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Ranking Minority Member
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Committee on Government Reform
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Hearing on “Access to Recovery: Increasing Participation and Access in Drug Treatment”

September 22, 2004

Mr. Chairman,

Thank you for holding today’s hearing on “Access to Recovery: Increasing Participation and Access in Drug Treatment.”

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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