

TESTIMONY  
of

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on

ACCESS TO RECOVERY

before the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.