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Reauthorization of the Alcohol, Drug Abuse and Mental Health Block Grant

Statement of
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Before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
House of Representatives

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Alcohol, Drug Abuse and Mental Health Block Grant (ADAMH). My testimony will summarize reviews we have underway on three major issues: (1) did the substance abuse and mental health set-aside provisions in the 1984 amendments create new or expanded services?; (2) did the requirements for increased collection of data on the uses of block grant funds produce meaningful information?; and (3) is the formula used to distribute ADAMH funds among states equitable?

IMPLEMENTATION OF THE SET-ASIDE PROVISIONS

The 1984 amendments added two provisions requiring states to set aside at least 5 percent of their allocations for new and expanded services for women alcoholics and drug abusers, and at least 10 percent for new and expanded services for disturbed children, underserved areas or underserved populations.

To see if state implementation of the set-asides was accomplishing these purposes, we visited eight states, and 19 local service providers in those states. The states were: California, Colorado, Kentucky, Michigan, Mississippi, New York, Texas, and Vermont. We also sent out questionnaires to over 250 groups in these 8 states that had an interest in alcohol, drug abuse and/or mental health issues. To date, responses have been returned by 145.

Our analysis suggests that the role of the set-asides in stimulating new and expanded services varied among states. It

depended on key factors such as: whether additional block grant funding was available, or whether a state had already initiated these types of services. To provide a clearer picture of our findings in the 8 states for each of the three services (alcohol, drug abuse and mental health), we have expressed our results in the context of 24 cases.

The set-aside clearly contributed to the creation of new or expanded services in 10 of the 24 cases. In each of the 10 cases, the states also received increased block grant funding as a result of the 1984 formula changes. For example, prior to 1984, Mississippi had no separate women's substance abuse programs. During 1986, it used about $160,000 of set-aside funds to support four local day-treatment substance abuse programs for women and a local 4-bed halfway house for women with alcohol or drug problems. We found the halfway house had served 38 women since opening in May, 1986 and referred 29 to other providers. In the 14 months prior to opening, the local community mental health center had to turn away 68 women for substance abuse treatment.

In the remaining 14 cases, the effects of the set-asides were less clear for two reasons. First, in 9 cases, states had already committed, or planned to commit, their own resources to new or expanded services which met the set-aside requirements. Two state officials commented that their existing on going efforts in this area were sufficient to respond to the intent of the set-aside. Second, in 5 cases, states passed down the set-

aside requirements to local service providers. As a result, it was more difficult to determine statewide impact because of a lack of data.

The majority of the 145 interest groups responding to our survey reported that their states had increased their commitment to women's substance abuse programs and to the designated mental health populations. However, most did not attribute these increased commitments to the federal set-aside requirements.

The Administration has proposed eliminating the set-aside requirements in 1988. State officials representing 22 of our 24 cases said they would continue similar funding for these services even without the federal requirements. Officials in 2 cases believed they would not be continued. In general, service providers were less optimistic. Only 4 of 19 we visited believed their programs would be continued if the set-aside provisions were removed. A majority of the interest groups involved with drug abuse and targeted mental health programs believed states would continue to maintain their commitments to these services. However, nearly 50 percent of the interest groups involved with alcohol services for women felt that state commitment to these services would not be maintained if the set-aside was eliminated.

DATA COLLECTION PROVISIONS

The 1984 amendments also required HHS to develop model data collection criteria and forms in consultation with appropriate national interest groups. The goal was to obtain national-level

data on services provided, the number and types of clients served, and total funding. So far, mental health data collection has not been initiated because HHS found several proposed forms to be overly burdensome.

For alcohol and drug abuse, however, HHS had already developed model standards in conjunction with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and contracted with them to collect these data starting in 1982. The 1984 amendments did not change these arrangements. Data are voluntarily provided by all states to NASADAD. However, they are not independently verified by either HHS or NASADAD. We assessed the quality and usefulness of data produced by these arrangements by examining the data collection systems in 6 states (California, Maryland, New York, Pennsylvania, Vermont, and Virginia).

We found some variation in the scope of the data collected and the procedures used to verify it. For example, California receives alcohol data from only 17 of its 58 counties and estimates the remainder for its submission to NASADAD. On the other hand, Maryland conducts periodic on-site monitoring, requires all substance abuse service providers to use consistent formats and makes state payments contingent upon service provider data submissions.

We believe that the usefulness of the NASADAD data depends on the purposes for which it is collected. The data seems adequate for a national perspective of programmatic trends. However, it may be inadequate for more precise purposes, such as

allocating funds. For example, the Anti-Drug bill formula allocates funds based in part on NASADAD's numbers of clients served. Since the proposed formula was announced, several states have requested an opportunity to revise the figures they submitted to NASADAD in order to increase their potential allocations.

If the uses of the data are to be increased, federal and state governments will have to improve the reliability of their collection strategies. This increased reliability can be achieved most effectively by (1) involving both levels of government in the design of the strategy, and (2) providing for federal and state monitoring of data quality. Also, federal funds could stimulate greater cooperation from the states--especially for data that primarily benefits the federal government.

ALLOCATION OF FUNDS BETWEEN STATES

Next, I would like to comment on the formula used to allocate ADAMH funds among states. The existing formula allocates $462 million based on the amount of funding states received from the 10 categorical programs consolidated into the block grant in 1981. Available funding above $462 million is allocated using the formula adopted in 1984.

To evaluate the equity of the formula, we converted each state's allotment into a dollar amount per "person at risk"--that is, those most vulnerable to substance abuse and mental health disorders. Estimates of the "at risk" population are based on a

1986 study done by the Institute for Health and Aging at the University of California at San Francisco.

Our analysis shows that ADAMH funding per "person at risk" is unevenly distributed among the states. Chart 1 compares the four states receiving the most funding per "person at risk" with the four states receiving the least funding. Nationwide, the average grant per "person at risk" is $55. The four lowest states (Maryland, Iowa, Wisconsin and Minnesota) receive between $29 and $33 per person--a little more than half the national average. In contrast, the four highest states (New Hampshire, Rhode Island, South Dakota and Vermont) receive between $99 and $160 per person--nearly two to almost three times the national average.

To get an idea of whether the distribution of federal funding is targeted to relatively underserved states, we contrasted the distribution of block grant funds with states' own funding for substance abuse services. We used fiscal year 1985 data for substance abuse programs since it was the most recently available data on state spending.

Chart 2 shows that the block grant gives somewhat higher allocations to those states that already spend well above the national average for their substance abuse programs. The first column of chart 2 shows that the 13 highest spending states spend at an average rate of $302 per "person at risk", compared to $29 per person in the 13 lowest states--a 10-to-1 spending

differential.[1] As shown in the second column, the ADAMH formula provides $61 per person, on the average, for the highest spending states and $46 per person for the lowest--a 1.3-to-1 differential. While this is a much smaller differential, it still favors the high spending states. When the funding for only the substance abuse portion of the block grant is considered (in the third column), the differential grows to a 2-to-1 advantage for the high-spending states.

Chart 3 shows that the combined effect of state spending and block grant funding for substance abuse results in a differential of 6-to-1 between the high and low spending states.

How can this spending gap among states be reduced? If the policy goal is to achieve greater equalization of funding, the second column of chart 4 shows allocations under a formula based on both a state's "at risk" population and its taxing capacity. This would provide larger grants to low-spending states and reduce the spending differential down to 4-to-1. This decrease occurs because the low-spending states tend to be states that are poor and have a low tax capacity, while high spending states tend to be wealthier.

This concludes my statement. I would be pleased to respond to any questions you may have.

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[1] The 13 highest spending states are: Alaska, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Mexico, New York, Rhode Island, Utah, Vermont, Wisconsin, and Wyoming. The 13 lowest are: Alabama, Arkansas, Hawaii, Kentucky, Minnesota, Mississippi, New Hampshire, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, and Texas.

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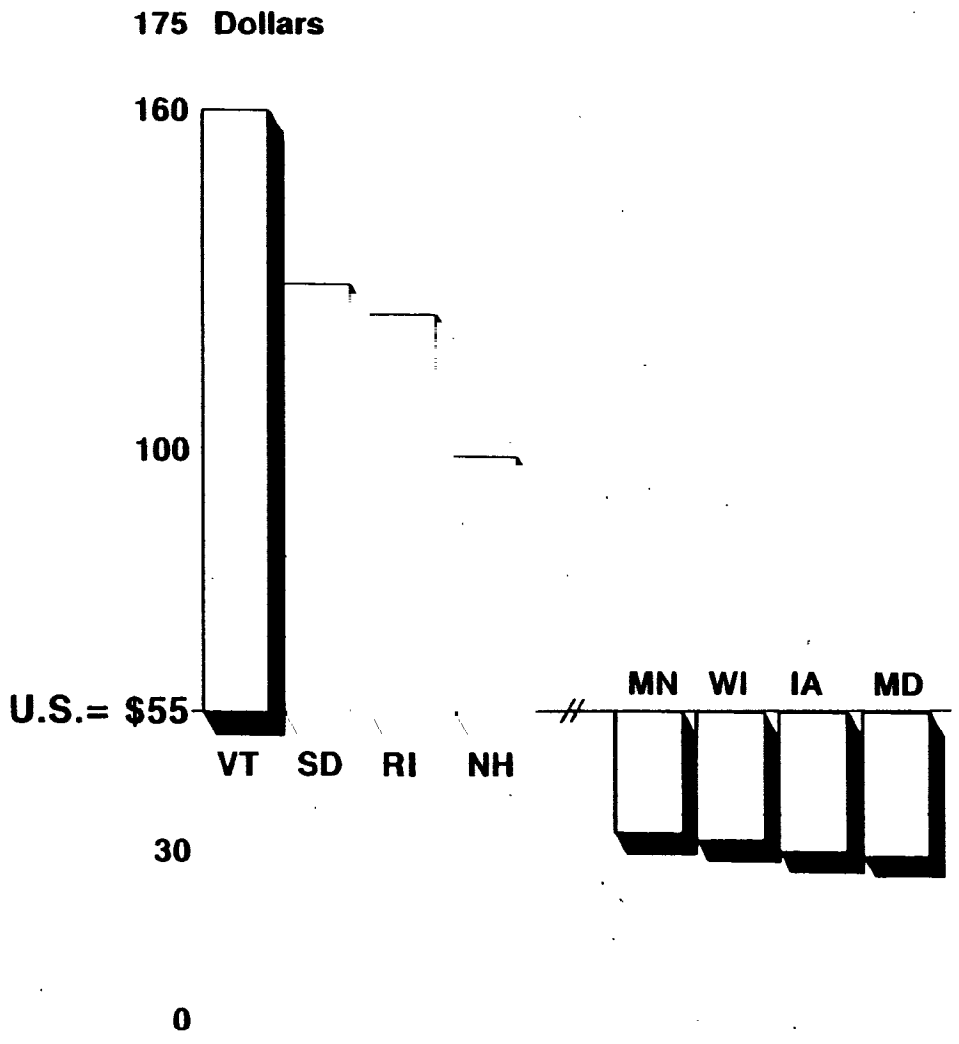
ADAMH Block Grant Allocations Per Person-at-Risk, Fiscal Year 1987



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ADAMH Block Grant Allocations Per Person-at-Risk Compared to States' Own Substance Abuse Spending, Fiscal Year 1985

	State Spending for Substance Abuse	Total Block Grant Allocations	Block Grant Allocations for Substance Abuse
13 High-Spending States	$302	$61	$63
13 Low-Spending States	$ 29	$46	$31
Spending Differentials	10-to-1	1.3-to-1	2-to-1

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Effect of Current Formula on Reducing States' Spending Differentials for Substance Abuse

	State Spending for Substance Abuse		Block Grant Allocations for Substance Abuse		Total Spending for Substance Abuse
13 High-Spending States	$302	+	$ 63	=	$365
13 Low-Spending States	$ 29	+	$ 31	=	$ 60
Spending Differentials	10-to-1		2-to-1		6-to-1

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Effect of An Equity-Based Formula on Reducing Substance Abuse Spending Differentials

	State Spending for Substance Abuse	+	Alternate Formula Allotment	=	Total Spending
13 High-Spending States	$302	+	$40	=	$342
13 Low-Spending States	$ 29	+	$49	=	$ 78
Spending Differentials	10-to-1		0.8-to-1		4-to-1