be dealt with accordingly.

But those who support a habit must be treated as a victim and a perpetrator. I truly wonder sometimes with a focus on interdiction rather than on treatment if I would have had the same opportunity to rebuild and reclaim my life 35 years ago, as I have. I was fortunate. My arrests and convictions all took place before my 18th birthday. And because I successfully completed my parole without incident for 5 years from my release from the California Youth Authority, my juvenile record was expunged, as it should have been.

With the difficulties of my adolescence behind me, I was allowed to rebuild my life, rise to the top of my craft while providing for my family and served my country with honor and distinction. Trustworthiness is not about having lived a perfect life. It is about honesty and integrity. I believe to be fully redeemed we must be fully restored. William Penn believed that, and when he and his followers laid plans for Philadelphia, the first American city, they built a penitentiary rather than a prison. It was a place of solitude where one could consider their actions, come to repentance and return to society.

I am not a recovered addict one slip away from remission. I am a highly successful professional, a father, a husband married 34 years, a church member, a member of my community who long ago, almost another life ago, struggled with addiction, because I struggled with self-doubt, self-hatred, self-destruction and a disillusioned moral crisis. Addiction is a symptom of a deeper plague. To effectively treat addiction we must have a comprehensive plan to address the root causes. Left untreated, those causes will only reappear or resurface in a different form.

I am here by God's grace to be sure, but I am here because those around me cared enough to come alongside me and offer help. My story is one of success. I am one for whom the system worked, where the unconditional love of family, community, Government resources, family doctor, faith-based organizations and self-determination and good counseling came together to save a life.

Mr. SOUDER. Thank you very much for your testimony.

Darren, you or Aaronette, who is going to give your testimony? You are Darren, you are next.

STATEMENT OF DARREN NOBLE

Mr. NOBLE. Good afternoon. Thank you for the chance to speak to you as a father in recovery. Aaronette and I are the proud parents of two children, Casey, who is 6, and Summer, who is 17 months old. Casey is here with us today. I am also the very proud stepfather of Joey Binkley.

I used meth for 14 years. My wife and I used meth together. We wanted to get help to stop hurting ourselves and our children. I tried treatment. I went into four different treatment programs, but each program was set up for single adults. I couldn't bring Aaronette or the children with me. So I couldn't concentrate on the treatment itself. I couldn't stop worrying about my wife still being in the situation that I had left. I couldn't stop worrying about my children, what was happening to my children.

For treatment to work, you need time and space to think about you. But I couldn't think about me. I could only worry about my family. So after many years of using meth, trying to get clean, using again, I ended up in prison. In 1999, I was arrested for manufacturing meth. I used to manufacture meth by myself out in the woods.

When I went into prison, I weighed about 120 pounds. I was not offered treatment in prison or after prison. After serving 3 years and 10 months, I was released.

Life didn't get better for us after prison. Aaronette and I continued to use meth. Our addiction got so terrible that in 2005, Aaronette gave birth to our second daughter, who was born with meth in her. Child welfare took our baby away. But child welfare, along with the family court program, placed us into Bridgeway's family treatment program. Aaronette went into the women and children's program. I went into the men's program.

I can't tell you how wonderful it felt to do treatment as a family. In the family treatment program, I knew that my wife and children were safe and healing. I could focus on my own treatment. But I could also heal with my family. At Bridgeway, we did family therapy, couples counseling, we had parenting classes. I learned how

to communicate with my wife. I learned how to honor her. You see, before, our relationship was based on drugs. But now we know how to talk to each other, love each other, and we also know how to be parents.

When I was using meth, my daughter Casey looked so scared. My daughter Summer lived with her grandmother. She was very attached to her grandmother. But today, our daughter Casey has a beautiful sparkle in her eye. She is doing well in school. And our daughter Summer has been returned to our custody, 7 months ago. She is inseparable from us. We are a family.

We have a support system made up of wonderful people from our family court and our family treatment program. They all worked together to help our family get clean and stable. Our social circle is made up of other parents in recovery. We are blessed. I am working in construction. We attend church. We still go to therapy. And we are a family with faith and hope.

Thank you.

Mr. SOUDER. Thank you. Aaronette, do you have a statement?

STATEMENT OF AARONETTE NOBLE

Mrs. NOBLE. Good afternoon. Thank you for the honor of speaking with you today. My name is Aaronette Noble. I am here with my husband, Darren, my son Joey and my daughter Casey. I am a wife, a mother and a recovering addict. I grew up in an alcoholic home. I smoked marijuana for the first time at the age of 7. I first drank alcohol at the age of 14, and I began using cocaine and methamphetamine at the ripe age of 17.

No one plans to have the disease of addiction take over their lives, and no one plans to end up in prison for methamphetamine abuse. No one plans to give birth to a tiny baby born with drugs in their system. No one plans to have their children tell them that they don't want to have anything to do with their mother. No one plans for these things. I know I didn't.

When I was using meth, I felt dead most of the time. All I did was breathe in and breathe out. I had no motivation. The world was a very dark place. I had no hope or no faith in anything or anyone. Every day I would wonder why I just didn't die. I was so angry at God, the world, and mostly at myself. My teeth and my hair were falling out, and other people had custody of my children. My husband and I were homeless and sleeping in our car.

Did I believe that family treatment could help me with all that was wrong in our lives? How could it? I had tried single adult programs but I never succeeded in staying clean. The programs were very short-term. They were only 90 days at most. I was not helped as a mother who had this shame and guilt because of my addiction. My children were not provided services. We could not heal together as a family.

After years of prison and inappropriate single adult treatment programs, my addiction to meth got worse. I gave birth to my daughter, Summer. Summer was born addicted to meth. She was removed from my custody by child welfare. At that point, however, a miracle happened. My children and I were referred to a comprehensive family treatment program. We entered into Bridgeway

Counseling and the Division of Family Services. My husband made a commitment to do the same.

Bridgeway had just opened a men's residential treatment center next to the women's center. We were the first married couple to be in treatment at the same time. It helped to know that we were doing this apart but also together. Our addiction tore our family apart, so you see, we needed to find our solution as a family. I received services I didn't even know I needed. I saw a psychiatrist, who helped me with my depression, and I could sleep better, think more clearly. It was like someone turned a light on in my head, and my mind wasn't constantly racing any more.

At Bridgeway, we started family therapy. I got counseling for past domestic violence and sexual abuse. I didn't even think I had issues in these areas until I finally opened up to my counselors and was truthful with myself. We took parenting classes, went to meetings and attended church. The Division of Family Services brought our baby to Bridgeway for Darren and me to see. She is a beautiful little girl with big blue eyes that can see right through you. I want her to only see good things in me today, and that is what she does. She gives me strength and courage.

After 30 days of doing Bridgeway's residential program, my family and I transitioned into Bridgeway's intensive outpatient program. The beginning of our sobriety was not easy, but maybe it shouldn't be. Maybe we needed to work and struggle. We entered into a shelter. I came to Bridgeway during the day. We then as a whole family purchased a used trailer for $500. I have to tell you, we love that trailer. It is our first sober home as a family.

My husband and I voluntarily joined a Family Safety Drug Court in order to have more structure and more support and allow the Division of Family Services to be an even bigger part of our lives. We had nothing left to hide. We only wanted our family back together. We only wanted to stay sober, we only wanted to make our children smile as often as we could.

We also continue to receive the family based treatment services of family counseling, therapy and parenting classes at Bridgeway. Our family is not an exception. There are hundreds of parents like us who are clean, sober and stabilized because of family treatment programs like Bridgeway.

But there are also many families in need of family treatment, and the waiting lists are long. There are only two family treatment programs in the whole State of Missouri, so many families get lost to the disease of addiction.

My beautiful little Summer, with the blue eyes, has been reunited with us now. She has been with us for 7 months. I am sure those of you who are parents can feel the light of having all your children next to you brings you. The light is with me today, it is with me here in Washington, DC, it is with me every moment. I know that being a parent is not just a right, today it is a privilege. It is mine and Darren's privilege to be parents.

No one plans to tear their world apart, and the world of their children. Today, because of available family treatment, I can plan every day to put their world back together. This is work, but it is the best kind of work. It is a struggle, but it is the best kind of struggle. We continue to go to meetings, we continue to meet with

the court, we continue to make sober friends. And we begin, for the first time, to be sober heroes to our children.

Thank you.

Mr. SOUDER. Thank you. Joey, are you going to share your story with us now?

STATEMENT OF JOSEPH BINKLEY

Mr. BINKLEY. Hello. My name is Joseph Binkley. I am 18 years old and am a recent graduate of Ritenour High School in St. Louis, MO. For most of my life, my mother has been addicted to drugs and alcohol. In my early years, I had no idea that my mother had anything wrong with her. And I had no idea about drug addiction or the symptoms thereof.

It wasn't until the end of elementary school that I realized that something was very wrong. My mother was acting very strange, and she had to be placed into treatment multiple times for drug abuse. I was not able to be with her during those times in treatment.

A short time afterwards, she went into prison. From that moment until about a year ago, I completely stopped talking to my mother. I did not want anything to do with her. I felt betrayed.

I lived with my father during my mother's incarceration. After getting out of prison, my mother was still using drugs.

It wasn't until I learned that my youngest sister, Summer, was about to be put up for adoption that I felt I had to do something about this issue. I joined my family in the family treatment program at Bridgeway. The family treatment program helped rebuild my family and healed my mother's issues. Throughout the experiences of my mother's addiction and recovery, I could not leave my family, because that would not have helped me or my family. I felt that I may not have done as well without their support.

We now can have birthday parties, graduation parties, and events such as those, just as any normal family would have. Surprisingly to most, my at-home issues have not affected me academically. Throughout the years, I have maintained a high grade point average. At the end of high school, I had around a 3.8 grade point average, perfect attendance and was involved with multiple groups and organizations, including Leadership, D.J. for the school radio station, RCO, Teenage Health Consultants, Mu Alpha Theta, varsity baseball, Ritenour Big Brother/Big Sister, and I was on homecoming court.

I was promoted to a managerial position at my job at ChuckaBurger, and I have also recently begun working as a driver for Pizza Hut. I have been accepted to Southeast Missouri State University with two scholarships, though I am still looking for more additional funding. I will begin Southeast Missouri State in the fall. I plan on becoming a physics teacher, so I am majoring in physics education.

Thank you.

Mr. SOUDER. Thank you for your testimony.

Dr. Rawson, we appreciate your being here today. I just want you to know I am not going to sing happy birthday to you, but we thank you for coming on your birthday. Maybe as a concession, when UCLA comes to Notre Dame this fall to lose, I will do at least

a clap in memory of your birthday and that you had come before the committee on your birthday. [Laughter.]

Thank you very much for joining us, and we are looking forward to your testimony.

STATEMENT OF RICHARD A. RAWSON, PH.D

Mr. RAWSON. Thank you, Chairman Souder. I want to thank you for the effort you have put in to address this problem of methamphetamine in the United States. For 20 years in southern California, we have been wrestling with this problem and trying to get some attention. Until your efforts, it has been somewhat challenging. This committee has been a breath of fresh air in giving us some assistance and attention to this problem.

My name is Rick Rawson. I am a professor at UCLA. And for the last 30 years, I have done work in the field of drug abuse. From 1983 until 1998, I ran a non-profit organization called the Matrix Institute in southern California. We were asked by the health director in San Bernardino County in 1986 to come and open a clinic because of a methamphetamine epidemic in San Bernardino in 1986. We had several other clinics at the time that were seeing hundreds of cocaine users, since that was the peak of the cocaine epidemic. But in San Bernardino County, methamphetamine was already a severe health problem.

The clinic we opened in 1986 in the first year saw 150 patients. This year it will see closer to 1,000 patients. Over that time, we have now seen between 7,000 or 8,000 methamphetamine users in that clinic.

In the late 1990's I went back to work. I had started at UCLA and I went back to work to UCLA and I have been there now for 10 years, overseeing a portfolio of research. But for 15 years, I sat in a chair and saw one patient right after another, half of them being cocaine users and half of them being methamphetamine users. We started to put together some treatments and developed a treatment model that has since become known as the Matrix Model that you have heard of, and we have collected some data on.

Now that I am a so-called methamphetamine expert, I spend about 100 days a year traveling around the country talking about methamphetamine and the problem and the treatment. I do hear some very interesting questions and myths. But of course, the one that is most interesting is this issue about methamphetamine users being untreatable. The term I frequently hear is that fewer than 5 percent of methamphetamine users get better.

I think that initial reference came from a Rolling Stone article in 1997, that is where that figure came from. It was one of our better scientific journals. [Laughter.]

In my written testimony, I give you some data on this comparability between treatment of methamphetamine users and treatment of other substance abuse disorders. But in short, we have run three controlled clinical trials and we have analyzed three large data sets where we have looked at meth users and cocaine users. We have looked at the data in every way we can possibly think of to look at it. We have found absolutely no evidence of any difference between those groups.

In fact, we think that the treatment for stimulant users, probably the outcome is better than it is for heroin addiction, except that heroin addiction, we have medications like methadone and buprenorphine, which we don't have for stimulants. But there is no evidence that I can find or that any of my colleagues have been able to find that meth users are any less responsive to treatment than any other patient populations.

Now, there are some slightly different issues that often need to be discussed in treatment, and that is what we have tried to program into our treatment materials. SAMHSA has evaluated these in a large-scale trial. But in general, across the board, our treatment outcome data for cocaine users, meth users, alcohol users, are all very comparable. We can't see any systematic difference.

Why has the myth occurred? I think probably it is developed because during the 1980's, when we saw large numbers of cocaine users in urban centers, and NIDA responded and developed a set of training materials, and these training materials were disseminated where there were cocaine problems, people became quite skilled at using these empirically based treatments.

However, in rural areas, where there really wasn't much of a cocaine problem in the 1980's and 1990's, they continued pretty much to use treatment methods that had been developed for alcoholics in the 1960's and 1970's, and just never gained any exposure to these new treatment strategies. When the meth users started showing up in the 1990's and this century, they didn't know what to do with them. They had never seen patients like this before. In the urban centers, they had, and they had adopted these treatments that have been useful.

So I think the issue is not so much that one addiction is any more difficult than the other, but that one group of treatment providers in geographic areas had never seen anything like this. So they were really struck with the difference between their meth users and their alcoholics, which had been their standard patient population.

I do think that the materials that SAMHSA has developed really are quite excellent. The dissemination of those materials and the training that goes on is going to be critical to getting the communities affected by methamphetamine providing effective treatment. I think that is a big need.

There are a couple of things I would like to mention, a couple of points that I think have not been mentioned. Three months ago, we had data presented from San Diego County. San Diego is also one of the cities that was impacted early by the meth problem.

The data they are presenting from San Diego—the epidemiologic data—suggests that right now the rates of meth use and admissions to treatment and emergency room visits are higher today than they have been any time in the last 20 years. This epidemic does not go away on its own. It is not one where it peaks and then you see a dropoff. We haven't seen any evidence in Hawaii or in Portland, OR, of any reduction in use. We have seen a reduction in labs, with the precursor controls, but not in use and not in the extent of the problem. I think that what you are doing with these hearings and getting attention to this problem is important, because I think it is going to continue to spread into the east coast

and into the urban centers. And I think it is going to persist in areas where it has been a problem for some time. That is what the San Diego data tell us.

Second, if you look at the Federal data on drug trends, and you look at adolescents, the Monitoring the Future data, you would think that there is no problem of meth use among adolescents. The California treatment data would suggest otherwise. In California, in the last data set that we looked at, almost a third of adolescents entering treatment were primary meth users. In some places, female admissions were over 50 percent. That is if you looked at alcohol, marijuana and everything, coming into treatment, we were seeing 50 percent of the girls coming in for methamphetamine dependence.

I think that we have to watch out that we don't let the same thing happen with the adolescent drug trends that we did with the adult drug trends, where we look at these surveys and say, well, I guess there is not a problem there. Our treatment data in California would suggest very differently, that adolescents are using methamphetamine, they are becoming dependent on methamphetamine.

And that should be a priority, because as you heard Dr. Volkow say, it affects adolescents' brains more profoundly. We are not sure about the recovery from meth for adolescents, although the story was very hopeful. It is a concern for us. So I do think that paying some attention to this problem with adolescents is important.

I appreciate the opportunity to speak to you. I am a big fan of this committee and the work that you have done. I would like to thank you all for taking this effort on.

Mr. SOUDER. Thank you very much.

Ms. Heaston, it is good to see you. Thank you for coming from Indiana to be with us today, and we look forward to your testimony.

STATEMENT OF LEAH C. HEASTON

Ms. HEASTON. Mr. Chairman and members of the committee, thank you for inviting me to participate in this hearing.

For most methamphetamine abusers, treatment options in rural areas may be few and far between. For the Bowen Center, even with the ongoing support of our local coordinating council, Drug-Free Noble County, Judge Michael Kramer, CADCA and the Indiana Division of Mental Health and Addiction, we are still having difficulties with the full implementation of the Matrix Model, due to the following barriers.

The first barrier to the availability of methamphetamine treatment in rural areas is the absence of qualified and experienced staff. Staff recruitment and retention of individuals is very difficult. Even with constant recruitment, openings are continuous. As a result of the absence of qualified staff, rural areas have been left recruiting and training from within. This process is very lengthy and expensive, especially as most rural areas are not experienced with the cocaine epidemic. So treatment starts to feel like an uphill battle.

Until rural areas have enough qualified, experienced staff providing these services, the outcomes for treatment will be affected. The

next barrier is summarized by Dr. Thomas Freese, as he states, "Training alone is insufficient if the funding necessary to deliver these treatment recommendations is not available." Treatment is not cheap. But it is less expensive to treat methamphetamine abusers than it is to incarcerate them. According to the principles of the Drug Addiction Treatment, A Research-Based Guide, it states that "conservative estimates indicate that for every dollar spent on treatment, four to seven dollars are returned in reduced crime, criminal justice costs, and theft."

The Noble County jail has a third of its population incarcerated for methamphetamine related crimes, and in 10 months spent one tenth of their medical budget on oral and dental damage from the use of methamphetamine. For most methamphetamine abusers, the cost of treatment is very high. Many have lost everything due to their use and do not have the money for food and shelter, let alone treatment. Those individuals with managed care may not be covered due to legal difficulties. And even if they are covered, the limitations of managed care make effective treatment extremely difficult.

Effective treatment should also include family therapy and case management, which is an additional cost. The lack of funding for these services is yet another barrier.

Another barrier is transportation. Transit systems do not exist in rural communities, and even if they do exist, the cost is prohibitive. Many individuals lack a driver's license, vehicle and even the money for gasoline. Women present another interesting challenge, as they are typically the primary caregiver and run the risk for pregnancy. They also have higher rates of mental health concerns, poverty and lack the skills necessary for employment.

In Indiana, 47 percent of the individuals abusing methamphetamine are women. Research shows that women are less likely than their male counterparts to access services. Women are also in need of child care service, which is an additional cost and barrier.

One way to increase the effectiveness of treatment is to have separate programs for men, women and adolescents. In rural areas, implementing one program is difficult. Three separate programs is almost impossible.

Due to the effects of methamphetamine on the brain, treatment needs to be long-term, intensive and comprehensive. It needs to include topics on methamphetamine, but also medical, psychiatric and mental health issues. Another barrier in rural areas is the difficulty recruiting and retaining psychiatrists. With the use of the Matrix Model, treatment is effective.

In summary, my recommendations for rural communities are: first, the continued and increased support of the Substance Abuse Prevention and Treatment Block grant. In Indiana, this block grant funds over 70 percent of all our addiction services, and 95 percent of prevention services.

Second, the continued support of CADCA, which assists communities with linkage to national evidence-based resources and the development of community-based interventions for the prevention and treatment of alcohol and drug abuse. Assist rural communities with resources for personnel recruitment, retention and training.

Provide resources for child care for those involved with treatment, and expand the access to treatment.

I would like to thank you for your time, and for your commitment in addressing these concerns.

Mr. SOUDER. Thank you very much.

Dr. Harle.

STATEMENT OF MICHAEL B. HARLE

Mr. HARLE. I am glad that you made me a doctor. I am going to work really hard to make sure that I live up to that. [Laughter.]

Good afternoon, Chairman Souder, and committee. I have written testimony here, and I don't want to read it, because I think that you can read it yourself. So I would like to comment on what I do have in my testimony and try to make those points that either you have asked questions about or that I have direct experience in.

I will just give you a little bit of my background. I am the president and executive director of Gaudenzia, Inc. We are the largest freestanding treatment program in the State of Pennsylvania, and we are soon to be the largest program probably in the State of Maryland. We are also located in Delaware.

We service an awful lot of people on any given day. We have been in existence since 1968. We have 91 programs in 51 locations. About 2,300 people a day are in outpatient and residential programs in the community and about 1,600 of those people are behind the walls in prison.

Additionally, we have 419 children under the age of 12 that are not addicted but are in treatment with their parents. We have six programs that are for women and their children and their family members. So we are pretty serious about doing this.

This month we will open up and additional program in the Park Heights section of Baltimore. By the way, right across the street from our facility is where they used to have those lines that Congressman Cummings talked about. I have observed those lines. Those lines still exist, but they do not exist near our treatment program, because one of the things that addicts don't like to be around is jails and treatment programs, while they are actively addicted. When they are not addicted, that is the place that you will find them.

I am presently also the president of Therapeutic Communities of America, which represents over 700 programs in 32 States, including Puerto Rico and the Virgin Islands. I have been witness, many of our TCA members are located in places like the central valley of California, where 100 percent of their treatment admissions are methamphetamine. Our treatment programs have been treating these people probably since 1968.

So to just let you know that it depends on where you live in the country on whether or not your admission is for methamphetamine. I think there was an earlier discussion in regard to the economics of this. Where it is more available, the treatment admissions go up. Where it is cheaper, treatment admissions go up. So there are many, many variables, and I think that the scientific panel gave you a lot of history about that.

But I can tell you that as a counselor, I gave you all my credentials, and I am going to give you a little bit of a different perspec-

tive. As a counselor, and I think I heard a little bit of this before, I didn't see differences in regards to the outcome for methamphetamine addicts. The challenges were different, the etiology of the disease was a little different. But what was really necessary was long-term treatment, in order for people to heal. Some of the psychosis that was talked about may continue. Some of it, with some of my clients, continued for years beyond that. Not as great, but you had to stay there with them, you had to get in there and be with them. The longer the addiction was, the longer you are going to have to spend time in treatment.

What I added to this was an attachment A. Attachment A shows that in the State of Washington, there was a recent study done where they say for every addict there is a cost offset of about $296 per person when you treat them. Methamphetamine treatment, stimulant treatment, is actually more cost effective than other treatments for other diseases. Not much, it is a difference of $19 per day that you save. So you save money when you provide treatment. And that is what I want to discuss.

The problem is that there are giant holes in our national treatment network. It does not exist in the right amounts in the right places throughout the country. You heard about the rural areas. You heard about the lack of family treatment. For some reason, as a society, we have not invested the kind of money in treatment programs as we have invested in the criminal justice system or in the prison system.

And I can attest to that, because I have more people on a daily basis behind the walls that I am treating on some days that I do in the community. We have a real problem here that we need to address. And it didn't just happen today. It is not at the doorstep of this committee. It has been a problem for the last decade or so. What we have done is we consistently leveled off our treatment and we have added things to our treatment system, such as managed care. It is not managed care, it is managed cost. And what it has done is it has reduced the length of stay of treatment. So our treatment system is more damaged today than it was 10 years ago.

Right now, if you are a crack addict in Philadelphia, sometimes the decisions on whether or not you are going to get treated are made on Wall Street. They are not being made where they need to be made. They are being made based on profit and loss, and short-term profit and loss, not long-term profit and loss. And that model does not work for substance abuse treatment. We have implemented it throughout the country. That is a problem, and a particular problem for rural areas.

And for women, and for women with children, this is very difficult to access treatment. When people are ready, keep in mind, you are going to have to use the criminal justice system. People don't wake up 1 day and say, you know what, I would really like to get treatment for my long-term crack addiction or my long-term methamphetamine addiction. They are psychotic when you are first talking to them.

So you are going to have to use outside forces to get them to the treatment door. And when you do, it needs to be the proper treatment for the proper length of stay. And I can tell you that we provide Therapeutic Communities, we have been doing it a long time,

there is a tremendous cost offset. It is a lot cheaper than any other way of treating them, and it is also a lot cheaper way to provide the help, by doing it long-term and doing it right the first time, instead of spending tons of money on the effects of the addiction.

Pennsylvania alone spends $3.4 billion, not treating addiction, on everything but the treatment itself. And I think that you can see there, there is a CASA study in 2001 that shows that across the Nation.

Now, the work force problem, if tomorrow you said we need to put up a treatment system now, we are going to do it now. It is going to take 10 years. You can't do it right away. We are going to have to use the targeted capacity, we are going to have to follow these epidemics. But think about it long-term. There is going to be another epidemic.

Right now in Pennsylvania, I have a 100 percent increase in treatment admissions for methamphetamine in Erie, Erie, PA, which is in the northwestern corner. I have a 275 percent increase in heroin in Philadelphia and the southeast of Pennsylvania. I have programs in the middle of Pennsylvania, it is moving together.

What happens in Harrisburg, the State capital, when these two things hit? I have two epidemics, and I don't have any more treatment programs, and I don't have any more staff. Matter of fact, most of my staff are getting to retire. Some of them are the methamphetamine folks that I used to treat in the early 1970's because Pennsylvania, the southeast corner, was where the Dupont, Allied Chemical, all the major precursors to make methamphetamine was. And we had an epidemic.

What we did is we moved the labs to southern California and to San Diego and made that now, it is called Crystal City, is what they call San Diego. What we did is we just moved it. So that is what we did, we made it illegal to sell those precursors in Delaware County, PA, and we moved it to Mexico and they moved it right back across the border. Eighty percent of the methamphetamine comes from labs in Mexico, 80 percent. And if you stop it in Iowa, they are going to produce more of it in Mexico. If you stop it in Mexico, they are going to produce it in Canada.

I am not casting aspersions on anybody, and if they can't get it in Canada, they are going to make it in Maryland, wherever there is profit in this. We have to reduce the demand. And to reduce the demand, you are going to need effective law enforcement, effective treatment and effective prevention. Right now, we don't have the treatment system to handle this epidemic. That is what they are telling you, we don't have the work force, we don't have the facilities and we need help.

It is going to require a long-term plan. There is no magic cure. And by the way, if you are looking for a magic cure for methamphetamine, I would guarantee you that same drug we come up with will end up getting abused and will change the molecules to that. Our clients look for magic cures. Do not look for magic cures. Look for long-term, hard-won solutions, just like these folks have had to do. They have had to work hard at it. Give them the right resources to do it.

It takes time, it takes effort. I am sorry for being so passionate about this. But I talk to people who die, we have many people who

succeed. We have a lot of people doing really well. But I also have the displeasure to speak to families who can't get their kids into treatment and they have passed away. We have people dying from this epidemic.

So please, think about a long-term plan for this. I have a lot of stuff in my testimony. I really don't think you need to hear that. I think my message is what I would like to get across, because I only have a limited time, so thank you.

Mr. SOUDER. Our last witness is Mr. Fleming—are you Doctor? Or do you want to become one?

Mr. FLEMING. Well, if you want, yes, I would love it. I get more money that way, I guess. [Laughter.]

STATEMENT OF PAT FLEMING

Mr. FLEMING. My name is Pat Fleming. I am the director of the Salt Lake County Division of Substance Abuse Services. I would like to thank you, Chairman Souder, and Ranking Member Cummings, for hanging in there all day today. You have asked some really, really great questions and for your leadership on this issue.

I am not going to read my whole statement, either, because I think a lot of it has been repeated. Treatment for methamphetamine does work, just know that, you have proof of it sitting at this table. It works.

Our big issue that we have in the United States of America right now is our capacity. We have one funded slot for every four people that need treatment. That is really what our big issue is.

What I would like to talk a little bit about is to give you a little bit of an idea of what we do in Salt Lake County and how we talk to our elected officials to get our local elected officials to pony up some dollars to help us with this issue. We have been rocked by methamphetamine. We were already on the ropes in our treatment system. Our treatment system was already under pressure and then methamphetamine hit. And we really are hurting right now.

It is an epidemic in Utah, it is an epidemic in Salt Lake County. Just about everybody that we get in there is using methamphetamine in some way, shape or form. We have to deal with this.

When I have talked to all our national organizations, the National Association of Counties, the National Association of State Alcohol and Drug Directors, National Association of County Behavioral Health Directors, I have been talking about this for 10 years. And it is so nice to have the national organizations and the Congress looking at this issue, because we definitely need help in this country with this.

I have 12,000 admissions in my treatment system. We are the largest treatment system in the inter-mountain west. I have 12,000 admissions a year. I have 48,000 people in Salt Lake County that need to be treated.

Now, as you know, the burden of providing substance abuse treatment in the United States of America has been put on the back of the taxpayers. Seventy-five percent of all of the services we provide in the United States are publicly funded. That is the first place we have to look. We cannot do that any longer. I know Congress will be dealing with health care reform in the next 3, 4, 5,

6 years. You definitely need to include this as part of the health care system. Substance abuse treatment needs to be treated as part of a disease. It is a disease, it is a chronic disease, it needs to be treated like a disease. You have to deal with it that way.

The second thing I think you need to do, and I am going to give you some very specifics here, because I think it is really important, I don't have very much time with you. By the way, I have to catch a plane at 6, so if there are any questions, I would appreciate those so I can get out of here.

The block grant. All due respect to Mr. Curie, I think he has done a wonderful job, I want more money in the block grant. Everybody has said that today here. We need $250 million more in the block grant to put it to $2 billion. Now, it sounds like a lot of money, but it is not a lot of money in terms of some of the things we are spending money on these days.

I think what we need to do is, if you want to earmark some money in the block grant for emerging drugs, whatever you want to do, go ahead and do that, that is fine. But the short-term solution is to get us more capacity. We know what to do, we know how to treat this drug. We can do it. But we need the money to help us with this.

Then the second thing I would say is, if you can work something into the health care reform package that starts to provide primary health care, as to substance abuse treatment, in the very beginning I think what you will start to see is maybe less demand on the block grant, less demand on the taxpayer.

Finally, the thing I would like to say to you right now is, methamphetamine has really rocked women in Salt Lake and in Utah. What we see is, we have now women using methamphetamine at higher rates than we have men using methamphetamine. That doesn't happen with any other drug. It does not happen with any other drug. And this is really worrisome to me. I have been doing this for 19 years, and I am very scared about that trend. Because what happens is, families fall apart without their mothers. They really do.

We have started four family treatment programs similar to the ones the Nobles are talking about. They are very, very effective. I finance those with Medicaid. If I don't have Medicaid, I am going to lose three of those four programs. So when Congress is dealing with the Medicaid issue, and I know it is real simple to say, optional services, we are going to cut this, we are going to cut that, there are faces that are connected with that.

So I think it has to be a three-pronged thing. We have to have health care and think about this as a health care issue, get it into health care, we have to have money in the short term in the block grant, $250 million, and we have to have Medicaid there, especially for women with their dependent children. That is how we pay for this.

I look at the obituaries every day. And in Salt Lake, it is kind of interesting, our obituaries all have pictures. They have a picture of that individual next to the obituary. And I have gotten pretty good at reading between the lines in obituaries to see who is dying of overdoses. And I will tell you, it is just staggering when you see

how many people pop up in the Salt Lake Tribune every day from this.

So I will conclude. I am just so tickled that you are dealing with this issue. It is a major national issue for us. But we need some leadership on this, and we don't need discretionary dollars. I know people talk about the voucher system, they talk about putting money in discretionary dollars are not what we need. We need foundation dollars. The block grant is the foundation. If Congress puts money into the block grant, our State legislature will put money in and my county council will put money in. Without the block grant, we don't have anything.

So I would just urge you to really pay attention to that, and thank you very much.

Mr. SOUDER. Thank you.

Do you have any questions directly for Mr. Fleming? He is not going to make it in rush hour unless he is out of here in the next 5 minutes.

Mr. CUMMINGS. Nothing, thank you.

Mr. SOUDER. I thank you for coming in from Salt Lake. If we have some additional questions, we will submit them to you in writing.

Mr. FLEMING. Thank you.

Mr. SOUDER. Let me first thank each of you for coming, for being with us in this long day. It is, as you can see, a very diverse hearing and very helpful. I appreciate the personal testimonies, which are always very helpful as we move into a hearing process. Partly, it is good to hear success stories, because sometimes when you go through this business, it just seems like you jump from one failure to another, are we going to get blown up on the border because of terrorism coming in, we have child abuse here and spouse abuse here, and all different kinds of crime. Of course, we don't know how to pay for health care, and Social Security is a mess, pensions are a mess. It just seems like we jump from one issue to the next.

So having some encouragement that in fact some of the money that taxpayers are investing works is very helpful to hear. Each of your testimonies were somewhat different from each other.

I think where I want to start is with Dr. Rawson. I found it really interesting what Mr. Harle said. So first let me get a factual thing down left over from the first panel. Let me start with Mr. Harle. Do you agree, Dr. Rawson, with his characterization that a lot of this early abuse started over by Philadelphia and Delaware County and then moved to San Diego, and that is why you saw some of this in San Diego early? Because that is a historical factoid that I hadn't heard.

Mr. RAWSON. I wasn't aware that it migrated like that. But yes, in the early 1980's, Philadelphia and the Philadelphia area was the leading area of methamphetamine abuse and dependence in the United States. I didn't know what had been done. I didn't know why it went away there.

But then it moved to San Diego, and that is where we started to see it, so I wasn't aware of that.

Mr. HARLE. A couple of facts. Dupont, Allied Chemical, Rohm and Haas, all the major chemical companies, actually in South Jersey, ARCO, all those companies were right there. The chemists

were there, the actual precursors were there. And there were drug addicts there.

What happened is they hooked up with the chemists and they started to make it. Also, they first started to hijack it, because they were making a legal amphetamine. But as time went on, they started making it out in the community as—they are doing the same thing now. As we were restricting it and restricting it, what started to happen is people got creative and started making it on their own, they started bootlegging it. And they were selling, because we didn't have the Internet, they were selling handwritten formulas to each other.

So they were recruiting chemist students out of high school to make it. It got really, really complicated. The motorcycle gangs, the Warlocks and the Pagans, took over the distribution of the drug up and down the east coast. They fanned out with that. So what happened is, there was a series of hearings, those drugs became illegal. The DEA was involved, and made those drugs illegal in the United States at all. I don't know the scientific, 2P2 I think is what they were called on the street.

And that was then moved to Mexico. It was very soon, a couple of years later, you would see, and we were lucky because we got cocaine to take its place. So I want to let you know, addiction didn't go away, we just switched chemicals is what we did. We gave this plague to San Diego.

Mr. SOUDER. One of the reasons I wanted to ask is that, given the fact that Philadelphia and San Diego are not usually considered rural areas out in the national forests, did the African-American community or other minority communities use meth at that time, when it first moved to San Diego?

Mr. HARLE. I can tell you what was happening. You had availability. You had heroin in the—matter of fact, you need to know this, because it is really important. You had $5 per bag heroin in Philadelphia, in the ghetto or in the projects, you got it inner city. Inner city, inner city. As you moved farther away from the inner city, the drug went up in price and it got cut. So it would get cut in half, that is they would cut the purity in half, and they would double the price.

So if you lived in the suburbs, you paid $10 a bag and you got half the purity. You got the availability thing. So what happened is in the inner city, where they would sell it, very similar to today, it was more powerful and cheaper. Methamphetamine was actually a suburban drug that was moving in toward the city, and if you lived outside, it was $10 for what they used to call a quarter of a teaspoon, which would have been a quarter of a teaspoon of it. In the inner city, though, that would be cut in half and it would cost you $20.

So what would happen is, there was trading going on. The suburban methamphetamine, speed freaks, we used to call them, monster, crank, it had all kinds of names, would trade for heroin, they would trade it, because it really had to do with who controlled the drug traffic. Keep in mind, the white motorcycle gangs and the suburban kids controlled, it had more to do with the availability of—I have a million theories of why one different than the other. Don't know why.

But I can tell you, the theory that it is different gets thrown right out the window when you talk about crack cocaine. Because crack cocaine, although it is not as long-lasting, has the same effects. And it decimated the inner city.

So I wouldn't get hung up as much in the type of drug as I would in the treatment. We need long-term quality treatment that is not drug-specific as much, but is addiction treatment. Because what happens is people will switch from one drug to another anyway. So you had better look at drug addiction as a holistic kind of view. If you don't, you are going to constantly have problems.

Now, you need to train our whole work force who hasn't seen methamphetamine in a long time on what the effects are. There is the Matrix, there are different models that you can use. But they are really techniques that can be integrated into a treatment program. You really need a treatment model that is adaptable across the whole country that can be adapted to whatever the new epidemic you have.

I have the same counselors treating heroin right now that I had treating cocaine that I had treating methamphetamine. The problem is, they are getting old and they are retiring and we don't have a new work force, we don't have enough resources to keep that alive.

Mr. SOUDER. Dr. Rawson, I wanted to ask you, one of the things, as we have heard from the Nobles, that is in fact different, at least in the "home cooker" group, is it tends to be more family. In other words, historically the models are enablers and users. Whereas when they are cooking, because you can turn people in, unless their whole family is either involved or at least you may have the kids, they may be involuntarily involved, but we have had testimony at some hearings where even the kids are often recruited to get the chemicals or participate in the cooking.

Does that require different models of treatment? Obviously today we heard about family treatment. Could you describe a little bit how your Matrix Model works and how it might be different in meth there from other types of drugs, or to deal with enablers and users?

Mr. RAWSON. Yes. The basic treatments with addiction are, as has been said, common across all addictions. Meth, really, a couple of the things that make it impact the family to a greater degree are the fact that people cook it in their homes, and you are seeing 50 percent of the users are women. Heroin is about three or four to one, men to women. So you are seeing many more women get involved, which obviously affects the children.

To do any kind of treatment and not have a family component with methamphetamine is not supported by any evidence. You have to work with the family. The family either has to be brought into treatment, as was described here, which is preferable, or at least be able to inform them and get them understanding the addiction, so they can provide appropriate support to the addict in his or her recovery. So it really means the individual person as the target really is changed.

With meth users, you really have to address the whole family, because in general, the addiction has affected the whole family. And it is not that this isn't true with alcoholism and cocaine addic-

tion and heroin addiction. But because of these two factors, because the home literally becomes saturated with the drug and the kids are often exposed to the drug and you see it all in that environment, and so many women are using that it makes it that much more important with methamphetamine than with other drugs.

Mrs. NOBLE. I would like to comment on that, if I could.

I tried, I do believe, three to four individual treatment programs before I went into Bridgeway, the family treatment program. And those treatments were more on education. And on the family treatment programs, they offer different services, like the domestic abuse, the sexual abuse, having a psychiatrist, psychologist you could talk to. Just so many more services were available. And for the children, parenting classes, family therapy, we were offered that.

And like I said in my testimony, I didn't even know I had issues in that. Addiction, not only to meth, but everything else, it starts out as an individual problem, but then it becomes a family problem, and then it becomes the community problem. So like I said, I went to three or four before that, and I knew all the just for todays and keep it simple. But I needed to find out why I kept using, what issues were with me. Because it is not just as simple as, I came to believe that a power greater—you have to be able to get the issues also so that you can intertwine that education in.

Also as a preventive for the future, my family is involved in it. Therefore, maybe he will be able to make better choices that I wasn't able to make, because my mom and dad were alcoholics, and I wasn't given the opportunity to learn and know that there were more choices to handle certain issues in life.

Mr. SOUDER. When you and Darren, Darren, did you have other abuse problems before meth?

Mr. NOBLE. Yes. I believe I was an addict at birth, it started out with alcohol, weed, heroin, cocaine, crack, meth.

Mr. SOUDER. But meth is what put you, in the end, into treatment?

Mr. NOBLE. Yes.

Mr. SOUDER. When both of you were abusing different types of drugs, one of the things we have heard from met addicts at the hearings that is slightly different that we have heard, but not completely different than other drugs, is that you tend to often become more isolated because of the impact of paranoia, fear of being discovered if you are home cooking, and you get isolated from most support groups. In other words, you are not necessarily going to be involved in church and community. Often you even leave your job.

Did you see that differently in the usage of this drug, or was that kind of a pattern that was developing anyway?

Mr. NOBLE. The only thing I can add is, outside of my addiction in general, the cooking the dope, I had been using since I was home from prison, I haven't cooked since I went to prison, I thought I could change my ways. But cooking is a high of its own. I don't know if you know that. But that is something that is separately addictive from using it and using my drugs. Cooking drugs, making dope was a high of its own. That is what dragged me away from my family, because that is all I was worried about. Forget everything else.

But in my addiction of using methamphetamine, the paranoia wasn't there the same as when I was cooking. That is how we have gotten better, through the family therapy.

Mr. CRONKHITE. If I could add something into this, first of all, Mr. Cummings, to perhaps try to answer one of your questions that you raised earlier, about why there may appear to be less participation in methamphetamine addiction in the African-American community, I would be interested to see if there were any statistics at some point of whether or not there was less methamphetamine use in the Italian American community. And one of the reasons is, there is a stronger sense of family, a stronger sense of community in general.

As the chairman was just stating, methamphetamine use is isolating, is not necessarily, you don't get together, pass a pipe around. Because it is so damaging physically, because it destroys your body so much, you actually end up, this emaciated, out of the concentration camp look, massive amounts of weight loss. I have known people who have been heroin addicts for 15 years and been successful brokers on Wall Street. You don't necessarily notice that they are having this kind of a problem.

So part of it, as an adolescent, with extreme acne that came as a result of this, with this great weight loss, with this psychosis that came around, it is not a socially active, group participation drug. So that is why I found for myself, and this was again, 35 years ago, but the people in the community who surrounded themselves around my life and helped me through the process, part of that whole process of course involved long term psychological counseling. It was not something that could happen overnight.

I was fortunate, I guess if we can use that term, fortunate in that I was arrested and I was entered into the California Youth Authority. So I had this long-term care, which was provided by the State as a youth offender. Other people may not have had that.

So I think when we start looking at these kinds of programs where we want to see somebody who can really be regenerated and brought back into society and become really the poster boy for success, you have to start looking at, part of it is, you have to first treat the victim, the addict, like he's been in a car wreck. Then there is going to be a long-term period of time of rehabilitation, just like somebody who goes from being on the ER stretcher to walking with a crutch to getting physical therapy to having long-term care before they can really run again at full speed. So it is not something that is going to happen overnight.

I was one of those suburban speed freaks in California whose graduate student friends at UCLA cooked the stuff up in the Hollywood hills and it was distributed by motorcycle gangs in Los Angeles. It is interesting, the paradigm does not seem to have changed much in that period of time. But again, I wonder whether or not, how much this loss of community, the loss of community support, we see that in data all over the country, plays an effect on these kinds of epidemics that are really isolating and further isolating as we become less connected to one another.

Mrs. NOBLE. I would like to go back to the family issue, of women, why I believe I used meth is because of the role that the mother plays. It is a tiring job. But with family therapy, it brought

us all together and everybody could distinguish their roles in the family and the church and the community.

I think the family unit has taken a back seat to a lot of things today in life. And drugs have gotten into our families to the extent where families aren't together any more, a lot of families aren't. And I believe that family therapy worked for us because it brought us together, it gave us an opportunity to address our issues, what each of us individually and together were going through.

Now we can communicate with each other. Now we can tell each other our hopes, our dreams, our expectations and work together as a unit, the way that it should be. Because before we went into this treatment place, we were lost. Before I went into this treatment place, I knew that jail or death was the only hope for me. And now, it has opened a lot of doors in my life. I have a life now.

Mr. SOUDER. Mr. Cummings.

Mr. CUMMINGS. I was just thinking about something that the chairman said at the beginning of this hearing. It is something that I just want to address to the Noble family. What the chairman said was that a lot of people look at this thing as a thing of choice, that is the use of drugs. And one of the things that I have noticed in my community, the Seventh Congressional District, as I move from place to place, Dr. Rawson, I have noticed that it seems as if people are becoming less and less sympathetic and empathetic, because they feel as if somebody made a choice.

And it is a real tough, it is a tough one. They see their property values going down, they see their families destroyed, they say to me, Congressman, I go out there, I bust my butt, I work hard every day, I can't come into my house at the end of the day and expect everything to be in place. And then it is hard for me to get excited, as much as I would love to provide funding for drug treatment, I don't have a lot of sympathy, because I go through problems, too. I have psychological problems, too, I can't afford a psychiatrist. But damn it, I get up every day, I work and I do the right things. And I can't even put my kid through school, but yet you want me to say, it is OK for you to go out there and bust your butt trying to get treatment for—and these are people who I would normally think would be sympathetic. But they get tired.

And what I said to a graduating class of African-American addicts, recovering addicts the other day for a drug court, I said, you have to understand, the public is saying, OK, I mean, a lot of the public is saying, you made a choice. And they are getting less and less tolerant of funding bad choices. And I think that is something, and I just wonder as you go through, and I am going to talk to the family in a minute, do you get any of that when you are moving around to your hundreds of conferences and all that kind of stuff? Or those are not the kind of everyday people that you talk to?

Mr. RAWSON. No, those are exactly the people I talk to. And yes, I think that there is a fatigue factor going on with that. However, if you look at California, in 2000 the California voters in the voter initiative passed Proposition 36, which put $600 million into the treatment system, as opposed to into the jail system. If you make it a choice between treatment, and you document that treatment works, and particularly if you hook it with the criminal justice system, the drug court movement, in my 30 years of working in this

field, is the most encouraging movement I have seen. Because it uses the leverage of the court system to push people in the door.

As was said earlier by someone, Mr. Curie, I think, people don't wake up 1 day and say, gee, I think I want to get sober. That happens in response to something, in response to some pressure. I think that the California voters, anyway, 6 or 5 years ago, were willing to put their money into treatment as opposed to the prisons. The voters in California are very sick of building prisons. We are the champs when it comes to building prisons.

And one of the places I went was Minnesota, where they are starting to see, more than starting to see the epidemic. Their basic model for wanting to put money into treatment was they didn't want to replicate California's experience with having to build so many prisons.

So I do think that there is a fatigue. I do think people are tired of having to deal with the problems in their communities. But when push comes to shove, and they have to choose and say, how are we going to deal with this, I think there is a recognition on the public's part that treating people with addiction disorders is a better use of money than locking them up in prisons. Because prisons simply make them better criminals.

Mr. CUMMINGS. I agree. I think you are absolutely right. I want you to understand, I am probably the No. 1 advocate of treatment in this Congress. But at the same time, I know that there are Members of this Congress who, if I hear this, I know that there are other people who hear it. And it is something that we may have to deal with even more so later on as budget stuff gets tighter and tighter. Because I think you are right, when you match it up with prison, building more prisons, it makes a lot of sense.

I have to get back to something, though. Why do you all think it is that women are more likely, I think it was you, Dr. Rawson, who said that with heroin, I guess heroin and cocaine, it is three to one men. With methamphetamine, it is basically pretty much 47 percent, if I remember correctly, women.

Mr. RAWSON. That is right.

Mr. CUMMINGS. Why is that?

Mr. RAWSON. I would point at three factors. You have heard weight loss as being an important one. The rates of depression among women in the general public are much higher. And methamphetamine is a very useful anti-depressant when you first start taking it.

And finally, Mrs. Noble's comments about the role of a woman in today's society, being a mother, taking care of the house, getting a job, having to take kids to things, methamphetamine can help you do all that stuff for a while. So it is a drug that does have good functional value for a while, and many of the women we talk to didn't get involved in it as a party drug. They got involved in it to get things done, to control their depression, to be able to work a 16 hour day and take care of all their responsibilities. You take heroin, you go take a nap.

Mr. CUMMINGS. And nod. Don't forget the nodding.

Mr. RAWSON. That is right. [Laughter.]

Cocaine is so short-acting that you can't take it enough, it is so expensive, you can't take it to extend a day for 16 hours. But meth-

amphetamine is the perfect drug. And if you are a woman with those demands, it really matches up well with the demands on a woman in today's society.

Mr. CUMMINGS. Mrs. Noble, I don't want you to repeat things that you have already said, but based on what he just said, do you have anything to add that you have not said already?

Mrs. NOBLE. Yes. I wanted to say, at first, using drugs is a choice. But once the disease of addiction sets in, it is no longer a choice. I had so much to say I lost it.

But I was going to say, we are going back to the family treatment. Maybe if my mom had went into family treatment, maybe if she would have gone into family treatment, then I would have learned the coping skills, where my son has had an opportunity to learn more. Now he can teach his children. Maybe it might stop the cycle of addiction. Because nothing else has.

Mr. CUMMINGS. Tell me something. One of the things, and I am going to get back to you, Mr. Harle, but one of the things we spend a lot of money on in this Congress are ads, anti-drug ads. And I am just wondering, I see you shaking your head already, Mrs. Noble, but we want to use our dollars effectively and efficiently. Have you ever looked at an ad and said, you know, they have a point here?

Mrs. NOBLE. No.

Mr. CUMMINGS. No?

Mrs. NOBLE. No.

Mr. CUMMINGS. So ads just didn't affect you?

Mrs. NOBLE. No. Too many distractions.

Mr. CUMMINGS. What about you, Mr. Noble?

Mr. NOBLE. To me, as a kid growing up, I don't think anything was—I wasn't scared, I wasn't intimidated by things. When I went out to try something, I went out to try it, especially drugs. When I am wanting to do something, I am not trying to shy away from the things they are telling me not to, as an addict. But me, I am a believer that me, I was born an addict. This is what I was destined to be.

But the treatment wasn't there for me, for me and my family to acknowledge. And like you were saying earlier with the lady, people who are opposed to treatment, say it is a waste of money, well, you could take that lady my record and ask me if she wants me to live next to her, in and out of prison and the shit I have done in my life, or you could take her who I am now after going through family treatment, or do you want this man living next to you?

Mr. SOUDER. Joey, let me ask you the same question. You saw the narcotics in your family. You got a 3.8 average, you are going to be a physics teacher, go to college. You made it through all this with all the activities. Did the ads or any of the anti-drug programs, your teachers, what helped change you?

Mr. BINKLEY. Well, I see the ads on TV, and there is so much else on TV, it is just another thing that is on TV, you don't really pay attention to it. You know the D.A.R.E. programs, I was in Teenage Health Consultants, which dealt a little bit with that. But it was more my home experiences to kind of let me know that is not good, that is not what I need to do. Because it just has a negative effect on the whole family.

You can even see people outside the family looking in, noticing that it is not a good thing, and they kind of shunned it. So I made sure to stay away from it.

Mr. CUMMINGS. Mr. Harle, you wanted to say something. Please.

Mr. HARLE. Yes, I think what you bring up, the stigma, the issue of stigma, our folks, and I say that in a loving kind of way, are not the kind of folks, when they are actively addicted to any of the drugs, that are really encouraging a lot of sympathy from anybody. Matter of fact, the kinds of stuff that our folks do when they are addicted would make anyone not want to fund anything. So we are pretty aware of that.

But what we need to do is educate the public that treatment works. I think people are frustrated. And most people have this, one out of four families is faced with this. So a lot of times, when you are talking to people and saying, I am really frustrated with this, they are talking about somebody that they know or in their own family. That is how much this is a part of our culture.

And I think if we can get across to people that this is a generational disease, and I think it is right here in front of us, it is a generational disease, and it will grow if we don't stop somewhere. What you need to know is, we have 8,000 clients, the majority of them, their age of first use was under 11 years old. If you are talking about people making choices, they are experimenting, and that is why I think prevention, as you talked about earlier, is important.

But it is really, the decisions that kids are making are before the age of 11 years old. And many of the kids that we are talking about are kids who have addiction in their family. I have 500 of them I see every day. Half of them are going to become CEOs, and they are going to be just like the young man right here, they are going to say, you know what, I have seen this in my family, I am not going to let it happen to me, I am going to work as hard as I possibly can not to let it happen.

The other 50 percent or 60 percent are going to end up with the problem themselves for biological or environmental or for whatever other reasons. This is a generational disease that we have to stop somewhere. And I agree, you are going to need all the support in the world to convince the folks in the community, and we are going to have to get behind you, people in recovery are going to have to get behind you, treatment providers are going to have to get behind you. Because I don't think, though, that the average citizen thinks that locking these folks any more is going to do anything. I think we have gotten that across.

Mr. CUMMINGS. I hope that you understand what I was saying.

Mr. HARLE. I got it.

Mr. CUMMINGS. And I know Mr. Noble did. I guess the frustration comes, and I am almost finished, Mr. Chairman, the frustration comes when people feel that people make bad decisions.

Mr. HARLE. Right.

Mr. CUMMINGS. And that they then have to pay for them. I think that is the problem. But between the two of you, what you said, I think is was you, Mrs. Noble, that said the No. 1 thing may be a choice, but then it is not a choice. But what you just said is so

powerful. It is starting with our kids. Then that means that we as adults are doing something wrong.

So in some kind of way, you think about a mother's and a father's love. I just heard what you said, Mr. Noble, about you getting high. If you have little kids, the one thing that I think should almost frighten any parent, should make any parent just go nuts, is to think that they are cutting off the future possibilities of their children being successful. Any parent.

Mrs. NOBLE. Can I comment on that?

Mr. CUMMINGS. Yes, please.

Mr. SOUDER. Actually, we have six votes over on the floor. So this will be your last comment.

Mrs. NOBLE. OK. In the addiction process, somewhere along the line, right became wrong and wrong became right. And that is what you teach your children. And that is what I taught my children.

But through the family based treatment programs, you get the opportunity to turn that around, to teach your kids what I was doing was not right.

Mr. CUMMINGS. Thank you.

Mrs. NOBLE. And you can bring the morals and everything back into your family.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. SOUDER. I want to thank each of you for coming, for taking time out. If there are additional comments that you want to submit, we will continue to try to work for additional treatment funds. But I want to give you this, you are leaders in the treatment movement.

And this is one of the facts that you have to face: every single politician is also going out and talking to people and they have family experiences. There is no one I have ever met in any prison or in any treatment program that hasn't said that they have been through multiple treatment programs. If you oversell treatment, you will not convince the elected officials or the voters to do this. It has started to happen in drug courts, that short-term data that says there is an 85 percent success rate is not convincing when we start to get long-term data. This is a hard business.

And as we heard today, there is going to be recidivism with it, and that you can't take artificial statistics. And partly overselling of treatment will result in people, and also there are different types of drug addicts. If the drug addict is violent, they are going to have a different opinion about treatment versus locking up, than treatment. And that is quickly shown, too.

But I think that we are moving into a more sophisticated period, and drug courts are starting to illustrate that. And if we can get nuanced approaches.

Then the last thing is, sometimes when you have an epidemic that hits the news, because there is also fatigue in news coverage, fatigue in what CSI and Law and Order can cover for that year or two, and when we have a new phenomenon come up, you find more willingness of the general public, particularly where you see something like meth, where they see labs going up and children getting damaged and the types of problems.

We have an opportunity right now to move the whole treatment debate as part of the meth debate. And one of my frustrations with the administration has been a lack of understanding that, because like you say, these things may not exactly repeat themselves, but they run. There are nuances to the differences, they are different, but to some degree, to avoid the fatigue, we have to have new angles with it.

So thank you very much for your personal testimonies today, for shedding so much light. I have sat through, and we have sat through so many of those hearings, and yet every one, today we have learned so many different angles with this. It has been tremendously helpful to us and hopefully it will be to anybody who watched it.

With that, we stand adjourned.

[Whereupon, at 5:18 p.m., the subcommittee was adjourned.]

[NOTE.—At the time of printing no prepared statements were available.]