BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

States Have Made Few Changes In Implementing The Alcohol, Drug Abuse, And Mental Health Services Block Grant

In 1981 the Congress consolidated 10 categorical programs into the alcohol, drug abuse, and mental health services block grant and gave the states broader administrative responsibilities Although federal support decreased as states began implementing the block grant, carryover of funds from 1981 categorical awards supported many service providers well into 1982 This mitigated the impact of federal funding reductions and allowed states to reserve block grant funds for future years

The combination of legislative earmarking of funds, the historical shared financial and administrative involvement between states and the federal government, and the relatively stable trends in total support obviated the need for states to make major program changes in 1982 and 1983 While program changes occurred at the service provider level, they stemmed from evolving community needs or changes in total funding rather than just the block grant

Established state agencies were carrying out their expanded management responsibilities and reported making administrative improvements Most states reported increased levels of involvement by legislatures and governors offices and sought public input through hearings and other methods Overall, state officials rated the block grant program more desirable, while about half the interest groups preferred the prior categorical approach

GAO/HRD-84-52
JUNE 6, 1984

Request for copies of GAO reports should be sent to:

U.S. General Accounting Office
Document Handling and Information
Services Facility
P.O. Box 6015
Gaithersburg, Md. 20760

Telephone (202) 275-6241

The first five copies of individual reports are free of charge. Additional copies of bound audit reports are $3.25 each. Additional copies of unbound report (i.e., letter reports) and most other publications are $1.00 each. There will be a 25% discount on all orders for 100 or more copies mailed to a single address. Sales orders must be prepaid on a cash, check, or money order basis. Check should be made out to the "Superintendent of Documents".

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-214417

To the President of the Senate and the
Speaker of the House of Representatives

Various committees of the Congress requested that the General Accounting Office review the implementation of the block grants created by the Omnibus Budget Reconciliation Act of 1981. The enclosed report provides comprehensive information concerning the progress states are making in implementing the alcohol, drug abuse, and mental health services block grant. It is one of several reports we will issue on block grant implementation.

Copies of this report are being sent to the appropriate House and Senate Committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and the Governors and legislatures of the states we visited.

Charles A. Bowsher
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

STATES HAVE MADE FEW CHANGES IN IMPLEMENTING THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES BLOCK GRANT

D I G E S T

The Omnibus Budget Reconciliation Act of 1981 substantially changed the administration of various federal domestic assistance programs by consolidating numerous federal categorical programs into several block grants and shifting primary administrative responsibility to states. This report focuses on one of those block grants--alcohol, drug abuse, and mental health (ADAMH) services--and is one of a series GAO will issue to give the Congress a status report on block grant implementation.

GAO did its work in 13 states: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. Together these states account for about 46 percent of the national ADAMH block grant appropriations and about 48 percent of the nation's population. While these states represent a diverse cross-section, GAO's work cannot be projected for the entire country.

BLOCK GRANT MERGES FEDERAL PROGRAMS AND EXPANDS STATES' AUTHORITY

The federal government has had a long-standing interest in helping fund alcohol, drug abuse, and community mental health programs. Initially, federal assistance was provided directly to community mental health centers and did not go through state agencies. The Mental Health Systems Act of 1980 gave states greater authority in administering community mental health programs, but it was never fully implemented before being superseded by the ADAMH program. Similarly, the alcohol program principally provided grants directly to local organizations, although it also included grants to states. In contrast, the drug program primarily provided grants to states, which administered the program.

GAO/HRD-84-52
JUNE 6, 1984

Tear Sheet

Even though the Congress consolidated 10 alcohol, drug abuse, and mental health programs into the ADAMH block grant and gave the states expanded administrative responsibility, it placed certain requirements on how states can allocate funds among the alcohol, drug abuse, and mental health program areas. Of their substance abuse funds, states must spend at least 35 percent for alcohol programs, 35 percent for drug programs, and 20 percent for prevention and early intervention activities. Additionally, states must fund certain community mental health centers which were previously federally funded in 1981. (See pp. 3 and 4.)

In 1982 about $428 million was distributed to states for the ADAMH program. This represented about a 21-percent reduction from the $541 million distributed in 1981 for programs consolidated into the block grant. In 1983, the distributions were increased approximately 9 percent to about $468 million, including $30 million from the Emergency Jobs Appropriations Act of 1983. (See p. 5.)

REDUCTIONS IN FEDERAL ADAMH SUPPORT OFFSET BY CATEGORICAL FUNDS AND INCREASED STATE FUNDS

The significance of block grant support for alcohol, drug abuse, and mental health activities, when compared to total support derived from state and block grant funds, varied among the 13 states. In 1983, the block grant portion ranged from 9 percent in California to 45 percent in Florida and Mississippi for the 11 states where data on all three ADAMH program areas were available. In addition to block grant and state funds, support came from other sources, such as fees and reimbursements from insurance companies. Decisions on the use of ADAMH block grant funds are made in the context of the overall availability of funds from all sources and are usually integrated into broader state planning processes. (See pp. 10 to 20.)

Although federal appropriations decreased as states began implementing the ADAMH block grant, outlays from 1981 categorical awards helped support state and local operations during 1982. In the 12 states operating the block grant in 1982, categorical outlays accounted for about 63 percent of total categorical and block grant funds expended in that year. Such outlays helped offset reduced federal appropriations and, in total, enabled these states to carry forward about 50 percent of their 1982 block grant award into 1983. By 1983, however, categorical funding had virtually dissipated, and the amount of block grant funds states carried over into 1984 had been reduced to 27 percent of their available 1983 funds. (See pp. 12 to 15.)

Also, between 1981 and 1983, 10 of the 11 states where GAO could obtain data on all three program areas increased the state contribution to total program support. Nine of these 11 states experienced increases in total program support between 1981 and 1983 ranging from 3 percent in Pennsylvania to 24 percent in Texas. Once total program support is adjusted for inflation, however, only five states show increases. (See pp. 14 and 15.)

NO MAJOR POLICY CHANGES OCCURRED AT STATE LEVEL

Before the block grant was enacted, states GAO visited provided a substantial amount of the financial support to community mental health centers, and they had considerable influence over the direction of mental health programs. States were also involved in managing federal alcohol and drug abuse categorical programs, which were often jointly supported by states. The combination of this historical shared financial and administrative involvement, the legislative earmarking of funds, and the relatively stable trend in total program support obviated the need for states to make major program changes.

For the most part, the portion of total program funds devoted to alcohol abuse, drug abuse, and mental health programs did not

change significantly between 1981 and 1983. The largest shift in the proportional share of total program funds among the three program areas was 7 percent during the period. Where changes did occur, the more frequent reductions were in the drug area, in part because of its greater reliance on federal funds. Total program support for drug abuse programs decreased in six states while decreasing in only two states for alcohol abuse and in none for mental health programs. (See pp. 22 and 23.)

According to program officials in the 13 states, few changes were made in program policies between 1981 and 1983. Only Colorado and Iowa changed the types of services offered, and most states reported few changes in the emphasis given to different types of services. These latter changes were generally attributed to the earmarking of funds for prevention and early intervention activities. (See pp. 29 and 30.)

Also, none of the 13 states changed policies relating to client eligibility or to the kinds of organizations eligible to receive block grant funds. Moreover, most states continued funding the same service provider network.

CHANGES OCCUR AT SERVICE PROVIDERS BUT NOT DIRECTLY RELATED TO ADAMH BLOCK GRANT

While few major state policy changes occurred, the 47 service providers GAO visited to obtain some limited examples of operations at the local level experienced a variety of changes. Generally, the impetus for these changes stemmed from changing community needs and total funding changes rather than just the block grant. (See pp. 31 to 37.)

About two-thirds of the service providers had more total operating funds in 1983 than in 1981 and served more clients. Typically, these service providers received less federal financial support in 1983 than in 1981, but other sources of funds had increased and

offset these reductions. However, about one-third of the service providers experienced reductions in total support and had served fewer clients. Also, of the 36 service providers where records were readily available, 35 reported no substantial changes in the makeup of the client population served.

STATES INVOLVED IN MANAGING PROGRAMS SUPPORTED WITH BLOCK GRANT FUNDS

States typically assigned block grant responsibilities to offices which administered the prior categorical programs or related state programs. Generally, states carried out their expanded management role by establishing program requirements, monitoring grantees, providing technical assistance, collecting data, and auditing funds. These efforts were often integrated with ongoing efforts for other related programs. (See pp. 38 to 43.)

The block grant was intended to enable states to manage programs more efficiently and effectively. According to state officials, the block grant enabled 11 of the 13 states to reduce the time and effort involved in reporting to the federal government, 8 to improve planning and budgeting, 8 to reduce the time and effort associated with preparing grant applications, and 4 to better use state personnel. While there were numerous indications of administrative simplification, specific cost savings could not be quantified, and officials offered varying perceptions of changes in administrative costs under the block grant. (See pp. 43 to 46.)

INCREASED PUBLIC PARTICIPATION AND INVOLVEMENT OF STATE ELECTED OFFICIALS

States reported conducting the mandated legislative hearings and preparing required reports. In addition, 12 states reported holding executive hearings and 12 states reported using one or more advisory groups. Many program officials reported that input from advisory groups and informal consultations influenced program decisions. Also, program officials in most states noted that governors and legislatures had the same or greater

involvement in ADAMH program decisions than they had under the prior categorical approach. (See pp. 50 to 58.)

Interest groups across the 13 states increased their activity with state officials under the block grant. They were most satisfied with their access to state officials. They were least satisfied with the availability of information before hearings, the opportunity to comment on revised ADAMH plans, and the timing of hearings relative to the states' decision-making process. Forty-seven percent believed that changes states have made adversely affected individuals or organizations that they represented, whereas about 28 percent viewed such changes favorably; the rest perceived no impact. (See pp. 58 to 60.)

OVERALL PERCEPTIONS DIFFER

Most state executive and legislative branch officials liked their increased flexibility and viewed the block grant as more desirable than the prior categorical approach. Conversely, about half the interest groups tended to view the block grant as less desirable. About 25 percent viewed the block grant as more desirable, and the remaining 25 percent perceived no change. While interest groups and state officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages. It was often difficult, however, for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. (See pp. 61 and 62.)

AGENCY COMMENTS

Department of Health and Human Services officials commented that this report was an informative summary of the implementation of the ADAMH block grant program. They provided oral comments, which were generally limited to technical matters, and these were incorporated, where appropriate, into this report.

Contents

ABBREVIATIONS

ADAMH	alcohol, drug abuse, and mental health
GAO	General Accounting Office
HHS	Department of Health and Human Services

CHAPTER 1

INTRODUCTION

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) substantially changed the administration of various federal domestic assistance programs by consolidating numerous federal categorical programs into block grants and shifting primary administrative responsibility to the states. Of the nine block grants enacted, four related to health services, one to social services, one to low-income energy assistance, one to education, one to community development, and one to community services.

The 1981 act gives states greater discretion, within certain legislated limitations, to determine programmatic needs, set priorities, allocate funds, and establish oversight mechanisms. Since the act was passed, the Congress, as well as the public and private sectors, has been greatly interested in how the states have exercised their additional discretion and what changes the block grant approach has held for services provided to the people. In August 1982 we provided the Congress an initial look at implementation of the 1981 legislation in our report entitled Early Observations on Block Grant Implementation (GAO/GGD-82-79, Aug. 24, 1982).

Subsequently, we embarked on a program designed to provide the Congress with a series of comprehensive, updated reports on states' implementation of these programs.[1] This report addresses the implementation of the alcohol, drug abuse, and mental health (ADAMH) services block grant.

ADAMH PROGRAM EVOLUTION AND HISTORY

The federal government has had a long-standing interest in helping provide services to the mentally ill and those needing assistance stemming from substance abuse. However, its role in each program area--mental health, alcohol abuse, and drug abuse--has evolved differently. As a result, the division of responsibilities between the federal government and the states has been somewhat different and has had an important influence on block grant implementation.

---

[1]Other reports issued include (1) States Are Making Good Progress in Implementing the Small Cities Community Development Block Grant Program, September 8, 1983 (GAO/RCED-83-186); (2) Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration, May 7, 1984 (GAO/HRD-84-35); (3) States Use Added Flexibility Offered by the Preventive Health and Health Services Block Grant, May 8, 1984 (GAO/HRD-84-41).

Focus of state and federal mental health efforts has undergone many changes

From the early years of our nation's history through the mid-1940's, state governments were almost solely responsible for the mentally ill. State mental hospitals evolved from small treatment-oriented facilities into large custodial care institutions. In time, state and local governments gradually began to rely on community-based mental hygiene clinics, and by 1946, there were slightly over 800 such clinics in the United States.

Concerned with the growing magnitude of the mental illness problem, however, the Congress established the National Institute of Mental Health in 1946 and provided funds for research, training, and grants to states for establishing clinics and treatment centers. Through these efforts, the federal government joined state and local governments in an intergovernmental partnership for mental health services.

In the 1950's and 1960's, the federal government continued to be concerned with the adequacy of government efforts and decided to take a more active role. In 1963, the Congress established the community mental health centers program, which provided direct federal grants to local groups to establish such centers throughout the country. With the exception of some limited planning responsibilities, state governments were effectively excluded from playing a significant role in the development of such community mental health centers.

Between 1964 and 1981 the federal investment in the community mental health program totaled about $2.9 billion, and an extensive network of 758 community mental health centers was serving several million persons. Nevertheless, in 1980 the Senate Committee on Labor and Human Resources concluded that the existing community mental health program was not providing adequate mental health treatment to those needing it and could not provide a truly integrated local-state-federal mental health system within its statutory framework. As a result, the Mental Health Systems Act of 1980 was enacted to give states greater authority in administering community mental health programs. Before this legislation was fully implemented, however, it was superseded by the ADAMH block grant.

Federal alcohol and drug programs involved states in different ways

In December 1970, the Congress established the National Institute on Alcohol Abuse and Alcoholism to develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse

and alcoholism and for the rehabilitation of alcohol abusers and alcoholics. The Institute's activities were funded through formula grants to the states, project grants to public and private nonprofit organizations, and contracts with public and private organizations and individuals.

The formula grant program helped each state establish and fund alcohol abuse programs based on its particular needs. The project grant program provided direct financial assistance for local community programs designed to meet the needs of special target populations, such as Indians and the impoverished.

An intense federal response to the nation's drug abuse problem began in the early 1970's with the establishment of the National Institute on Drug Abuse. The programs created were similar to those authorized for the alcohol area. A formula grant program assisted states in combating the drug abuse problem, and a project grant and contract program provided drug abuse treatment services.

While the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse administered similar programs, they used different methods for distributing funds. The former's project grant program distributed funds directly to local service providers, bypassing state alcohol abuse treatment and rehabilitation programs. In contrast, although initially using a direct funding method, by 1976 the National Institute on Drug Abuse primarily funded its drug program through a single contract to each state for administering a statewide network of services. The state had the primary responsibility to select, fund, and monitor the local service providers.

THE ADAMH BLOCK GRANT

Effective October 1, 1981, the Omnibus Budget Reconciliation Act of 1981 amended the Public Health Service Act by establishing the ADAMH block grant. Ten prior categorical programs were consolidated into the block grant, and by July 1982 all states were administering the program.

The purpose of the ADAMH block grant is to provide funds to states for establishing and maintaining programs that combat alcohol and drug abuse, that care for the mentally ill, and that promote mental health with the following activities:

--Planning, establishing, maintaining, coordinating, and evaluating programs for the development of effective prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse.

--Providing services through community mental health centers for people who are chronically mentally ill, severely mentally disturbed children and adolescents, mentally ill elderly, and underserved populations.

--Coordinating mental health and health care services provided within health care centers.

The 1981 act requires states to provide the Secretary, Department of Health and Human Services (HHS), information on ADAMH block grant activities, such as (1) a report describing the intended use of funds; (2) a statement which, among other things, assures that the state will identify the populations and areas needing services and will use funds in accordance with the act's purposes; (3) an annual report on block grant activities; and (4) an annual audit report on program expenditures.

In addition, states had to use their entire fiscal year 1982 allotments to support mental health and substance abuse services proportionally to their use of federal funds for these services in certain prior years. For fiscal years 1983 and 1984, the amount decreased to 95 percent and 85 percent, respectively, of the total allotment. States must also certify in their applications that at least 35 percent of their substance abuse funds will go to alcohol abuse programs, at least 35 percent to drug abuse programs, and at least 20 percent to prevention programs.

To receive funds in any one of the three authorized allotment years, a state also must agree to make grants to every community mental health center that received a grant in fiscal year 1981 under the Community Mental Health Centers Act and that would have been eligible for a grant under that act in the appropriate allotment year. The states must also certify in their applications that grants made to community mental health centers will be used to provide services that are easily accessible to patients residing in a defined mental health area regardless of their ability to pay, with special attention given to the chronically mentally ill. Each center is to provide outpatient services, have 24-hour emergency care services, provide day treatment or partial hospitalization, screen patients for admission to state mental health facilities, and offer consultation and education services.

The implementation of the ADAMH block grant was accompanied by federal funding reductions. The 1982 block grant funds distributed to states were about 21 percent below the 1981 levels for all of the categoricals consolidated into the block grant. Funding to states rose about 9 percent in fiscal year 1983, but

the 1983 levels were still below the 1981 levels. The following table shows the appropriations and distributions to all of the states for the 1980-84 period.

Total ADAMH Block Grant Funding

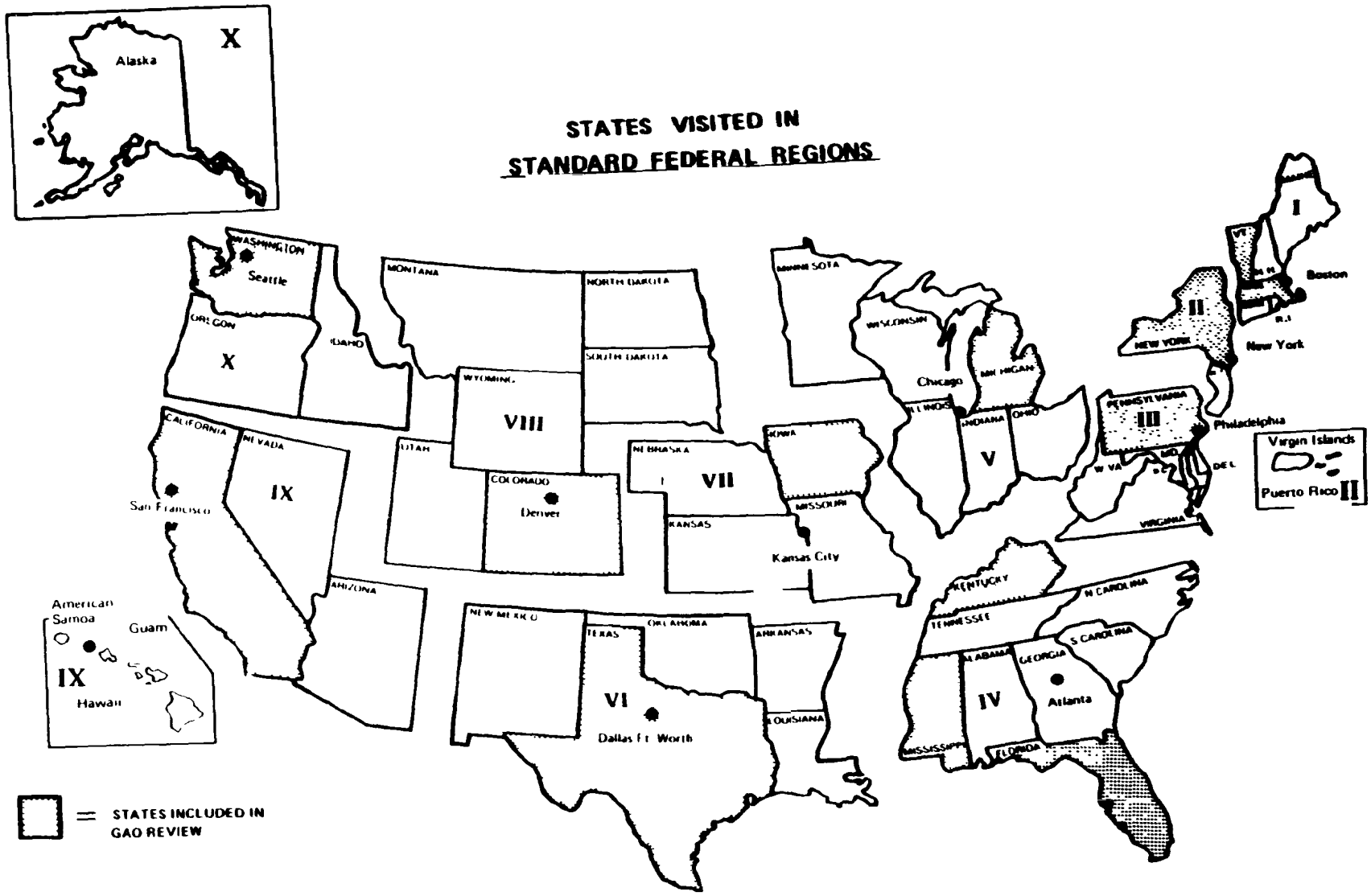
Fiscal year	Appropriations	Distributed to states[a]	Year-to-year changes in funds distributed	
			Dollars	Percent
	(millions)			
1980	$625.1	$625.1	$ -	-
1981	585.3	541.2	(83.9)	(13.4)
1982	432.0	428.1	(113.1)	(20.9)
1983	469.0[b]	468.0	39.9	9.3
1984	462.0	462.0	(6.0)	(1.3)

[a]The full amount of appropriated funds, according to HHS officials, was not distributed to the states for the following reasons: (1) in 1981, $30.2 million was rescinded, $10.7 million lapsed, and $3.2 million was used for national monitoring, evaluation, and reporting activities; (2) in 1982, $3.9 million was used by HHS to administer the ADAMH block grant; and (3) in 1983, $1 million was used for national mental health activities.

[b]The 1983 appropriation includes $30 million in supplemental funding through the Emergency Jobs Appropriation Act of 1983 (Public Law 98-8).

OBJECTIVES, SCOPE, AND METHODOLOGY

Our primary objective in work on all block grants is to provide the Congress with comprehensive reports on the states' progress in implementing them. To do that, as shown in the map on the following page, we performed our work in 13 states: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. These states were selected to attain geographic balance. The states had differing fiscal conditions, varying ranges of per capita incomes, and varying degrees of involvement by state executive and legislative branches in overseeing and appropriating federal funds. At least 1 state was selected in every standard federal region, and in total, the 13 states accounted for approximately 46 percent of the 1982 ADAMH block grant funds and about 48 percent of the nation's population. Our sample of 13 states was a judgmental selection, and the results are not intended to be projected to the nation as a whole.


STATES VISITED IN
STANDARD FEDERAL REGIONS
Alaska
X
Seattle
Boston
New York
Chicago
Philadelphia
Virgin Islands
Puerto Rico
San Francisco
Denver
Kansas City
Atlanta
Dallas Ft Worth
American Samoa
Guam
Hawaii
= STATES INCLUDED IN GAO REVIEW

Our review focused on how states are implementing the ADAMH block grant and what changes, particularly those related to the block grant, have occurred since the consolidation of the prior categorical programs. Information was obtained at three management levels: HHS headquarters, the state, and service providers.

At the federal level, we obtained data on ADAMH fund allocations for fiscal years 1980-83 and certain funding and program information concerning awards made under the categorical programs. Also, we discussed with headquarters officials HHS policies for implementing and monitoring the program.

At the state and local levels we used a wide variety of data collection instruments and approaches to obtain information from individuals or organizations responsible for or having an interest in (1) a single block grant and (2) multiple block grants. These instruments were designed with the objective of gathering consistent information across states and across block grants where reasonable and practical.

The first set of information sources included state program officials responsible for administering the ADAMH block grant and individual service providers. To obtain information from these sources, we used a state program officials questionnaire, financial information schedules, a state audit guide, a service provider data collection guide, and an administrative cost guide.

Almost identical versions of the program officials questionnaire and administrative cost guide were used for all block grants. The other three instruments had to be tailored to each block grant because of differences in the types of programs and services provided under each block grant and the manner in which financial information had to be collected. Our analysis of financial trends focused on changes in total program support from federal, state, and other sources, not exclusively on block grant funds. As a result, we did not determine whether states had complied with the specific requirements in the block grant legislation governing the use and earmarking of ADAMH funds for specific purposes.

The service provider data collection guide was used not to obtain comprehensive data from the service provider level but rather to identify examples of the implications, for service providers, of state policies and practices in block grant implementation. We visited 47 service providers which were judgmentally selected by considering types and size of service providers, location in the state (urban and rural areas), and types of

ADAMH services provided. These 47 providers are not statistically representative of the total universe of providers, and they represent only a small portion of the total number of service providers in the 13 states. In our selection, we attempted to include where appropriate at least three service providers from each state visited.

The second set of information sources included representatives from the governor's office, officials from the state legislature, and public interest groups. To obtain information from these sources, we used questionnaires which generally asked about the respondent's specific experience with the block grants and obtained perceptions concerning the block grant concept.

The questionnaires sent to public interest groups solicited their views concerning how the state in which the group is located had implemented and administered block grants. We identified interest groups by contacting about 200 national level organizations, a private organization with extensive knowledge about block grants, and officials in the states we visited and by reviewing mailing lists provided by HHS. Although not a representative sample of all concerned public interest groups, 1,662 questionnaires pertaining to all block grants under review were mailed out and 786 responses were received, of which 255 indicated having at least some knowledge of their state's implementation of the ADAMH block grant.

A detailed discussion of the content, source of information, and method of administration for each data collection instrument is included in appendix I. Our work was conducted in accordance with generally accepted government auditing standards.

All questionnaires were pretested and subjected to external review prior to their use. The extent of pretest and review varied, but in each case one or more knowledgeable state officials or other organizations provided their comments concerning the questionnaire or completed the questionnaire and discussed their observations with us. Also, the service provider data collection guide was discussed with various service providers. The design of the financial information schedule was developed in close consultation with the Urban Institute and HHS.

Our fieldwork on the ADAMH block grant was done primarily between January and August 1983. At the conclusion of our work, summaries were prepared containing the data developed, using the financial information schedules and the state audit guide. We briefed state officials on the information contained in the summaries and gave them an opportunity to comment on its accuracy

and completeness. Our summaries were modified, where appropriate, on the basis of comments provided by state officials. The final summaries, together with information received directly from questionnaire respondents, were used to prepare this report.

The information presented in this report was developed for the purpose of assessing the status of ADAMH block grant implementation and not intended to evaluate states' effectiveness in devising or managing programs. The following chapters focus on the funding patterns that have emerged under the ADAMH block grant and how they differed from the prior categorical programs, changes made at the state and service provider level to the type of ADAMH services offered and how they are delivered, state organization and management changes made, and the involvement of citizens, state elected officials, and interest groups in processes which led to decisions on how block grant funds would be used.

CHAPTER 2

FUNDING PRIORITIES REMAIN ESSENTIALLY UNCHANGED

A major objective of block grants was to give states more authority to establish funding priorities to better meet state needs. States historically have funded their own alcohol, drug abuse, and mental health programs and have had key roles in administering some aspects of the federal categorical programs.

Although federal allocations were reduced, total funds for the programs supported by the ADAMH block grant have increased between 1981 and 1983 in 9 of the 13 states. The increases were due primarily to federal categorical funds which overlapped the initial block grant allocations and increased state support. However, the growth in total program support varied among the states, and after adjusting for inflation, only five states showed increases.

While the block grant has somewhat expanded the states' opportunities to alter prior categorical funding patterns, reduced federal funding and legislative requirements that specify funding levels for certain ADAMH program areas have tempered these opportunities. Essentially, states have placed great importance on integrating the block grant with established state programs.

ADAMH BLOCK GRANT PLANNING GENERALLY DONE AS PART OF BROADER STATE PLANNING EFFORTS

Because alcohol, drug abuse, and mental health programs were administered by more than one department in 11 of the 13 states, various approaches are used to plan how ADAMH funds will be used. In 12 of the 13 states, ADAMH plans are integrated with state alcohol, drug abuse, and mental health program plans or included in a comprehensive health and human services state plan. Only Mississippi developed a separate ADAMH block grant plan.

The significance of direct federal support for alcohol, drug abuse, and mental health activities, when compared to total support derived from state funds and direct federal funds, varied among the states, as shown in appendix II. In 1983 the block grant portion ranged from 9 percent in California to 45 percent in Florida and Mississippi for the 11 states where data were available for all three ADAMH program areas. Also, each of the program areas relied on federal support to significantly different degrees, with the drug abuse area experiencing the greatest reliance.

Additionally, states supplement state and block grant moneys by using funds from other sources, such as fees and reimbursements from Medicaid and insurance companies which cover certain costs associated with alcohol, drug abuse, and mental health treatment.

Although most of the states have integrated ADAMH block planning into some broader state planning processes, states used different approaches in planning for their alcohol, drug abuse, and mental health programs. Two states combined all three programs into one comprehensive planning effort. For example, New York requires local and state agencies to prepare plans for alcohol, drug abuse, and mental health programs. These plans are used to develop a comprehensive statewide plan, which is used in the budgeting process and is referred to in the state's ADAMH block grant application and intended use report.

In two other states, planning for alcohol, drug abuse, and mental health programs is included in planning activities encompassing several other state health and human service programs. For example, Vermont's single comprehensive state plan encompasses a number of social and health services programs. This plan served as the state ADAMH application as well as the application for five other federal block grant programs.

Six states combined alcohol and drug programs into one substance abuse planning effort and planned separately for mental health activities. For example, Iowa prepares an annual substance abuse plan describing the state's need for services and proposed programs to meet those needs. The state's 1982-83 plan served as the substance abuse portion of Iowa's 1983 ADAMH block grant application, and a separate mental health plan incorporating county mental health and mental retardation needs served as the mental health portion.

Another three states plan separately for each ADAMH program area. For example, California prepares separate annual plans for its alcohol abuse, drug abuse, and mental health activities which draw on county plans for information on service needs. California officials stated that, while state alcohol, drug abuse, and mental health plans describe overall program goals and county allocation policies, funding priority decisions are made primarily through the state's budget process.

As a result of the various planning approaches and sources of funds, decisions on the use of ADAMH block grant funds are generally made in the context of established state goals and objectives for substance abuse and mental health programs and are based on the availability of funds from all sources.

REDUCTIONS IN FEDERAL ADAMH SUPPORT OFFSET BY CATEGORICAL FUNDS AND INCREASED STATE FUNDS

Because the federal government and states previously shared responsibility for directly funding alcohol, drug abuse, and mental health services, it was very difficult to construct a complete picture of total support for these programs in 1981. States' records contained data on their own alcohol, drug abuse, and mental health programs, but states did not have complete information on the prior federal mental health program grants, which went directly to local community mental health centers. Similarly, many federal alcohol categorical grants under the predecessor programs went to local entities, bypassing the states.

Nevertheless, for most states we were able to develop financial information for the 1981-83 period on total program support by using data from state records and information obtained from HHS on the prior categorical programs. While this information on total program support had to be partially developed by estimating and allocating prior categorical awards, it provides a reasonable basis for assessing trends in overall program financing. Such a framework is essential to understanding how trends in total program support were influenced by the reductions in federal appropriations accompanying the block grant.

The 1982 national block grant awards for alcohol, drug abuse, and mental health programs were about 21 percent less than the 1981 federal awards for the categorical programs merged into the block grant. The 1983 national awards were 13 percent below the 1981 level. The 1982 and 1983 block grant awards decreased 32 percent and 25 percent, respectively, when compared to the 1980 categorical awards.[1]

As shown in appendix III, in 12 of the 13 states reductions in federal awards for alcohol, drug abuse, and mental health programs from 1981 to 1982 ranged from 34 percent in Vermont to 12 percent in Texas. In Iowa, the 1982 block grant award was 2 percent higher than federal categorical awards made in 1981. Comparing the 1983 block grant awards with 1981 categorical awards again shows 12 states experiencing reductions, ranging

---

[1]Comparisons to 1980 are included because ADAMH block grant funds are allocated to states based on each state's share of total prior categorical substance abuse funds received in 1980 and categorical mental health funds received in 1981.

from 24 percent in Vermont to 4 percent in Texas, while Iowa's award was 17 percent greater.[2]

Despite these reductions, total program support for alcohol, drug abuse, and mental health programs increased from 1981 to 1983 in most states we visited. We were able to obtain funding information for all three program areas in 11 of the 13 states. In 9 of these 11 states, total program support increased between 1981 and 1983, while such overall support declined in 2 states--California and Kentucky. Because mental health funding data were not readily available in Michigan and New York, comparisons of changes in total program support were not possible. However, the substance abuse funding data obtained showed a 20-percent increase for both states between 1981 and 1983.

As shown in table 2.1, changes in total program support between 1981 and 1983 varied widely among the states and ranged from a 24-percent increase in Texas to an 8-percent decrease in Kentucky.

Changes in total program support did not parallel changes in national block grant allocations because of two key factors--carryover funds from categorical awards and changes in state funding. The availability of categorical funds during block grant years helped offset the impact of reduced federal support and enabled states to carry forward block grant funds into future years. Increases in state funds also helped to offset the federal reductions in most states.

---

[2]Iowa's block grant allocations are greater than its 1981 categorical awards because 98 percent of Iowa's block grant allocation is based on its 1980 substance abuse awards, which were much greater than its 1981 awards.

Table 2.1

Changes In Total ADAMH Program Support

	Estimated total support[a]			Changes from 1981 and 1983	
	1981	1982	1983	Amount	Percent
	(000 omitted)				
California[b]	$540,298	$550,792	$548,465	$(2,327)[c]	(1)[d]
Colorado	51,311	51,960	53,110	1,799	4
Florida[e]	90,314	96,220	94,164	3,850	4
Iowa[b]	12,268	13,140	14,072	1,804	15
Kentucky	31,767	29,752	29,336	(2,431)	(8)
Massachusetts	72,512	78,657	82,783	10,271	14
Michigan[f]	50,677	56,339	60,566	9,889	20
Mississippi[g]	9,292	10,387	10,122	830	9
New York[b,f]	227,325	267,742	272,143	44,816	20
Pennsylvania	218,833	223,205	226,192	7,359	3
Texas	61,378	64,893	76,184	14,806	24
Vermont	15,197	15,928	17,016	1,819	12
Washington[e]	40,634	49,212	46,351	5,717	14

[a]Total program support includes federal ADAMH categorical and block grant funds, state funds, and where available, other federal funds for related programs, local government contributions, and fees, copayments, and reimbursements.

[b]Represents state fiscal year data.

[c]Since California did not accept the block grant until July 1982, this amount represents the change between 1982 and 1983.

[d]Reduction was less than 1 percent.

[e]Does not include funds from other sources.

[f]Represents substance abuse programs only.

[g]Includes only categorical, block grant, and state funds.

As shown in table 2.2, adjusting total program support using a 9-percent consumer price index inflation rate for the 1981-83 period showed increased funding levels in 5 of the 11 states where data on all three program areas were available.[3] The increases ranged from 3 percent in Vermont to 14 percent in Texas. The reductions in Kentucky's and California's programs increase to 15 and 3 percent, while Mississippi's program remains relatively constant after adjusting for annual inflation. Michigan and New York continue to show increases in substance abuse program funding.

Categorical funds help offset impact of federal funding reductions

For the most part, the categorical programs consolidated into the ADAMH block grant funded specific service projects administered by state and local entities. These grants were awarded at various times throughout the federal fiscal year and usually had a 12-month funding period. Many grants, especially in the alcohol abuse and mental health categorical programs, had funding periods that began during the last quarter of federal fiscal year 1981 or the first quarter of federal fiscal year 1982. In 12 of the 13 states,[4] about 68 percent of the 1981 awards extended into fiscal year 1982; some continued into 1983.

As a result, many service providers were able to fund much of their 1982 operations with categorical funds. Categorical funds comprised about 63 percent of the estimated total federal categorical and block grant funds used in the 12 states during 1982. In 1983 the use of categorical funds had decreased to only 4 percent with most of the funds available only in one state.

---

[3]In our reports on the maternal and child health and the preventive health and health services block grant programs we used the Gross National Product Deflator index for "State and Local Purchases of Goods and Services" to adjust for inflation. In the ADAMH program, block grants to the states reviewed were typically used to support service providers that were nonprofit organizations. Since the state and local purchases of goods and services index is not targeted to nonprofit organizations, and no other specific deflator index for nonprofit organizations is available, we used the widely accepted consumer price index to adjust for inflation.

[4]California did not accept the ADAMH block grant until July 1, 1982, and therefore grants made to entities in California were excluded from this analysis.

Table 2.2

Total Program Support
Adjusted for Inflation

	Total program support[a]		Changes	
	1981	1983 adjusted	Amount	Percent
	---------(000 omitted)----------			
California[b,c]	$550,792	$533,371	$(17,421)	(3)
Colorado	51,311	48,725	(2,586)	(5)
Florida[d]	90,314	86,389	(3,925)	(4)
Iowa[b]	12,268	12,910	642	5
Kentucky	31,767	26,914	(4,853)	(15)
Massachusetts	72,512	75,948	3,436	5
Michigan[e]	50,677	55,565	4,888	10
Mississippi[f]	9,292	9,286	(6)	(1)[g]
New York[b,e]	227,325	249,672	22,347	10
Pennsylvania	218,833	207,516	(11,317)	(5)
Texas	61,378	69,894	8,516	14
Vermont	15,197	15,610	413	3
Washington[d]	40,634	42,524	1,890	5

[a]Total program support includes federal ADAMH categorical and block grant funds, state funds, and where available, other federal funds for related programs, local government contributions, and fees, copayments, and reimbursements.

[b]Represents state fiscal year data.

[c]Since California did not accept the block grant until July 1982, this amount represents the change between 1982 and 1983.

[d]Does not include funds from other sources.

[e]Represents substance abuse programs only.

[f]Includes only categorical, block grant, and state funds.

[g]Represents less than 1 percent.

Further, as shown in table 2.3, categorical funds comprised at least 50 percent of total categorical and block grant funds in 11 of the 12 states during 1982. In six states such funds accounted for 70 percent or more of total 1982 categorical and block grant funds.

Table 2.3

Categorical Funds Used
During First Year of Block Grant Implementation

State	1982	Percent of total categorical and block grant funds
	(000 omitted)	
Colorado	$ 5,818	70
Florida	21,876	62
Iowa	1,478	67
Kentucky	2,339	74
Massachusetts	17,151	84
Michigan	7,798	41
Mississippi	4,029	72
New York	31,116	56
Pennsylvania	21,931	70
Texas	14,605	78
Vermont	2,655	60
Washington	6,855	51

Having large amounts of categorical grant funds available reduced the amount of block grant funds the states had to spend in 1982. For example, in 1981 about $29.2 million was awarded to ADAMH categorical program grantees in Florida. About $22 million of these funds was still available after October 1, 1981, when the state received its $22.4 million ADAMH block grant award. Also, as permitted under the block grant legislation, Florida officials transferred about $1.9 million into ADAMH from the social services block grant. Thus, about $46.3 million in federal categorical and block grant funds was available during 1982, of which an estimated $35.4 million was actually used for services, resulting in a $10.8 million carryover of ADAMH block grant funds into 1983.

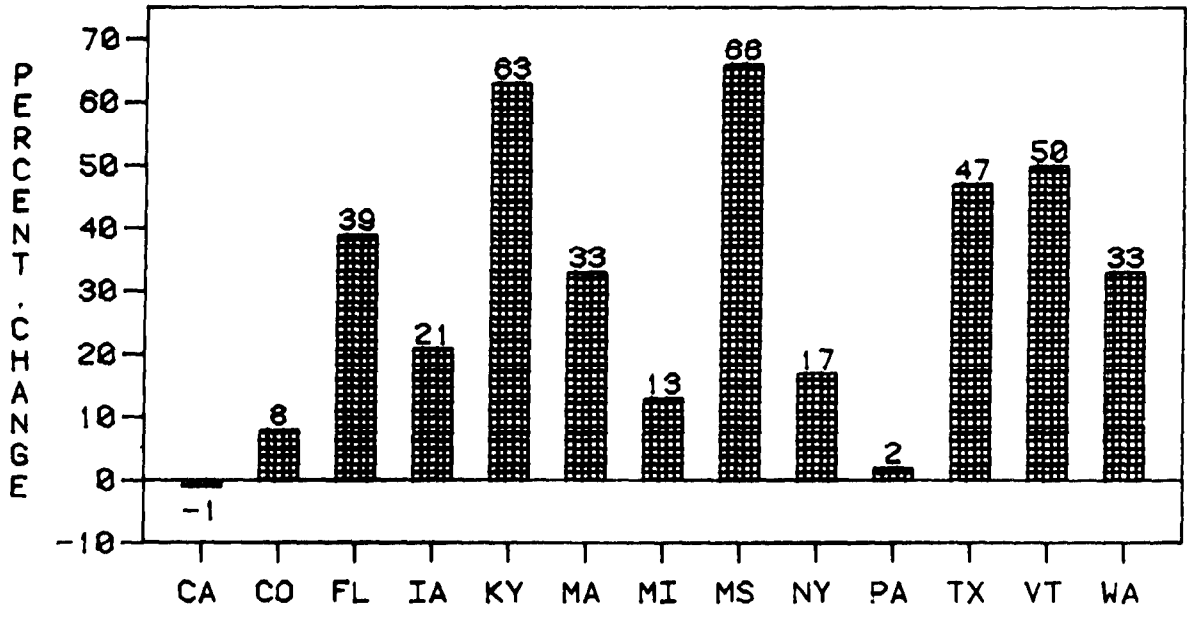
Consequently, despite reduced federal support for ADAMH services in Florida of about 23 percent in 1982 and 17 percent in 1983 (see app. III), ADAMH service providers in Florida were funded at 100 percent of the 1981 categorical grant level during 1982. Further, substance abuse service providers and mental health service providers were funded in 1983 at 90 percent and 84 percent, respectively, of their 1981 categorical grant levels. State officials said that these reductions were part of a planned gradual funding decrease rather than an abrupt decrease after 2 years of full funding at the 1981 level. The larger decrease for mental health programs was due to an unanticipated shortage of state funds.

The overlapping of federal categorical and block grant funding during 1982 helped offset the immediate impact of federal appropriation reductions and allowed states to reserve block grant funds for future years. In the aggregate, 12 states included in our analysis were able to carry forward about 50 percent of their 1982 block grant funds into 1983. This ranged from 13 percent in Michigan to 80 percent in Massachusetts. Block grant carryover from 1983 to 1984 ranged from 5 percent in Florida to 46 percent in Kentucky, and in the aggregate, the 12 states carried over about 27 percent of available 1983 funds into 1984. HHS officials noted that the availability of categorical carryover moneys in 1982 and 1983 made that period atypical, and as a result, the funding pattern in those years may not be indicative of future funding trends.

Most states increase their contribution to ADAMH program funding

As shown in chart 2.1, 10 of the 11 states for which we obtained data on all three ADAMH program areas increased their contributions to total program support between 1981 and 1983. These increases ranged from 2 percent in Pennsylvania to 66 percent in Mississippi. Only California showed a slight reduction in its fiscal year 1983 support as compared to its fiscal year 1982 support. State contributions to the substance abuse programs in Michigan and New York also increased during this period by 13 and 17 percent, respectively.

CHART 2.1
PERCENT CHANGE IN THE USE OF STATE FUNDING
FOR ADAMH BLOCK GRANT PROGRAMS BY STATE
(1981 -- 1983)



A major factor influencing increases in the states' contribution to total program funding was the anticipated reduction in federal block grant funding. For example, Florida officials indicated that state support was increased by about 39 percent, or $14 million, from 1981 to 1983 to offset reductions in federal block grant funds. The officials anticipated providing an additional $12.8 million in state support for 1984 to offset further federal reductions. Vermont officials said that the $1.8 million increase in the state's contribution between 1981 and 1983 was intended to offset federal funding reductions as well as to increase state-initiated programs.

As shown in table 2.4, compared to 1981, state funding accounted for a larger portion of 1983 program support in 9 of the 13 states. The extent to which this occurred, however, varied among the states. For example, Iowa's state contributions increased only 1 percent, from 25 to 26 percent of total program funding. However, Kentucky's share of total program support grew from 19 percent to 34 percent.

Table 2.4

Percent of Total Program Support Derived From State Funds

	1981 percent of total program support	1983 percent of total program support
California[a]	76	75
Colorado	52	55
Florida	39	52
Iowa[b]	25	26
Kentucky	19	34
Massachusetts	64	75
Michigan[c]	37	35
Mississippi[d]	36	55
New York[b,c]	40	39
Pennsylvania	48	47
Texas	41	48
Vermont	24	32
Washington	57	66

[a]Represents percent of state fiscal year 1982 and 1983 funds.

[b]Percent based on state fiscal year data.

[c]Represents substance abuse programs only.

[d]Represents percent of categorical, block grant, and state funds only.

Changes in other funding sources vary

In addition to block grant and state funds, other sources of funds are available to support state alcohol, drug abuse, and mental health programs. For instance, under the block grant legislation, states may transfer funds from certain other block grants into ADAMH and, conversely, from ADAMH to other health block grants. Only two states exercised this option during the 1982-83 period. Florida transferred $1.9 million in 1982 and $7.8 million in 1983 from the social services block grant into ADAMH. Colorado transferred $143,000 in 1982 and $178,000 in 1983 out of ADAMH and into the maternal and child health block grant and $146,000 in 1983 to the preventive health and health services block grant.

Most states received funding support for their alcohol, drug abuse, and mental health programs from still other federal sources. In both 1981 and 1983, a major source of these funds was reimbursements under the states' Medicaid programs, which are partially funded from title XIX of the Social Security Act. Other sources included grants for education and senior citizens programs and from other federal assistance programs.

In 7 of the 12 states where we were able to obtain data, these other federal sources provided less than 10 percent of the total program support for substance abuse and/or mental health programs. However, in several other states, the title XIX Medicaid program was a major source of support because the prior categorical programs encouraged states to seek support from a variety of sources other than their federal grant. For example, in Pennsylvania title XIX funds constituted about 16 percent of the state's 1983 alcohol, drug abuse, and mental health program support, and a 25-percent increase in the use of this source of support since 1981 has helped offset the reduction in ADAMH funds. Similarly, in New York, Medicaid payments and other federal support represented about 33 percent of the state's total substance abuse program funding in 1983. Again, an increase of about 38 percent from 1981 to 1983 helped New York offset ADAMH funding reductions. Conversely, a 33-percent reduction in the use of other federal funds in Kentucky between 1981 and 1983 for ADAMH block grant supported programs was a major factor in the overall 8-percent reduction in total support for the state's alcohol, drug abuse, and mental health programs.

Also, funding from client fees, reimbursements from insurance companies, and local support represented more than 14 percent of total support in eight states. For example, in 1983 these funds represented 52 percent of total support for alcohol, drug abuse, and mental health programs in Iowa and 43 percent of the substance abuse programs in Michigan. Complete data on the changes occurring in other funding support between 1981 and 1983 for all three ADAMH program areas were available in only four states. Colorado's other support decreased by 9 percent, while Iowa, Kentucky, and Pennsylvania experienced increases of 24 percent, 12 percent, and 12 percent, respectively.

Jobs Bill funds supplement 1984 ADAMH block grant

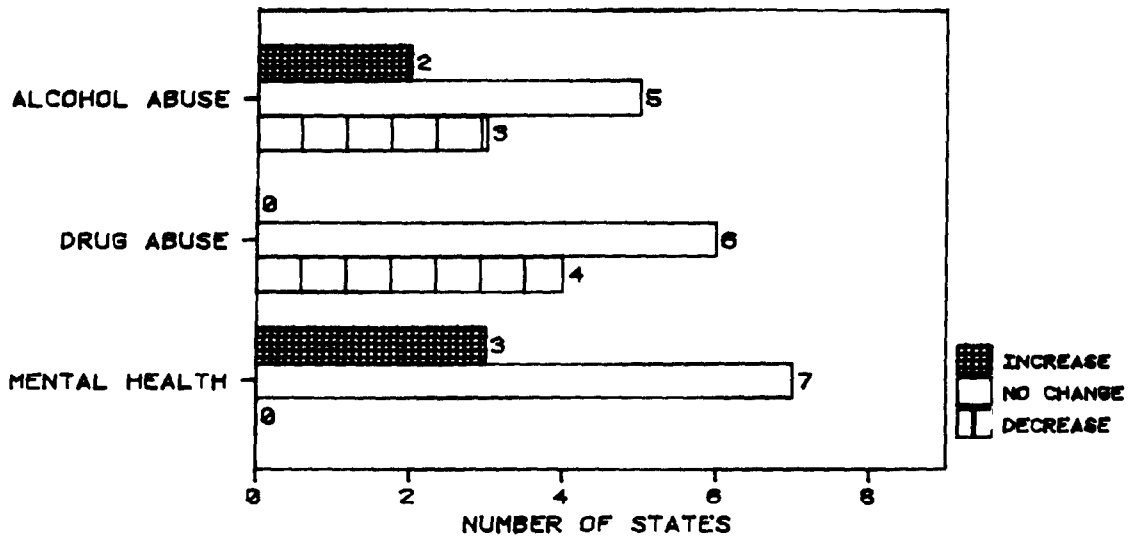
In March 1983, the Congress passed the Emergency Jobs Appropriations Act of 1983 (Public Law 98-8). This law, commonly known as the Jobs Bill, provided funds for job opportunities and health services, of which $30 million went to the ADAMH block grant. The 13 states received about $14 million, or about 46 percent. According to state officials, most of these funds will be spent in 1984.

State officials in 4 of the 13 states reported that Jobs Bill funds would be distributed and used in much the same manner as the fiscal year 1983 or 1984 block grant funds. In Florida, officials reported that about 90 percent of the Jobs Bill funds would be used for mental health programs, including two pilot projects dealing with continuity of patient care. In Washington, these funds are being used to increase funding to community mental health centers and to provide substance abuse counseling to individuals who have lost their jobs. In the other seven states, Jobs Bill funds were distributed and/or targeted to programs and clients in areas with unemployment problems. For example, Pennsylvania's funds were distributed to local service areas based on the relative number of unemployed persons in the area. These funds were targeted toward meeting the anticipated increased demand for services placed on the system by unemployed workers and their families.

NO MAJOR SHIFTS IN PROGRAM EMPHASIS BUT DRUG PROGRAMS MOST AFFECTED BY FUNDING CHANGES

Some changes have occurred in the proportion of total alcohol, drug abuse, and mental health program funds used for each of the three program areas since block grant implementation. As shown in chart 2.2, for the 10 states where complete data were available by program area, the proportion of total program support devoted to alcohol abuse programs decreased in 3 states, remained relatively stable in 5, and increased in 2. The proportion for drug abuse programs decreased in four states and remained relatively stable in six, while the share of total program support for mental health programs remained relatively stable in seven states and increased in three.

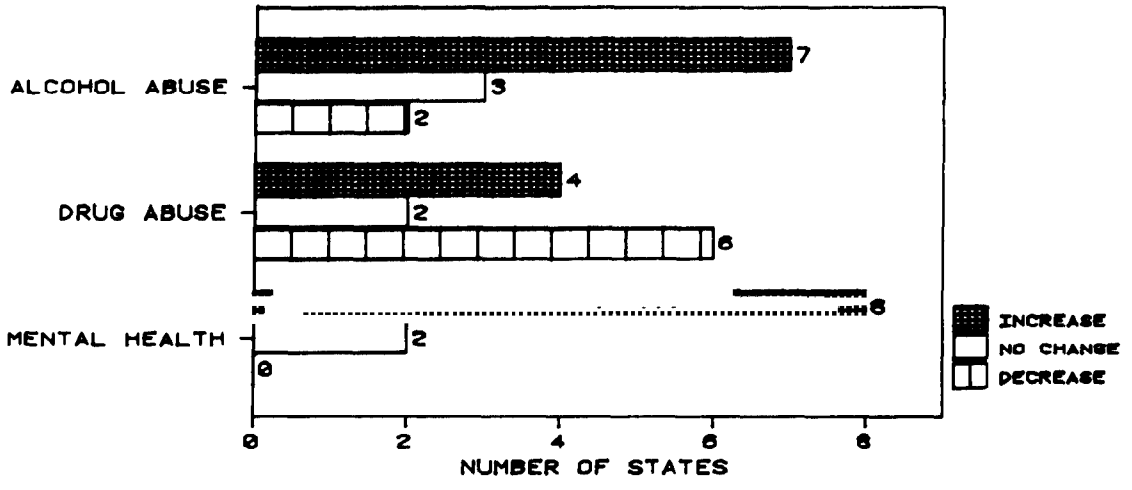
CHART 2.2
CHANGE IN THE PERCENT OF TOTAL ADAMH
BLOCK GRANT FUNDS USED BY PROGRAM AREA
(1981 -- 1983)



These changes indicate that no major shift has occurred in state priorities among the three program areas. As shown in appendixes IV through VI, the largest proportional change in total program support among the program areas in the 10 states between 1981 and 1983 was 7 percent. This change occurred in Texas, where the alcohol abuse program's share of total support increased by 7 percent, and in Washington, where the mental health program's share of total support also increased by 7 percent.

Although major shifts in emphasis have not occurred, drug abuse programs have been most affected by funding changes. As shown in chart 2.3 and in appendixes IV through VI for the 12 states where substance abuse data were available, support for drug abuse programs decreased in 6 states, remained relatively stable in 2, and increased in 4, while alcohol abuse funding decreased in 2 states, remained relatively stable in 3, and increased in 7. For the 10 states where mental health data were available, funding remained relatively stable in 2 and increased in 8.

CHART 2.3
CHANGE IN THE AMOUNT OF TOTAL ADAMH
BLOCK GRANT FUNDS USED BY PROGRAM AREA
(1981 -- 1983)



EARMARKING PROVISIONS CAUSE SOME FUNDING SHIFTS

The 1981 legislation contains provisions which (1) specify a formula for states to use in allocating ADAMH funds to substance abuse and mental health activities, (2) require continued funding of certain community mental health centers, (3) set minimum percentages for block grant funding of alcohol and drug abuse activities, and (4) set minimum percentages for block grant funding of substance abuse prevention/early intervention activities. Although our work was not designed to verify each state's compliance with these earmarking provisions, we did obtain some information on the effects the provisions had on the states' program funding decisions. Generally, these provisions helped maintain program continuity in the transition to the block grant. However, in some states the minimum funding level provisions for alcohol abuse, drug abuse, and overall substance abuse prevention/early intervention programs caused some noticeable changes in the relative funding levels for alcohol and drug abuse activities.

New York and California change how federal substance abuse funds are used

The legislation requires that, of the funds earmarked for substance abuse activities, at least 35 percent must be used for alcohol abuse and another 35 percent for drug abuse programs. In most states this provision was not cited as a major concern to state program officials. However, as a result of the provision, New York and California decreased the funds directed toward drug abuse activities to achieve the minimum funding level for alcohol abuse programs.

Before the block grant, 75 percent of the federal substance abuse funds spent in New York were devoted to drug abuse activities, while 25 percent were devoted to alcohol abuse activities. The 35-percent minimum funding provision caused New York to shift funds from its drug abuse program to alcohol abuse. According to state officials, the overall reduction in federal substance abuse support combined with the 10-percent shift of funds to alcohol abuse will have a significant impact on drug abuse services. The categorical carryover moneys lessened the immediate impact of these funding shifts. However, state officials anticipate that drug abuse service providers may begin experiencing waiting lists of clients needing services.

California's funding policy passed along all federal funding reductions to counties administering substance abuse programs, while state funding levels remained relatively unchanged. In 1983, this policy, together with the 35-percent minimum funding requirement for alcohol abuse activities, resulted in a 27-percent reduction in the amount of federal drug abuse treatment funds distributed to counties previously funded with categorical funds.

Substance abuse prevention funds increase

Another legislative provision requires each state to use at least 20 percent of its ADAMH substance abuse funds for prevention and early intervention activities. This requirement was cited by 5 of the 13 states as the primary reason for increases in funding levels for prevention/early intervention services. For example, this requirement prompted Vermont's prevention funding to almost double from about $180,000 in 1981 to approximately $357,000 in 1983. Also, Iowa reported that the number of counties providing substance abuse prevention services more than doubled during 1983, and total prevention funds increased by $300,000, or 27 percent, from 1982 levels.

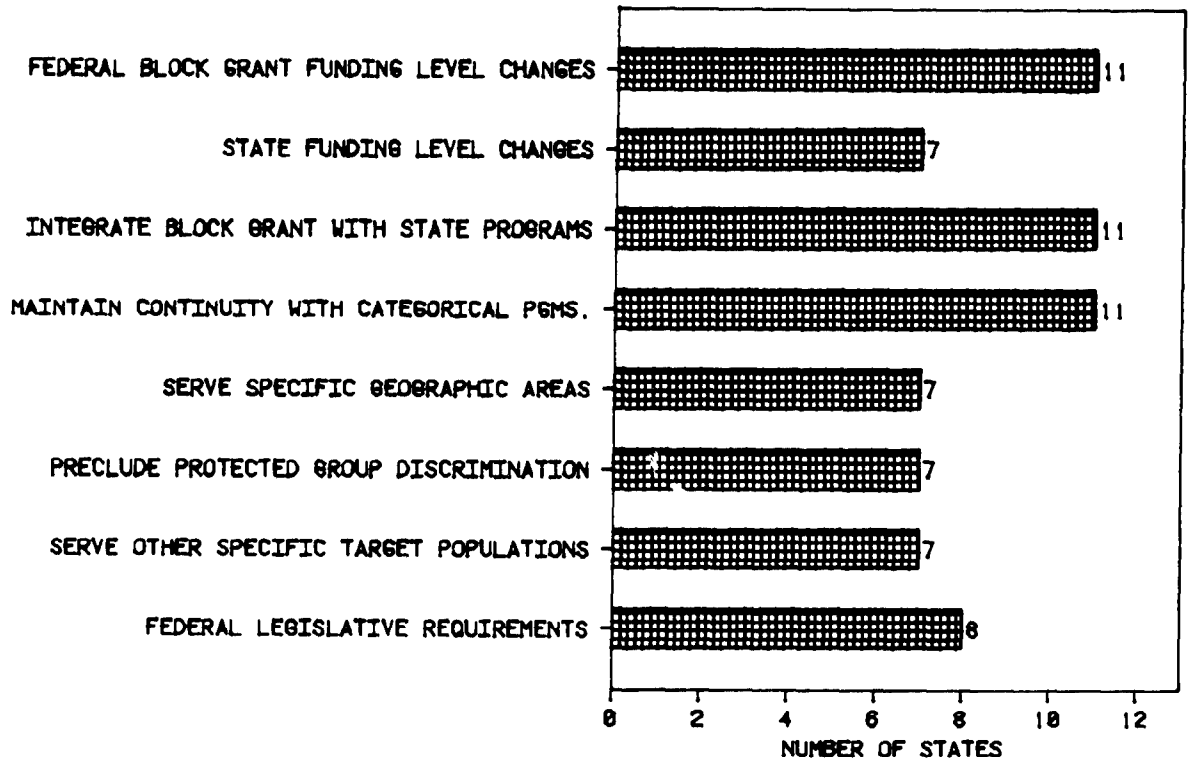
Texas and Pennsylvania also reported that this provision resulted in a greater use of federal funds for prevention and early intervention services. Officials in both states explained that the requirement diverted funds away from substance abuse treatment activities. For example, Pennsylvania used all federal substance abuse categorical funds for treatment activities except for about $800,000, which went to prevention and early intervention. State officials said that more than $3 million in state and local funds were also used for these services. Under the block grant, the state increased the amount of federal funds used for prevention activities to about $2 million by decreasing existing treatment programs about $1.2 million. State officials explained that continued use of treatment funds for prevention will eventually result in the elimination of some treatment services and/or the use of some treatment providers. Texas state officials also indicated that the increased funding for prevention activities will contribute to reductions in drug abuse treatment service funds during 1984 and 1985 of 10 to 20 percent each year.

SEVERAL KEY FACTORS INFLUENCE PROGRAM PRIORITIES

Program officials from all 13 states considered a number of factors in establishing priorities for the use of ADAMH block grant funds. As shown in chart 2.4, changes in the level of federal funding for alcohol, drug abuse, and mental health programs was a key factor cited by officials in 11 states. Officials in seven of these states also said state funding changes were important for priority-setting decisions. As discussed earlier, with the reduction in federal funds accompanying the ADAMH block grant, most of the states increased state support for alcohol, drug abuse, and mental health programs.

CHART 2.4

PROGRAM OFFICIALS' OPINIONS ABOUT SELECTED FACTORS THAT WERE OF GREAT IMPORTANCE IN SETTING ADAMH BLOCK GRANT PRIORITIES[a]



[a]In most instances, program officials' responses did not cover all three ADAMH program areas.

Another key factor in establishing program priorities was the desire to integrate federal funds into high-priority state programs. Eliminating the categorical programs and increasing the states' authority to decide how federal funds would be spent has enhanced the states' abilities to achieve the goals and objectives of already established state priority programs. In some states, however, the federal legislative requirements, such as the earmarking provisions discussed earlier, influenced the extent to which states were able to integrate federal funds with state programs.

Maintaining program continuity in the transition to the block grant was also a major factor cited by state program officials. Officials in Kentucky and Michigan, for example, expressed satisfaction with the existing service delivery networks in those states and made little or no changes. In California, officials stated that uncertainty about continued

federal funding beyond the current block grant authorization period prompted their decision to sustain existing programs rather than increase or create new programs.

CONCLUSIONS

Although federal allocations decreased as states began implementing the ADAMH block grant, carryover of funds from the 1981 categorical awards continued to support many service providers well into 1982. This helped mitigate the impact of the federal funding reductions and allowed states to reserve block grant funds for future years. Increases in state support also helped to offset federal funding reductions as most states began assuming a larger portion of overall program costs.

The availability of categorical funds and the increased level of state funding contributed to an overall increase between 1981 and 1983 in funds used for alcohol, drug abuse, and mental health programs in nine states despite the reductions in federal allocations to these programs. After adjusting for inflation, however, only five of these states continued to show growth in total program funds. In Michigan and New York, where data were available only on the alcohol and drug program areas, total substance abuse program funds increased during this period both before and after inflation was considered.

In establishing program priorities, states reported that federal funding changes, the desire to integrate federal block grant funds into already established state programs, and maintaining program continuity in the transition to the block grant were key factors influencing decisions. Also, some state officials reported that federal legislative requirements also played a role in the states' priority-setting decisions.

For the most part, the proportion of total program funds devoted to alcohol abuse, drug abuse, and mental health programs did not change significantly between 1981 and 1983. A 7-percent shift in the proportional share of total program funds occurred in two states and was the largest proportional shift among the three programs. However, total program support for drug abuse programs decreased in six states while decreasing in only two states for alcohol abuse and in none for mental health programs. The more frequent reductions in the drug area stemmed, in part, from its greater reliance on federal funds.

CHAPTER 3

FEW POLICIES CHANGE AT STATE LEVEL

BUT CHANGES OCCUR AT SERVICE PROVIDER LEVEL

Program officials reported few changes in state policies concerning the types of services offered, the network of service providers, or individuals eligible to be served since block grant implementation. The legislative earmarking of funds, the historical cofinancial and administrative involvement between the state and federal government in ADAMH programs, and the relatively stable trend in total funds available obviated the need to make major changes. While state policy did not change, service providers we visited experienced a variety of changes. Generally, the impetus for these changes was attributed to a multiplicity of program and funding dynamics rather than the block grant.

LIMITED CHANGES MADE BY STATES IN KINDS OF SERVICES PROVIDED

Most state alcohol and drug abuse programs provide a full array of counseling and medical services, including individual and group therapy, detoxification, medical screening, education, consultation, and job counseling and placement. Mental health programs, which are generally operated separately, usually provide emergency care, day care, outpatient services, and residential care. Since block grant implementation, state officials reported few additions or deletions in the types of services provided. Specifically, between 1981 and 1983, in the 13 states:

--11 made no major changes in alcohol services offered,

--12 made no major changes in drug services offered, and

--none made major changes in mental health services offered.

Where changes were made, they were narrow in scope and limited to the addition or deletion of a particular type of service. For example, in 1982, Colorado added an employee assistance program to its existing array of alcohol services. In that same year, Iowa dropped a similar activity in its alcohol and drug program.

Also, most states reported few changes in the emphasis placed on the different services. Where such changes occurred, they generally emanated from the legislative provision requiring

that 20 percent of alcohol and drug funds be used for prevention and early intervention activities. As a result of this provision, five states reported increasing emphasis on prevention activities. In the mental health area, four states reported increasing emphasis on care to the chronically mentally ill. Five states increased emphasis on followup care for patients released from mental institutions, and four states reported placing greater emphasis on community-based residential care.

SERVICE PROVIDER NETWORK NOT CHANGED

Through 1983, none of the 13 states had changed policies governing the types of organizations eligible to receive block grant funds. There have been some changes in organizations actually funded due to the competitive nature of the grant process and the changing financial condition of certain providers, but overall, states have essentially continued to fund the same network of alcohol, drug abuse, and mental health service providers that were previously funded. The stability in the service provider network stemmed, in part, from the ADAMH program provisions that required states to continue funding all eligible community mental health centers that received funds in 1981 under the Community Mental Health Centers Act.

In Kentucky and Mississippi, nearly all the predecessor categorical grants and state support for alcohol, drug abuse, and mental health went to regional community mental health centers. For 1982, 1983, and 1984 these states allocated block grant funds to the same centers. The amounts allocated varied from the categorical program, but each eligible center that received categorical funds now receives ADAMH block grant funds. Neither state made any major awards to new service providers. With the exception of a few alcohol and drug abuse service providers, New York continued funding all providers that had received grants under the categorical program. While there have been some changes in the amount of funds awarded, no agencies previously supported were defunded as a result of the ADAMH program. Similarly, California adopted policies that encouraged county agencies to maintain existing arrangements with providers, and no major changes were reported in the network of service providers.

CLIENT ELIGIBILITY UNCHANGED

The ADAMH program is broadly targeted to establish and maintain programs that combat alcohol and drug abuse, care for the mentally ill, and promote mental health. Neither the ADAMH program nor the predecessor categorical programs contained eligibility requirements, such as "means" tests based on income or other criteria, which would restrict an individual's ability to

participate. None of the 13 states reported any major changes in the kinds of clients eligible for services as a result of the ADAMH block grant, and state eligibility and targeting policies essentially remained unchanged.

In California, for example, state officials reported that the ADAMH program accounted for about 2 percent of the total support for mental health and that all services required under the ADAMH program closely paralleled the state's program. No changes were made in eligibility criteria, according to state officials, and no new policies or strategies for targeting services were established. Similarly, New York program officials reported that they were continuing to serve the same general client population served under the categorical programs and that services are provided to individuals in need. For example, statewide community mental health programs continue to be targeted to the chronically mentally ill and the elderly and children.

CHANGES OCCUR AT SERVICE PROVIDER LEVEL BUT IMPACT OF ADAMH PROGRAM OBSCURE

While state agencies have made few policy changes, the 47 service providers we visited had experienced a wide range of changes. At most of the service providers, the total funds available had increased, and staffing levels and the number of clients served remained relatively stable or increased between 1981 and 1983. Conversely, the total funds available had decreased from 4 to 51 percent at 14 service providers, and 16 reported that fewer clients were being served in 1983 than in 1981.

These service providers were not statistically representative of all organizations supported in part with ADAMH funds, but they do provide examples of how some service providers have fared under the ADAMH block grant. Each of the service providers was unique in some aspect. They had been in business for different lengths of time, were set up to serve varying local needs, embraced different professional approaches to treatment, and were generally organized to meet funding opportunities that had previously existed.

While service provider officials reported numerous changes, they were usually not directly related to the ADAMH block grant but were attributed to a multiplicity of program dynamics, such as changing needs of communities being served. Moreover, block grant funds provided less than 50 percent of the total program support at 39 of the 47 clinics visited, and changes in other funding sources also influenced program direction.

Total funds available to service providers vary

Of the 46 clinics visited that had funding data available, 32 had more total operating funds in 1983 than in 1981. Typically, federal funding had decreased but was offset by increased state and local support. Fourteen clinics were not as fortunate, however, because their total funds available had declined. The following examples illustrate the range of funding situations experienced by service providers we visited and highlight their varied circumstances and adjustments made in response to funding changes.

Colorado alcohol center expands operations

The total funds available to a Colorado alcohol center we visited had increased by over $200,000 from 1981 to 1983, and the estimated funds available for 1984 were expected to increase by more than $25,000. As shown in the table below, federal funds had decreased, but state and local support increased substantially.

Source of funds	1981	1982	1983
Federal categorical grants	$ 89,762	$ 0	$ 0
ADAMH grant	0	22,430	58,561
State grants	280,540	310,540	367,088
County and local grants	0	20,000	108,000
Fees for services and other sources of funds	5,000	19,000	44,250
Total funds available	$375,302	$371,970	$577,899

As total funds available rose, the center increased its staff from 18 in 1981 to 21 in 1983, added 4 volunteer staff, and increased the operating hours for its outpatient program. The center is now open 6 days a week for 12 hours a day, whereas in 1981 it operated 5 days a week for 9 hours a day. Also, total clients served increased from 1,629 in 1981 to 2,716 in 1983, and the director reported that services had been expanded to women and Hispanics through additional training and new staff.

Previously, this center had been operated by a county health department but was reorganized in January 1984 as a separate, private, nonprofit corporation serving 11 rural counties in northern Colorado. The director stated one reason for reorganizing was the concern that federal funding would continue

to decrease. Center officials also believed they could market more services to generate additional revenue. For example, the center has a program for persons found to be driving under the influence of alcohol, which operates on a profitable basis. The center hopes to use the funds generated by this program to subsidize its halfway house and detoxification services. The center also plans to increase its employee services program to local industries and expand services into other regions of Colorado.

Major reductions at a Mississippi health center

One health center we visited provided alcohol, drug abuse, and mental health services in central Mississippi. It had experienced a 36-percent decrease in total operating funds between 1981 and 1983. Grants from county governments have increased but not enough to offset declines in federal, state, and private funds. The reduced support, in part, occurred because the state began allocating funds based on a formula weighted heavily on the population served. According to the director, the formula was designed to achieve more equitable funding among all centers but made no special provision for those that had previously relied heavily on direct federal grants. Funds available to the center from 1981 to 1983 are shown below:

Sources of funds	1981	1982	1983
Federal	$1,134,540	$1,288,720	$ 544,882
State	316,719	283,223	234,127
Local	150,000	175,000	240,000
Other	52,000	25,600	34,652
Total funds available	$1,653,259	$1,772,543	$1,053,661

While the center has not eliminated any services, the case load per staff member, according to the director, has increased about 25 percent since block grant implementation. Also, certain services are no longer provided by the center's satellite clinics, and the center's staff has decreased by over 50 percent since 1981 as shown below:

Type of staff	1981	1982	1983
Professional	16	15	8
Paraprofessional	21	18	12
Administrative	24	19	10
Total	61	52	30

Further staff reductions are anticipated if funds are not increased. The director said that the reduced administrative staff has increased the amount of time the professional staff spend on administrative matters, thereby reducing the time available to provide services. The number of clients served has also decreased from 2,275 in 1982 to 1,781 in 1983.

The director reported that the ADAMH block grant had changed the center's relationship with the state because the state now has more control over the total funds available. According to the director, the state has increased emphasis on services to the chronically mental ill, and the center is now trying to increase those services in order to get additional funding.

Many program dynamics at work in large New York City drug abuse center

A large New York City center we visited specialized in treating substance abusers with psychological, chronic schizophrenic, and paranoia problems. It serves about 1,250 clients, including about 825 clients in a methadone maintenance program. The total funds available to the center have increased by $1.2 million since 1981 as shown below:

New York City Drug Center

Source of funds	1981	1982	1983
Medicare/Medicaid	$ 425,165	$ 978,051	$1,094,553
State and city[a]	2,396,067	2,949,877	2,883,744
Foundations	29,500	26,000	30,576
Donations	6,591	2,118	3,705
Patient fees	26,397	73,780	104,179
Total available	$2,883,700	$4,029,826	$4,116,757

[a]State funds include all National Institute on Drug Abuse grants in 1981 and all ADAMH grants in 1982 and 1983.

The increase has come from increased state funds, Medicare/Medicaid reimbursements, and patient fees. The center has experienced a sharp increase in Medicare and Medicaid funds. According to the director, the center has aggressively pursued these payments and is encouraging more clients to apply for Medicare and Medicaid. The center also instituted a sliding fee schedule in 1981 for its methadone clients. The fees were set at $5 in 1981, increased to $7.50 in 1982, and to $10 in July

1983. Despite the increase, the director said no one has been turned away because of inability to pay.

The increased funds have been used to expand services. According to the director, the center has added a 40-bed, short-stay methadone maintenance facility and expanded its methadone abstinence residential program. The center director also said that the expansion of services since 1981 was not directly related to ADAMH block grant implementation but stemmed from the changing needs of the community served. The center director said that even with the increase in funds, the staff salaries are low and not competitive and more money is needed. In an effort to raise money and reduce costs, the center plans to buy the building it now leases and rent out unneeded space.

Drug program in Florida experienced little change

The Corner Drugstore in Gainsville, Florida, is a non-profit corporation which provides a broad spectrum of services for youths. It has been funded principally by direct federal grants and state funds. Total funds available, of which about one-third relate to drug programs, have been reduced since 1981 as a result of the phase-down of the Drugstore's federally supported Runaway Youth Program. Total funds available between 1981 and 1983 are shown below.

Source of funds	1981	1982	1983
Federal:			
Runaway Youth Program	$192,393	$ 27,494	$ 0
ADAMH	0	19,374	58,016
Other	7,478	298	0
Total federal	199,871	47,166	58,016
State funds	232,092	265,276	283,682
Donations, fees, & third-party payments	32,167	33,914	36,551
Total funds available	$464,130	$346,356	$378,249

According to the Drugstore director, there have been no major changes in the types of services provided in the drug abuse program. The major emphasis is drug abuse prevention, consultation and education, and transition programs.

In 1983, however, the Drugstore curtailed services to the "hard core" drug addicts to concentrate on persons just beginning to experiment with drugs and to those having emotional problems and a tendency to use drugs. This change did not stem from the implementation of the ADAMH program, but was made to more effectively deal with the latter types of clients and to accommodate university students who served short-term internships at the Drugstore. We were advised that only 20 hard core drug addicts were affected by this change and that they had been referred to the Veterans Administration, local community mental health centers, and hospitals in the area which were better able to treat them.

Other major drug program activities remain unchanged, and over the past 3 years, staff levels have been fairly stable. The director said no significant changes occurred in the client population served, but the total number of clients served has decreased slightly from 6,525 in 1981 to 6,374 in 1983.

Staffing trends at providers generally stable

About half of the 43 providers that reported data had decreased their staffing level since 1981, and about half had increased their staffs or remained at the same level. The staff decreases were more prevalent at providers that had less funds available to them during 1983. However, 10 providers that had increases in funds available also reduced their staff.

Generally the staffing level adjustments were relatively minor, according to the provider officials, although some states experienced substantial changes. For example, a mental health center in Texas increased its staff from 78 in 1981 to 116 in 1983 as result of a 44-percent increase in the total funds available. Conversely, after experiencing a 22-percent reduction in total funds available, a large mental health center in Pennsylvania reduced its staff from 100 to 54, and as indicated on page 33, a Mississippi provider reduced its staff by about 50 percent after major cuts in financial assistance.

Trends in clients served

Changes in the number of clients served at the 44 service providers that provided data were mixed. Compared with 1981 levels, 27 of the providers served more clients in 1983. These increases ranged from 3 percent at a Mississippi center to 201 percent in a small Texas alcohol prevention program.

Conversely, 16 providers were serving fewer clients in 1983 than in 1981. These decreases ranged from 0.2 percent at a

Vermont center to 74 percent at a Pennsylvania alcohol and drug abuse project. The Pennsylvania project director attributed the reduction to a pre-block grant bankruptcy of one of the clinics it had supported, rather than the ADAMH program.

Officials at 35 of the 47 locations reviewed further reported no significant changes in clientele served. Only one service provider reported any significant changes in clientele served. In that case a higher proportion of women and Hispanics was being served in 1983 than in 1981. The other 11 providers did not have the data readily available to make comparisons.

CONCLUSIONS

Since block grant implementation, few changes have occurred in state policies governing the kinds of services provided, the network of service providers, or individuals eligible for alcohol, drug abuse, and mental health services. The long-standing shared federal-state responsibility for program management and earmarking restrictions in the legislation as well as the relatively stable funding levels obviated the need to make major policy changes.

Whether the new state management will lead to more program changes is not clear. Because of the short time of operating under the ADAMH program and the continuing benefit of the funds carried over from 1981, changes may be yet to come.

While states had made few policy changes, the service providers we visited experienced a wide range of changes in their operations. Generally, these changes were not directly attributed to the implementation of the ADAMH block grant but to an array of program dynamics and often stemmed from cuts or increases in the total funding available to the providers.

CHAPTER 4

STATES MADE LIMITED CHANGES TO ORGANIZATIONAL STRUCTURE AND PROCEDURES FOR MANAGING ADAMH PROGRAMS

A key feature of the block grant was the flexibility it provided states to organize their operations and adjust their management procedures so that ADAMH services could be provided more efficiently and effectively. Because the states already had their own programs and were involved in administering certain prior categorical programs, new opportunities for organizational changes were limited. However, some states made changes to improve program management. Other management activities, such as establishing program requirements, providing technical assistance, monitoring, data collection, and auditing were underway and often integrated into ongoing state efforts. The reduced federal requirements, together with the management flexibility provided to the states, produced indications of administrative simplification; however, specific administrative cost savings could not be quantified.

ORGANIZATIONAL CHANGES LIMITED AND NOT DIRECTLY ATTRIBUTED TO BLOCK GRANT

Under the prior alcohol and drug abuse categorical formula grant programs, all funds flowed through state governments, which played a major role in program administration. Additionally, even when other former federally funded substance abuse programs made grants directly to local entities, states reviewed grantee applications in relation to comprehensive state plans. Although states did not administer federal grants that formerly went to the community mental health centers, most of the 13 states also provided state funds to those centers and included them in the state comprehensive mental health plan.

Because of their administrative involvement under the prior categorical programs and through state-funded programs, states were not required to make major organizational adjustments for the ADAMH block grant. In 12 of 13 states we visited, responsibility for ADAMH programs was assigned to the state office or offices formerly involved in administering the categorical grants or related state programs. For the most part, these states integrated the distribution of ADAMH funds into their county or regional based service delivery network, which provided services through grants and contracts or, in some cases, directly.

For example, in Pennsylvania, drug and alcohol service providers previously funded directly by the federal government have been integrated into the county-based network of single county authorities which make up the statewide drug and alcohol service system. Both ADAMH and state funds are provided to these authorities, which in turn fund service providers or provide services directly. Also, in order to meet the block grant 20-percent prevention/intervention requirements, "mini-blocks" were allotted to these authorities specifically for these purposes. Through this allocation all 43 single county authorities received federal money, including 14 that had not previously received federal alcohol or drug abuse funds.

Mental health services in Pennsylvania are also provided through a system of 43 county-based units. The state allocates funds to these units, which in turn contract with private, independent service providers. Some units do, however, provide services directly.

Iowa and Massachusetts, however, changed the organizational placement or designation of entities responsible for implementing portions of the block grant. Iowa consolidated the administration and financing of all mental health services to improve overall management of state mental health programs. A new office, the Division of Mental Health, Mental Retardation, and Developmental Disabilities, was established within the Department of Social Services. The University of Iowa's Mental Health Authority, which had previously managed mental health programs, was abolished. In Massachusetts, the Division of Drug Rehabilitation was transferred from the Department of Mental Health to the Department of Public Health.

Service delivery structures generally remain the same under the block grant

States generally maintained the service delivery systems that existed before block grant implementation. In most instances, states used the same alcohol and drug abuse providers funded either directly by the federal government or through the state under the prior categorical programs. Moreover, in accordance with statutory earmarking provisions regarding funding to certain community mental health centers, states have continued to fund these centers as well as others operating as part of the state service network.

In the 13 states we visited, no ADAMH-funded substance abuse or mental health services were provided directly by state agencies. Rather, states allocated funds to local entities, which funded local service providers or, in some instances, delivered services directly.

The expanded decisionmaking authority offered by the block grant enabled states to better coordinate and integrate the former directly funded substance abuse and community mental health programs with the existing state service delivery network. Where decisions on substance abuse and mental health service delivery occur at the substate level, the integration of state and federal funds enabled local entities to better coordinate the use of funds with local goals and priorities.

STATES CARRY OUT GRANT MANAGEMENT RESPONSIBILITIES

Under the block grant, states assumed additional management responsibilities for those programs that were formerly directly funded by the federal government. These responsibilities include establishing program requirements, monitoring, providing technical assistance, collecting data, and auditing. To some extent, these activities were already being carried out by states, but the block grant expanded the scope of their involvement. Generally, the 13 states carried out these responsibilities, although different approaches and emphases were noted among the states.

Requirements imposed on service providers

The block grant increased states' flexibility to manage program activities in accordance with state priorities and procedures. States no longer had to comply with numerous federal requirements. However, the Congress did establish certain prohibitions and restrictions pertaining to the use of funds. Prohibited activities include providing inpatient services, making cash payments to intended recipients of health services, purchasing or improving land, acquiring or permanently improving a building or other facility, purchasing major medical equipment, satisfying matching requirements for other federal programs, or providing financial assistance to organizations other than public or nonprofit entities.

States generally use contracts, published policy guidance or manuals, and state laws or regulations to insure compliance with federal prohibitions and restrictions on the use of block grant funds.

Besides federal restrictions, 3 of the 13 states also placed additional restrictions on service providers. Mississippi placed limits on salary increases and required advance approval for out-of-state travel, and California placed a 10-percent ceiling on administrative costs at the county level and required a 10-percent local match for state mental health

funds. In Iowa, the state required that at least 25 percent of the substance abuse grants be used for treatment services.

Monitoring responsibilities are integrated with ongoing state efforts

Under the ADAMH program, the monitoring of service providers for compliance with program requirements has shifted from the federal government to the states. State program officials report that this new responsibility is generally being carried out through ongoing efforts to monitor state funds. Like the federal government, most states used site visits as well as reports to monitor compliance with federal and state program requirements.

Monitoring block grant service providers in conjunction with other state programs occurred in most states since many service providers receive funds from both federal and state sources. State officials reported that block grant implementation had little effect on the extent of monitoring for all three program areas in 5 of the 13 states. Officials from two states said that monitoring had increased for all program areas. One state official said it had decreased for all three areas. The remaining five states experienced a mixture of increases or decreases among the three program areas.

Six states reported that ADAMH block grant implementation has resulted in monitoring improvements. For example, Colorado officials stated that they extended state procedures to all alcohol and drug program service providers to achieve a uniform application of standards and more efficient monitoring efforts. Also, Pennsylvania alcohol and drug program officials reported that monitoring is now accomplished through a single state system which meets federal and state needs. Florida officials reported reductions in federal and state coordination problems but said they missed the expertise of HHS representation that had made site visits. Program officials in the other seven states said that the implementation of the ADAMH block grant program has not improved monitoring in their states.

States provide technical assistance

Officials in 13 states reported that technical assistance on some aspect of the program was provided to recipients of ADAMH block grant funds. State technical assistance typically covered federal and state requirements, data issues, and programmatic issues. The recipients included local governments, and hospitals and clinics. In providing assistance, states made the greatest use of site visits, visits by local recipients to the state office, letters and written state guidance, and telephone contacts.

Data collection efforts remain about the same

All states collect data on programs supported with block grant funds; however, the types of data and the programs for which they were obtained vary. The most common types of data collected include information on services provided, client characteristics, and client geographic location.

Most officials reported that the amount spent to collect program data has remained about the same since block grant implementation. Depending on the program area, the remaining four states experienced increases in the amount spent to collect data. The need to meet the requirements of state legislatures and the budgetary processes also influenced states' decisions to continue the existing data collection efforts. Some state agencies indicated that the desire to maintain cross-state data comparability and the use of the data to monitor administrative cost ceilings were also important factors.

State program officials said additional information would be useful but there were barriers to collecting it. Officials differed on which type of data would be most useful, but many indicated that additional program effectiveness data would be useful. Most officials believed that additional collection efforts would increase the burden to local grantees. Limited financial resources, inadequate staff resources, and measurement difficulties in defining or obtaining information were also cited as barriers to obtaining additional data. Most states anticipate the amount of information collected in 1984 will remain at the current level.

States now arrange for audits of block grant funds

State audits of ADAMH expenditures are a key oversight feature of the block grant legislation. States are required to obtain annual independent audits of the ADAMH block grant and to make copies of audits available to HHS and to the public. Generally, state auditors plan to conduct state-level ADAMH block grant audits as part of single department-wide audits or state-wide audits. State officials told us that GAO's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions" will be used.

Texas and Iowa were the only states that had completed state-level ADAMH audits as of October 1983. Nine other states had state-level ADAMH audits in process as of October 1983, and audits were planned but not yet started in the remaining two

states. According to Texas officials, the state auditor performed the audit in accordance with Office of Management and Budget guidance, and it covered the entire Texas Commission on Alcoholism for fiscal year September 1981 through August 1982. Audit reports on the state drug and mental health programs, which are administered by two other state agencies, have not been issued. The audit report on the Texas Commission on Alcoholism states that the financial statements fairly presented the Commission's financial position; however, it did note that certain substate recipients of alcohol grants had not yet been audited. Iowa's audit report on the Department of Substance Abuse for 1982 said that the financial statements fairly presented the Department's financial position and the results of its operations. In addition, as of January 1984, data developed by the HHS Inspector General for 42 states showed that 23 ADAMH audits were complete, 13 were in process, and 6 were planned. These audits covered fiscal year 1982 funds.

State agencies generally arrange ADAMH subrecipient audits, and state internal auditors and certified public accountants generally conduct them. About half of the states plan to audit all ADAMH service providers, and others plan to audit on a sample basis. All states also plan to audit ADAMH service providers on an annual basis. Although very limited data were available on the status of service provider audits, states reported 139 audits complete, 8 in process, and 344 planned as of October 31, 1983.

BLOCK GRANT IMPLEMENTATION ACCOMPANIED BY ADMINISTRATIVE SIMPLIFICATION

Block grant implementation was accompanied by reduced federal administrative requirements in such areas as preparing applications and reports. In addition, it gave states flexibility to establish procedures they believed were best suited to managing programs efficiently and effectively. Together, these block grant attributes were intended to simplify program administration and reduce costs.

Most states reported that they were able to reduce time and effort involved in preparing grant applications and reporting to the federal government on block grant activities. Many states also reported that the block grant enabled them to standardize or change administrative requirements and to improve planning and budgeting and the use of personnel.

Program officials report that reduced federal application and reporting requirements have positive impact

Under the prior categorical programs, management activities, such as application preparation and reporting, had to be performed separately for each categorical program in accordance with specific federal directives. The block grant gives states greater discretion to approach these management activities in accordance with their own priorities and procedures. States must submit an application containing specified assurances and a description of how they intend to use block grant funds. The Secretary of HHS can prescribe the application form, but may not prescribe how the states will comply with the requirements. The Secretary chose not to specify the form or content, and consequently the approach taken in preparing applications, as well as the type of information included, varied.

Under the prior mental health categorical program, funds usually went directly from the federal government to community mental health centers and bypassed the state governments. However, states previously were required to prepare a plan detailing the statewide program for community mental health centers. Although all states took on additional application responsibilities with regard to the mental health portion of the block grant, 8 of the 13 states reported that they spent less time and effort preparing their 1983 application for mental health funds than preparing the statewide plan under the prior categorical program.

A substantial portion of the alcohol and drug abuse funds, however, did go through the states. Officials in 11 of the 13 states said that they devoted less time and effort to preparing the 1983 alcohol and drug abuse portions of the ADAMH application than they had applying for the prior categorical programs. Officials from 6 of the 11 states said the application requirements had a positive effect on their ability to manage substance abuse programs supported with block grant funds. Generally, this was because fewer requirements were being placed on the states. Texas officials, for example, noted that the consolidation of categorical programs eliminated inconsistencies in application requirements.

Two states reported they spent the same amount of time and effort preparing the application as they did previously. Both states indicated, however, that application requirements under the block grant had neither a positive nor a negative effect on program management.

States must submit an annual report to HHS on activities funded under the block grant. This report must contain information to determine how funds were spent, what activities were supported, and who received the funds. Copies of the report must be provided, upon request, to interested persons.

Eleven of the 13 states reported that they spent less time and effort reporting to the federal government under the alcohol and drug abuse portions of the ADAMH block grant than they did under those prior categorical programs. Five of these 11 states further indicated that the reporting requirements had a positive effect on program management. Pennsylvania officials reported that the effect was very positive and explained that under the prior categorical drug program there were monthly reporting requirements. Under the block grant, these have been eliminated.

Two states reported that they spent more time reporting to the federal government. Both states said this is due primarily to the additional mental health program responsibility. Florida officials explained that under the former categorical program each local mental health agency reported directly to HHS; however, now the state must submit an annual report.[1] Vermont officials said that the state is also generating data in anticipation of future federal reporting requirements.

In addition to most states spending less time and effort reporting to the federal government, five states reported that they were able to make management improvements in their alcohol and drug abuse programs as a result of the block grant. For example, Washington officials said that the reduction in federal reporting requirements has permitted the state to eliminate unneeded data collection efforts and has allowed the consolidation of alcohol and drug abuse data systems. Also, Michigan officials said that contract management has improved because the state has been able to standardize planning, reporting, and evaluation requirements, which has resulted in less paperwork and simplified management.

Three states noted specific management improvements in reporting on mental health programs. California officials noted that under the block grant, mental health services will now be reported in state reporting and data collection terminology and the state can better determine program costs. Texas officials explained that they were able to improve the client data system, as well as standardize performance and work load measures.

---

[1]This additional reporting responsibility applies to all other states, even though in the aggregate they spent less time and effort on reporting.

Florida officials said that mental health centers no longer need to prepare annual renewal grants because block grant funds are part of the state planning and reporting process.

States report improvements in planning and budgeting, administrative procedures, and use of personnel

Officials in 8 of the 13 states said that the block grant program was a factor in their states' efforts to make management improvements in planning and budgeting ADAMH services. The type of improvements included standardizing budget processes and consolidating program planning processes.

For example, Florida officials reported that the block grant is now included in the state appropriation process, thereby providing greater control over resource expenditures. Washington officials said that they now award 2-year contracts to service providers rather than 6-month and 1-year contracts in order to make contract periods coincide with the state biennial budget process. In Texas, officials reported that block grant alcohol funds are now consolidated with state funds, making it easier to control the program. Also, in the mental health area, Texas officials reported that they now see more stability in maintaining services. In Colorado, officials said they are now applying existing state planning and budgeting procedures throughout the state to achieve more uniform and efficient administration.

Officials in 8 of the 13 states said they changed or standardized their administrative requirements for at least one of the three program areas. Officials in three of these eight states said that the block grant was a factor in their decision. The types of changes included standardizing certain reporting systems and establishing new application procedures. For example, officials in Mississippi reported that the same state grant application and award procedures are now used for all ADAMH program funds, which has simplified administrative procedures. As a result, state officials believe control over funds has been improved.

Four states reported improvements in using state personnel. For example, California officials said that the fewer reporting requirements had permitted staff to spend more time administering the program. Washington substance abuse officials reported that the elimination of separate categorical program site visits has enabled the state to use staff for other important work and allowed them to reduce staff.

QUANTIFICATION AND COMPARISON OF ADMINISTRATIVE COSTS NOT POSSIBLE

As discussed in the two previous sections, states have experienced a mixture of increased grant management responsibilities and administrative simplification under the block grant. Some believed that the administrative savings associated with the block grant approach could offset some federal funding reductions. Others were less optimistic in their estimates of cost savings, but many believed that fewer layers of administration, better state and local coordination of services, fewer federal regulations and requirements, and better targeting of services could lead to cost savings.

However, while much was said about the administrative cost savings that might be achieved, specific savings could not be quantified. Essentially, two types of data must exist to determine specific administrative cost savings:

--Uniform administrative cost data at the state level based on uniform state definitions of administrative costs.

--Comprehensive baseline data on prior programs.

State approaches to defining administrative costs differ widely

Six of the 13 states have written definitions of administrative costs that apply to the ADAMH block grant. Officials in two other states provided unwritten definitions, and another state has a written definition for the alcohol and drug abuse portion and an unwritten definition for the mental health portion. The remaining four states have no definition. Although the nine states that defined administrative costs did it in a manner essentially consistent with federal guidance, the specific definitions ranged from very vague and general to very precise and detailed. Also, only five states have definitions that identify costs for subrecipients.

In addition to the differences in administrative cost definitions, states use various procedures for computing and documenting administrative costs, and many states have no procedures at all. Also, only 3 of the 13 states have provided subrecipients with instructions for computing administrative costs.

At the time of our fieldwork, 7 of the 13 states had information on the 1982 administrative costs. None of these states exceeded the 10-percent limit for the block grant. One of these states uses its own funds rather than block grant funds to administer the block grant.

Comprehensive baseline data on prior categorical programs not available

The ability to measure savings is also hampered by the lack of comprehensive baseline data on the cost of administering the prior categorical programs. At the state level, only 4 of the 13 states reported information on the cost of administering the prior alcohol and drug abuse categorical programs. Also, at the federal level, program officials said that it would be extremely difficult to determine the administrative cost of the prior categorical programs because no comprehensive pre-block data exist.

The inability to specifically determine administrative costs is not something new. In 1978, we reported that despite growing interest in the administrative cost question, little information was available on the cost or staff resources used to administer individual assistance programs. As a result, data to enlighten the debates over the cost of program administration were fragmentary and inconsistent. Essentially, that condition prevails for the ADAMH block grant today.

State officials provide varying perceptions about administrative costs

While there are numerous indications of administrative simplification and management improvement, quantifying any overall administrative savings appears impractical. Therefore, the best indicators of administrative cost savings are probably the perceptions of state officials, who have had the greatest contact with administering both the block grant and the prior categorical programs.

These perceptions tend to support the notion that block grants have simplified some areas of administration but have brought added responsibilities in other areas, especially in the mental health program, and that the impact on cost cannot be quantified. For example:

--A Kentucky official said that the flexibility of block grants allows more funds to be spent for direct services but that the impact on administrative costs cannot be quantified. The official pointed out that the health department's personnel costs have declined by about 20 percent, but many factors were involved, including economic conditions and budget cuts.

--A Pennsylvania health department official said the department has not attempted to measure administrative savings resulting from the ADAMH service block grant, but to his knowledge, no positions have been eliminated.

--A Colorado health department official said that the block grant did not reduce the cost of administering alcohol and drug abuse programs. A mental health program official said that administrative costs at the state level increased because federal money previously went directly to mental health centers under the categorical grants and the state was not responsible for administration.

CONCLUSIONS

States made limited changes in organizational structures for ADAMH programs at the state level, and they carried out their expanded management role under the block grant. States imposed requirements on service providers and monitored them for compliance, provided technical assistance, collected data on programs, and had program audits underway in most states. Because some of these activities were integrated into ongoing state efforts, the states' workload did not substantially increase.

The reduced federal requirements and the management flexibility associated with the block grant produced indications of administrative simplification. Most states spent less time preparing grant applications and reporting to the federal government, and many states reported specific management improvements related to planning and budgeting, standardizing administrative requirements, and the use of personnel. However, specific administrative cost savings could not be quantified in a comprehensive manner. Accordingly, the perceptions of state officials remain the best indicators of changes in administrative costs emanating from the block grant.

CHAPTER 5

INVOLVEMENT IN PROGRAM DECISIONS UNDER BLOCK GRANT APPROACH INCREASED FOR STATE OFFICIALS AND CITIZEN INTEREST GROUPS

Under the ADAMH block grant, state officials reported that some governors and most legislatures became more involved in program decisions than they were under the prior categoricals. This increased involvement usually manifested itself through the state budget and appropriations processes. State officials generally considered block grants to be more flexible, and some believed there was increased public participation over the prior categorical approach.

States took various steps to obtain citizen input. In addition to the mandated legislative hearings and circulating reports on the intended use of ADAMH funds, all states reported holding executive branch hearings and most reported using advisory committees. These self-initiated mechanisms often influenced ADAMH program decisions.

While half of the interest groups we surveyed participated in public hearings, interest group satisfaction with state efforts to facilitate public input was mixed. Also, while state officials generally believed the block grant approach was a more desirable way to fund ADAMH services, many interest group respondents preferred the prior categoricals.

EXPANDED GUBERNATORIAL AND LEGISLATIVE INVOLVEMENT

State program officials perceived that governors and legislatures in most of the 13 states had the same or greater levels of involvement in ADAMH program decisions as they had under the prior categorical approach. However, as shown in table 5.1, program officials noted more increases in legislative involvement than in gubernatorial involvement. Seven of 13 alcohol and drug abuse program officials saw no change in the degree of gubernatorial involvement in relation to prior categorical programs.

Table 5.1

State Program Officials' Perceptions of Gubernatorial and Legislative Involvement in ADAMH Block Grant vs. Prior Categorical Program Decisions

	Governors' level of involvement (no. of states)			Legislatures' level of involvement (no. of states)		
	Greater	Same	Less	Greater	Same	Less
Alcohol	5	7	1	9	4	0
Drug abuse	5	7	1	9	4	0
Mental health	7	5	1	10	3	0

When the perceptions of involvement in block grant decisions are compared to perceptions of involvement in related state-funded programs, gubernatorial involvement is about the same in most states, as shown in table 5.2. Legislatures tended to be less involved in block grant decisions than in state-funded program decisions.

Table 5.2

State Program Officials' Perceptions of Gubernatorial and Legislative Involvement in ADAMH Block Grant vs. State-Funded Programs

	Governors' level of involvement (no. of states)			Legislatures' level of involvement (no. of states)		
	Greater	Same	Less	Greater	Same	Less
Alcohol	5	7	1	1	5	7
Drug abuse	2	9	2	2	4	7
Mental health	2	7	4	1	4	8

Governors used several mechanisms to obtain information on or to exercise control over block grants. All relied on their opportunities to review budget submissions. About three-quarters of the governors also used public hearings, advisory committees, and the review and approval of federal grant applications. Although these latter mechanisms were not as frequently used in some states, others made great use of them. For example, Mississippi's governor created an advisory committee to oversee block grant implementation and relied extensively on this group's recommendations. In Texas, because concern over earmarking restrictions presented difficulties in accepting the ADAMH block grant, the governor created an advisory board consisting of three agency heads to resolve the problem.

Only the governor's office in Texas made specific changes in the methods used to obtain information on or exercise control over the block grants. Officials now hold smaller, local hearings before preparing the intended use reports and before the statewide agency hearings process.

Like the governors, the legislatures relied heavily on the state budget and appropriations process to oversee block grants. Legislatures in all 13 states appropriate ADAMH block grant funds, and 10 of the 13 states appropriate ADAMH block grant funds along with state funds for specific items or program activities within each block. In Massachusetts and Michigan, federal funds are appropriated for each block on a lump-sum basis, and in Kentucky, federal funds for more than one block grant are appropriated together as a lump sum. Also, 11 state legislatures have relied on information in state agency reports on federal grant operations, including the ADAMH block grant.

Legislative staff in six states said their legislatures were greatly involved in ADAMH block grant decisions. This was an increase over the prior categorical programs, where legislative staff in only 4 of the 13 states noted a high degree of involvement. Legislatures in nine states did not make significant changes in ADAMH block grant proposals submitted by their governors. However, in Michigan and New York, legislatures maintained or increased funds for specific services provided under the block grant, and in California, the legislature changed the grantee funding mechanism from a forward-funding to a reimbursement basis. The Colorado legislature decreased funding to specific geographic areas, transferred funds from ADAMH to other blocks, and changed the funds allocated to administrative costs. Like most of the governors, most legislatures are not planning changes in their oversight mechanisms for the blocks.

Gubernatorial and legislative officials identified a number of block grant characteristics which encouraged their involvement. The most commonly cited were consolidation of related categorical programs, greater state authority to set program priorities, and the ability to transfer funds between blocks. For example, legislative committees were primarily responsible for Colorado's decision to transfer $178,000 from the ADAMH block to the maternal and child health block grant in 1983.

Conversely, gubernatorial staff in 11 states said that statutory prohibitions and restrictions on the use of funds tended to adversely affect the governor's ability to oversee block grant planning and implementation. However, a smaller proportion of legislative officials believed that these prohibitions and restrictions also tended to discourage legislative involvement.

STATES USE A VARIETY OF METHODS TO OBTAIN CITIZEN INPUT

States accepting ADAMH block grant funds must conduct legislative hearings, submit a report on the intended use of federal ADAMH block grant funds, and prepare an annual report on their ADAMH activities. The 13 states addressed these requirements but did so in various ways. In addition, states generally provided other opportunities for citizen input. All the states reported holding executive branch hearings for at least one of the three main program areas comprising ADAMH, and 12 states had at least one advisory committee for ADAMH-funded programs.

Alcohol and drug abuse program officials in nine states saw little or no change in the levels of public participation under the block grant as compared to the prior categorical approach, but mental health officials in six states noted an increase. Although there were varying views on changes in the level of public participation, program officials in many states noted that citizen input from hearings and advisory groups influenced their program decisions.

Legislators in all states participated in public hearings

The law requires state legislatures to conduct public hearings on the proposed use and distribution of federal ADAMH block grant funds. Seventeen legislative committees in 12 of the 13 states told us they conducted a combined total of 44 hearings addressing the use of ADAMH block grant funds. In Mississippi, legislators participated in three regional hearings jointly sponsored by the governor and the legislature.

Eleven of the 17 committees holding hearings had budget or appropriations responsibilities, and 7 were joint house-senate committees. In the aggregate, three-quarters of their hearings were held in state capitals. The legislative hearings often differed in scope. Nine were solely on the ADAMH block grant; 12 considered ADAMH in conjunction with other block grants; 20 considered ADAMH as part of the appropriations process for state-funded programs; and the rest considered ADAMH in conjunction with other issues. Legislative committees in five states indicated that input received at legislative hearings affected state decisions on the ADAMH block grant. However, program officials in only two states viewed citizen input through legislative hearings as more important in overall program decisions than input they obtained in executive branch hearings or advisory groups.

State mailing lists were used most frequently to notify the public of hearings; newspapers were the next most frequently used method. About two-fifths of the committees gave 1 to 2 weeks' advance notice of their hearings; the rest gave 2 to 4 weeks. On average, 72 persons attended each legislative hearing, ranging from 15 in New York to 300 in Massachusetts.[1]

Legislative committees in four states plan to change their public hearings processes. California plans to hold more hearings outside the state capital, Kentucky plans to improve its notification process, New York plans to hold fewer hearings and hold them later in the allocation decisionmaking process, and Texas plans to hold its hearings earlier in its decisionmaking process.

States made intended use reports available for comment

All 13 states distributed reports on the intended use of ADAMH funds for fiscal year 1983. However, program officials in only four states believed the solicitation of comments on intended use reports was of greater importance to them as a means of soliciting citizen input than the use of executive branch hearings or advisory groups. Only alcohol and drug abuse officials in Mississippi said they used comments received on proposed plans in their decisionmaking process, while mental health officials in four states said such comments were used.

Because many states have different agencies handling the three components of the ADAMH block, intended use reports were sometimes handled differently within a state. For example, Pennsylvania's Office of Mental Health in the Department of Public Welfare circulated copies of the comprehensive state mental health plan in lieu of the ADAMH intended use report, whereas the Office of Drug and Alcohol in the Department of Health circulated the draft ADAMH application for comment.

Interest groups were evenly split in their satisfaction or dissatisfaction with state efforts to facilitate comments on state plans. However, a greater share were dissatisfied with the timing of the comment period relative to states' allocation decisionmaking processes. Five states plan changes to the way intended use reports are circulated. Kentucky, Iowa, and Washington officials in all three program areas and Pennsylvania mental health officials plan to request comments from more

---

[1]Averages exclude those hearings for which data were not available.

groups and individuals. Kentucky and Washington in all three program areas and Michigan mental health officials also plan to solicit comments earlier in their states' decisionmaking processes.

All states prepared annual reports

All 13 states reported preparing annual reports on their fiscal year 1982 activities in all three ADAMH program areas. They also made the reports publicly available either as separate reports or in summary form as part of the next year's intended use report. With the exception of Kentucky and Washington, all states have also submitted annual reports to HHS.

Alcohol and drug abuse program officials in some states told us they sent copies of annual reports to a wide variety of groups. Mental health officials in some states also sent copies of annual reports to a diverse group, but most states targeted legislators, service providers, and organizations representing the handicapped.

All states conducted executive branch hearings

The governor's office and/or state executive agencies reported sponsoring hearings in at least one of the three ADAMH program areas in all 13 states, and 10 states reported holding hearings for all three program areas. Most executive branch hearings were held outside of state capitals. Before the ADAMH block grant, only 3 of the 13 states held executive branch hearings, and only Massachusetts held hearings addressing all three of the former categorical program areas. Iowa held hearings for the alcohol and drug abuse categoricals, and New York held hearings for alcohol only.

The approach to conducting the ADAMH executive branch hearings varied. For example, Michigan and Pennsylvania held hearings for their alcohol and drug abuse programs separate from mental health hearings, while California held hearings only for its mental health block grant funds. In eight other states, hearings for the three program areas were combined. In five of these eight states, ADAMH was considered in conjunction with other block grants or state-funded programs.

Several other factors are useful in comparing state executive hearing efforts: the use of media to announce hearings, the amount of advance notice for the hearings, and the availability of state intended use reports before hearings. Newspapers and state mailing lists were used most frequently to

notify the public of hearings. Only two states, Iowa and Mississippi, made great use of radio or television as a notification method. Most states provided 2 to 4 weeks of advance notice for public hearings, and in three states more than 4 weeks of notice was given. In Vermont, advance notice of 1 week or less was given. Copies of intended use plans were publicly available before hearings in all states but Vermont.

Fifty-three percent of the interest group respondents[2] familiar with ADAMH said they attended or testified at either executive or legislative hearings. More of these interest groups were satisfied than dissatisfied with the location, amount of time allotted, and number of hearings. Conversely, more groups were dissatisfied with the availability of information and the timing of hearings relative to states' decisionmaking processes. Groups were divided on their satisfaction or dissatisfaction with the amount of advance notice of hearings given by states.

Three states plan to change their executive hearings process. Kentucky plans to hold fewer hearings but to hold them earlier in the decisionmaking process; mental health officials in Michigan also plan to hold hearings earlier. Iowa's division of mental health plans to hold block grant hearings for the first time.

Widespread use of advisory committees

Twelve of the 13 states reported using a total of 28 advisory committees or task forces as part of their ADAMH decisionmaking process. Vermont was the only state that did not use any advisory groups. Only nine advisory committees focused exclusively on ADAMH block grant programs. Seven groups focused on ADAMH in conjunction with other blocks, while seven others focused on ADAMH in conjunction with related state-funded programs. The rest dealt with a broader range of issues.

The governor had the responsibility of appointing all advisory committee members in two states. In two other states, they were all appointed by state agency officials. In the remaining

---

[2]In our survey of interest groups in the 13 states, 255 of the 786 respondents indicated they had some knowledge of ADAMH-funded programs. Not all 255, however, answered every question in our survey, and percentages are based on the total number of respondents to each question. The number of responses to our questions ranged from 67 to 255. The actual numbers, in addition to the percentages reported in the text, are detailed in appendix VII.

states, appointments were made by officials from different areas of state government. Most states had a wide range of groups represented on advisory committees, with private citizens, service providers, and technical experts being the most prevalent. Six states had legislators and/or gubernatorial staff on their committees.

Twenty percent of the ADAMH interest groups were involved with state-sponsored advisory committees. They were fairly evenly split in their satisfaction or dissatisfaction with the role and composition of the advisory groups. Five of the 12 states that used advisory committees have discontinued or plan to discontinue some of them, but four of these states have other advisory committees that address ADAMH programs. The remaining seven states plan to continue their advisory groups.

Role of citizen input in state ADAMH program decisions

ADAMH program officials relied on diverse sources of information when setting alcohol, drug abuse, and mental health program priorities and objectives. Table 5.3 shows more states placed great importance on information from advisory groups, informal consultation with state program officials, and statistical measures of service needs than they did on other sources of information. Few states placed great importance on information gathered in legislative public hearings.

Table 5.3

State Program Officials' Opinions as to the Sources of Information That Were of Great Importance in Making ADAMH Decisions

	Number of states		
	Alcohol	Drug abuse	Mental health
Statistical measures of program performance	4	5	7
Statistical measures of service needs	6	6	9
Comments on draft plans	4	4	4
Executive branch public hearings	4	4	4
Legislative public hearings	2	2	3
Advisory groups	9	8	8
State-sponsored conferences	4	4	5
Informal consultations with program officials	8	8	8

Program officials in 9 of the 13 states made program changes based on information they received from comments, on intended use reports, testimony at executive public hearings, and/or recommendations from advisory groups. For example:

--Testimony and written comments on the intended use reports disclosed an error in California's proposed allocation of funds to community mental health centers which was corrected by state officials.

--Hearings in Michigan disclosed an overuse of certain treatment centers for alcohol and drug abuse. As a result, priorities were reordered to emphasize help for adolescents and women and to provide more preventive services. In addition, based on information received at hearings, Michigan mental health officials decided to allocate more resources to the Detroit area because it had a greater demand for services.

--Advisory groups in Washington emphasized the need to revise the distribution formula to give more weight to population. The state adopted these changes in its plan. Similar concerns raised during hearings in Mississippi led to changes in the state's distribution formula.

Program officials in the remaining four states believed the input they received from public hearings, comments on intended use reports, or advisory committees had no effect on their program decisions.

PERCEPTIONS OF INTEREST GROUPS AND STATE OFFICIALS

While many interest groups increased their activity with state officials under block grants, their satisfaction with state efforts to facilitate input into ADAMH program decisions was generally mixed. Also, more interest groups were dissatisfied than satisfied with the states' responses to their concerns, and they generally believed state decisions adversely affected groups they represented. State officials were generally pleased with the block grant approach, while many interest groups perceived block grants to be a less desirable way of funding ADAMH services.

Interest groups and service providers give mixed reaction on state input process and decisions

Over 30 percent of the interest group respondents that focused on ADAMH told us they had increased their levels of

activity with state legislatures and/or state executive agencies since block grant implementation. Most of these were statewide organizations involved in a wide range of activities to learn about or influence ADAMH programs. Chart 5.1 shows that interest groups participated in various aspects of the citizen input process. Attending or providing testimony at hearings was the most widely used input process, with 53 percent of the interest group respondents participating.

CHART 5.1
ADAMH INTEREST GROUP PARTICIPATION
IN THE BLOCK GRANT PROCESS

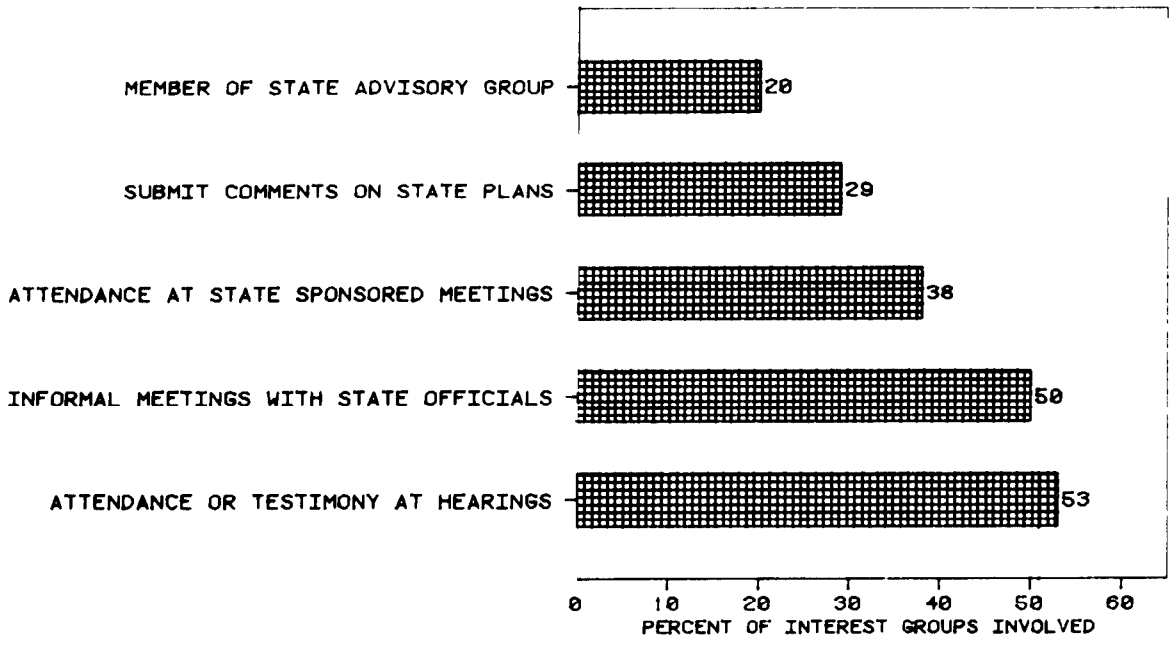


Table 5.4 shows that more interest groups attended or testified at executive than legislative hearings.

Table 5.4

Percent of Interest Group Participation
in Different Aspects of Hearings Process
(out of 255 respondents)

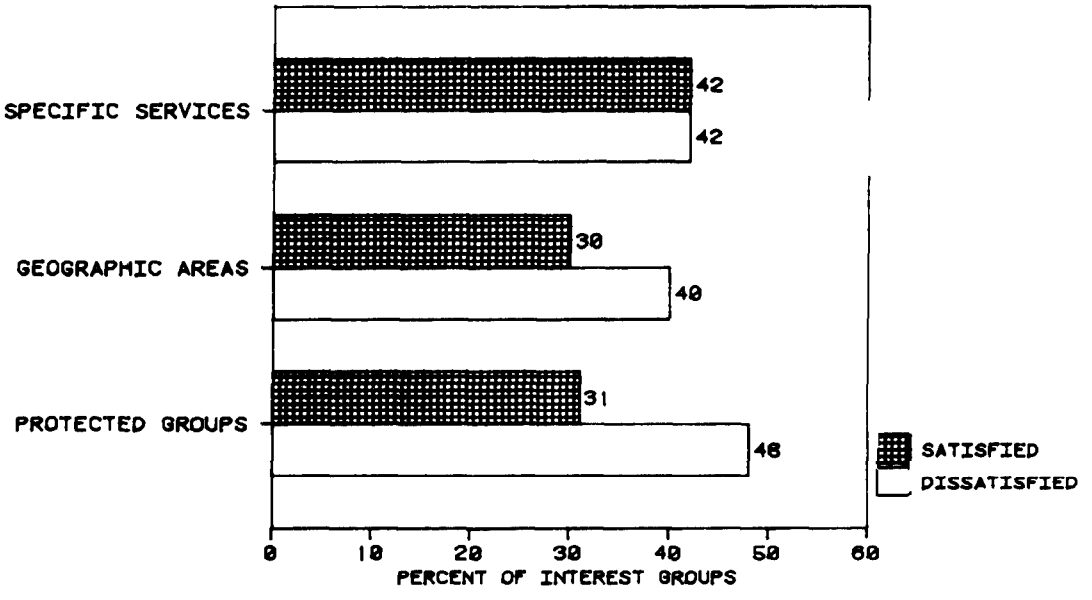
Aspect of process	Percent
Attendance at:	
Executive hearings	45
Legislative hearings	30
Testimony at:	
Executive hearings	22
Legislative hearings	14

There was no clear trend in interest group satisfaction or dissatisfaction with state methods for facilitating citizen input. The major area of satisfaction was with the accessibility of state officials for informal consultation (65 percent). The major areas of dissatisfaction related to the availability of information on the planned use of funds before hearings (52 percent), the timing of hearings relative to states' allocation decisionmaking processes (48 percent), and the opportunity to comment on modifications to state plans (56 percent). Interest groups that actively participated in the state's overall processes through such activities as testifying, attending hearings, or submitting comments on state plans were more satisfied with state processes to obtain citizen input than interest groups that were not actively involved.

Three issues most often cited as being of great or very great concern to interest groups were the need to maintain or increase funding for specific services (72 percent), for geographic areas (48 percent), and for services to protected groups, such as minorities and the handicapped (59 percent). Program officials also told us that they perceived a great concern about these three issues during the executive branch hearings.

Chart 5.2 shows that interest group respondents that had concerns about the need to maintain or increase funds for specific services were fairly evenly divided concerning their satisfaction or dissatisfaction with state responses to this concern. However, they were less satisfied with state efforts to maintain or increase funds for specific geographic areas or for protected groups. Also, 47 percent of interest group respondents believed that the changes states made to programs supported with the ADAMH block grant funds adversely affected the groups or individuals they represented. Only 28 percent of these interest groups viewed state changes favorably. The remaining groups were unsure or said there was no impact.

CHART 5.2
DEGREE OF SATISFACTION WITH STATE RESPONSES
TO ISSUES OF GREAT CONCERN TO INTEREST GROUPS



Of the 47 service providers we visited, 36 said that they relied on informal consultation with state officials to convey their views. Thirty-two service providers attended state-sponsored conferences, meetings, or surveys. Twenty-five service providers attended state executive branch hearings and had input to advisory committees or task forces. Organizations representing the views of service providers also provided input on the ADAMH block grant. Of the 47 service providers we visited, 22 reported that organizations representing their interests attended legislative hearings, 21 reported that their organizations had informal consultations with state officials, and 20 reported that their organizations attended state executive branch hearings.

State officials and interest groups have different perceptions of block grant approach

Program officials for alcohol and drug abuse programs in 11 of the 13 states said the ADAMH block grant provided them more flexibility than prior categorical programs. Program officials

for mental health programs in 8 of the 13 states responded similarly. Gubernatorial staff in 8 of the 13 states agreed. Most legislative leaders in six states believed block grants, in general, were more flexible than the prior categorical programs. Also, alcohol and drug abuse program officials in 11 states believed that federal block grant requirements were less burdensome than those of the prior categoricals, as did mental health program officials in 7 states.

State officials generally believed the block grant approach was a more desirable funding mechanism than the categorical programs. Most legislative leaders in 10 of the 13 states and gubernatorial staffs in 10 states said block grants, in general, were a more desirable approach to funding programs than the categorical approach. Similarly, alcohol and drug abuse program officials in 12 states and mental health program officials in 11 states also believed the block grant approach was more desirable. Three legislative leaders believed that the block grants were a less desirable approach as did mental health officials in one state. The other state officials saw little or no difference between the approaches.

Interest groups, on the other hand, did not generally perceive the block grant approach to be a desirable method of funding ADAMH programs. Only 26 percent of interest group respondents said the block grant approach was more desirable than categorical programs, while 49 percent saw the approach as less desirable. The remaining 25 percent saw little or no difference. Those respondents who were less satisfied with the block grant approach generally perceived that state block grant decisions had adversely affected the groups or individuals they represented.

While interest groups and state officials had differing views on the desirability of the block grant, both expressed concern about the federal funding reductions that accompanied the block. In our opinion, it was often difficult for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. Accordingly, officials in several states experiencing funding cuts commented that the advantages of their expanded flexibility were somewhat diminished by the reduced federal funding, and selected interest groups in those states were concerned about the implications that reduced funding held for the organizations and individuals they represented.

CONCLUSIONS

The increased flexibility of the block grant approach, particularly the opportunity to set priorities for previously directly federally funded programs, in our opinion, has contributed to the increased role of some governors and most legislatures. This increased involvement of state elected officials has been accompanied by some increase in interest group involvement in the decisionmaking process for ADAMH programs. States took steps in addition to basic federal requirements to obtain public input, and many states used input from advisory committees when making program decisions.

Interest groups were generally pleased with their access to state officials; however, their assessment of other aspects of state efforts to facilitate public input was mixed. Many were dissatisfied with the availability of information before hearings and the timing of hearings in relation to when state decisions were made. Also, they had a mixed reaction regarding the adequacy of state responses to their primary concerns.

In general, state officials found the block grant approach to be more flexible and less burdensome and viewed it as a more desirable method of funding ADAMH services. On the other hand, many interest groups generally viewed it to be a less desirable method of funding ADAMH services and believed that state changes to programs supported with block grant funds adversely affected the groups they represented.

DESCRIPTION OF GAO'S

DATA COLLECTION METHODOLOGY

To obtain information concerning the implementation and administration of block grants in 13 states, we collected data from two sets of sources:

1. Individuals or organizations having an interest in a single block grant, such as the state office that administers the block grant.

2. Individuals or organizations potentially having interest in more than one block grant, such as groups within the state legislature.

In some instances we obtained data directly from records available at organizations we visited; however, most of the data were provided to us by individuals or organizations. Most data collection took place during the period January to August 1983.

We developed four data collection instruments for obtaining information from the first set of sources referred to above and five for obtaining information from the second set of sources. The instruments we used to obtain information from sources having an interest in a single block grant were:

--Program Officials Questionnaire.

--Financial Information Schedules.

--State Audit Guide.

--Service Provider Data Collection Guide.

Almost identical versions of the Program Officials Questionnaire were used for all block grants we reviewed. The other three instruments listed above were to a much greater degree tailored to the specific block grant.

Questionnaires were used to obtain information from sources with potential interest in more than one block grant. The five respondent groups for these questionnaires were

--governors' offices,

--state legislative leadership,

--state legislative committees,

--state legislative fiscal officer(s), and

--public interest groups.

The approach we generally took with these questionnaires was to ask about the respondent's specific experience with the block grants and then ask some questions about general impressions and views concerning the block grant concept.

The primary focus of our study was at the state level; thus, most of our data collection took place there. Even when collecting data from other than the state level, state implementation and administration remained our major interests. The questions in the Public Interest Groups Questionnaire concerned the group's views as to the manner in which the state implemented and administered each block grant. The Service Provider Data Collection Guide was used not to obtain comprehensive data from the service provider level but rather to identify some of the implications, for service providers, of state policies and practices in block grant implementation.

The questionnaires were pretested and subjected to external review prior to their use. The extent of pretest and review varied with the questionnaire, but in each case one or more state officials or organizations knowledgeable about block grants received copies of the questionnaire and provided their comments concerning the questionnaire.

The Financial Information Schedules were discussed with other organizations that had obtained similar information at the state level in the past. The topics to be included in the Service Provider Data Collection Guide were discussed with service providers before the final instrument was produced.

The sections below present a detailed description of the contents of each of the data collection instruments as well as information on the source of the data and the method by which the instrument was administered.

PROGRAM OFFICIALS QUESTIONNAIRE

Content

This questionnaire was designed to elicit information about the administration of the block grant. It asked state program officials about

--the ways in which the state established priorities on program objectives,

--the procedures used to obtain the views of citizens and other interested groups,

--the scope of the state's data collection efforts,

--the extent to which technical assistance was provided to state and local recipients,

--the state's procedures and practices for monitoring service providers, and

--the state's general impressions concerning block grants.

Source of information

The questionnaires were completed by senior level officials in the program offices primarily responsible for administering the block grant in the 13 states included in our study. We specified in the questionnaire that the responses to the questionnaire should represent the official position of the program office.

Method of administration

Our field staff identified the senior program official in each state and delivered the questionnaire to the office of that official. The state program official was asked to complete the questionnaire with help, if necessary, from other staff and return the questionnaire to our representative who delivered it. A series of selective follow-up questions were developed to obtain additional information, primarily when certain responses were given.

FINANCIAL INFORMATION SCHEDULES

Content

The purpose of these schedules was to obtain the best available data on how states were spending block grant funds in addition to other sources of funds on ADAMH program areas. These schedules show for fiscal years 1981 to 1983 the amount of expenditures for each predecessor categorical program area from

--federal categorical funds going through the state government,

--block grant funds,

--other ADAMH-related federal funds,

--state-administered Medicaid and social service program funds,

--ADAMH-related state funds, and

--other funds, such as local community and county funds, fees for services, copayments, and reimbursements from private third-party payors.

Since a major portion of the predecessor alcohol abuse categorical funds, some drug abuse categorical funds, and all of the mental health categorical funds went directly to local community service providers, data on the use of these funds were not generally available at the state level. In order to include these major funding sources in our analyses, we determined the amount of direct categorical program funds awarded to grantees in each state and estimated the amount spent in each fiscal year. Our estimates were made assuming grant funds were spent in equal monthly increments over the grant budget periods. Using these estimates, in conjunction with the data obtained from the states, enabled us to more accurately reflect the level of activity in each state and program area and address the effect of categorical funds used during block grant years.

The financial data were generally collected on a federal fiscal year basis to coincide with the grant periods for the ADAMH block grant awards. However, this was not feasible in California, Iowa, and New York, so state fiscal year data were used in these states.

Source of information

The financial data were obtained from program and budget information available at the state level and from grants management and budget officials of the federal Alcohol, Drug Abuse, and Mental Health Administration.

In some instances at the state level, actual expenditure data were not available, and estimated figures were provided. In these cases, however, state officials agreed that the data provided represented the best available information at the time we completed our fieldwork. The estimates of the individual service providers' use of categorical funds awarded directly by the federal government were added to the state level data by our headquarters staff.

At times, individual service providers had to be contacted for expenditure data. We also consulted with officials from the Urban Institute and HHS on the design of the financial information schedules because of their knowledge and ongoing work in these areas.

Method of administration

Our staff worked with state program and budget officials to complete our pro forma expenditure schedules.

STATE AUDIT GUIDE

Content

We used this audit guide to collect information on the state administration and management of the ADAMH block grant. The areas included

--reviewing the overall state health, substance abuse, and mental health planning processes and determining how planning for ADAMH block grant funds and programs fit into these processes;

--identifying the administrative structure the state used to deliver ADAMH services;

--reviewing program areas supported with ADAMH funds to determine and analyze expenditure trends by programs and sources of funding;

--obtaining types of services provided within each ADAMH program area and identifying changes made to services provided since the state adopted the block grant;

--identifying changes made to the types of providers eligible to provide services and beneficiaries of services since the state adopted the block grant; and

--obtaining changes made to the methods for distributing federal categorical and block grant funds.

Source of information

The information was obtained from state officials through interviews and state documents.

Method of administration

A detailed audit guide was used by our field staff to obtain this information. Follow-up meetings were held with state officials for further information or clarification of data.

SERVICE PROVIDER DATA COLLECTION GUIDE

Content

This guide was used by our field staff to collect information concerning services provided through the use of block grant and other funds. The areas covered in this guide included

--descriptive information about the service provider,

--sources of service provider funding,

--scope of specific services provided,

--methods of service delivery, and

--information about clients served by the provider.

Source of information

A total of 47 service providers were visited by our field staff in the 13 states. Those service providers were judgmentally selected in order to provide some coverage by range of (a) types and sizes of providers (e.g., state, private, nonprofit), (b) types of ADAMH services provided, and (c) location in the state (urban and rural areas). In our selection, we attempted to include where appropriate at least three service providers, which were previously funded by the categorical program, from each state we visited. We also selected two agencies that had not been funded under the categorical program.

The service providers were selected from a list provided by the state ADAMH program officials.

Method of administration

The instrument was completed on-site by our field staff. Interviews with service provider officials and staff and review of documents such as annual reports and internal audits served as the basis for the data recorded on the instrument.

GOVERNOR'S OFFICE QUESTIONNAIRE

Content

This questionnaire focused on the role played by the governor and his office in implementing and administering the block grants. Questions included were

--the extent of the governor's involvement in the decision-making process regarding block grant funding and administration,

--what the governor did to obtain information or exercise control over the setting of state program priorities,

--whether there are any changes anticipated in the way in which the governor will exercise control in the future,

--if additional federal technical assistance would have been useful, and

--what the governor's general impression was about block grants.

Source of information

The questionnaire was completed by the governor or a representative designated by the governor.

Method of administration

The questionnaire was mailed directly to the governor, with all governors or their designated representative responding. When complete, the questionnaires were returned to one of our representatives.

STATE LEGISLATIVE LEADERSHIP QUESTIONNAIRE

Content

This questionnaire was used to obtain information about the perceptions of state legislative leaders concerning block grants. The questions asked legislative leaders included

--how block grants affected the way in which the state legislature set program priorities and funding priorities,

--what the major benefits were of funding programs through block grants,

--how block grants could be improved, and

--their general impressions about block grants.

Source of information

We compiled a list of legislative leaders based on a publication by the Council of State Governments, State Legislative Leadership; Committees and Staff, 1983-84. Generally there were four per state: the presiding officer of the senate, the senate minority leader, the speaker of the house, and the house minority leader. A total of 48 questionnaires were administered, and 40 completed questionnaires were returned, for a response rate of 83 percent.

Method of administration

Our staff delivered the questionnaire to the offices of the legislative leaders in each state. We asked that they complete the questionnaire and return it to our representative.

STATE LEGISLATIVE COMMITTEES QUESTIONNAIRE

Content

The questionnaire requested information about public hearings concerning block grants held by committees of the state legislature in the 13 states. Questions included were

--how many hearings were held and where,

--who sponsored the public hearings,

--what mechanisms were used to inform citizens that hearings were being held,

--who testified at the hearings, and

--what were the concerns of those testifying.

Source of information

Our field staff attempted to identify those committees in each state that held public hearings for 1983 concerning block grants. The questionnaires were completed by senior committee staff responsible for organizing public hearings on block grants. Twenty-eight committees received questionnaires, and all completed and returned them.

Method of administration

Our staff delivered the questionnaire to each legislative committee that held public hearings for 1983 block grants. A senior committee staffmember was requested to complete the questionnaire and return it to our staff member who delivered it. We followed up on selected questions for additional information.

STATE LEGISLATIVE FISCAL OFFICER QUESTIOINNAIRE

Content

The purpose of this questionnaire was to obtain information about the procedures used by the state legislatures to control and monitor block grant programs. Specifically, we asked

--what control or monitoring mechanisms the state legislature has and whether they have changed since block grants were implemented by the state,

--how block grant funds are appropriated,

--whether public hearings led to changes in the use of block grant funds,

--what role the legislature played in changing executive agencies' block grant plans or proposals, and

--the fiscal officer's general impressions about block grants.

Source of information

Legislative fiscal officers are generally the directors of the permanent, professional staffs of state legislatures. To identify the appropriate staff persons to whom we should direct our questionnaire, we sought the assistance of the National Conference on State Legislatures, the National Association of State Fiscal Officers, and the Council of State Governments.

Method of administration

Our staff delivered 19 questionnaires to fiscal officers in our 13 states. Seventeen were completed and returned, for an 89-percent response rate. We followed up on questions for additional information, as needed.

PUBLIC INTEREST GROUP QUESTIONNAIRE

Content

This questionnaire asked various public interest groups about

--their involvement with and perceptions of block grants,

--perceptions about the state's efforts to solicit and incorporate citizen input into state program decisions made on block grants,

--their views as to the impact of changes made by the state on those represented by the group, and

--their perceptions of changes in civil rights enforcement as a result of block grants.

Source of information

The names and addresses of interest groups were obtained from several sources. Initially we contacted about 200 national level organizations and asked if they had state affiliates that might have dealt with the implementation of the block grants. From those that responded affirmatively, we requested the names and addresses of their state affiliates. The list of 200 national level organizations was compiled from lists developed by GAO staff, from mailing lists of organizations interested in specific block grants compiled by HHS, and from the staff of a private organization with extensive knowledge about block grants.

This list was supplemented, where possible, by lists of interest groups compiled from attendance rosters kept by state agencies during their public hearings. The availability and usefulness of these lists varied by state.

Once an initial list was compiled, we sent it to our staff in each of the 13 states. They, in turn, showed these lists to state officials involved with the block grants and to a small, diverse group of respondents on the lists. These groups provided corrections and recommended additions of groups that they felt were active in block grant implementation but were not on the list we had initially compiled.

The results of the selection process were not intended to be viewed as either the universe of public interest groups knowledgeable about block grants or a representative sample of

public interest groups for any state or block grant. We believe, however, the interest groups we contacted provided a diverse cross-section of organizations knowledgeable about the ADAMH block grant implementation.

Method of administration

Questionnaires were mailed to the identified public interest groups with an enclosed, stamped, preaddressed envelope. A follow-up letter and questionnaire were sent to those who failed to respond within 3 weeks after the initial mailing.

Of the 1,662 groups on our final list, 786 returned completed questionnaires, for a 47-percent response rate. Of the completed questionnaires, 255 indicated that they had at least some knowledge of the implementation of the ADAMH block grant in the state in which their organization was located.

PERCENT OF TOTAL STATE AND DIRECT FEDERAL FUNDS CONTRIBUTED BY CATEGORICAL AND/OR BLOCK GRANTS 1981, 1982, AND 1983

State	Total state and direct federal funds used			Categorical and/or block grant funds			Percent of total		
	1981	1982	1983	1981	1982	1983	1981	1982	1983
	(000 omitted)								
California[a]	$475,203	$466,169	$453,210	$57,329	$49,049	$41,386	12	11	9
Colorado	35,201	35,689	37,516	8,406	8,336	8,633	24	23	23
Florida	66,864	77,739	89,863	31,312	35,420	40,612	47	46	45
Iowa[a]	5,524	5,446	6,152	2,513	2,129	2,496	45	39	41
Kentucky	11,311	10,364	13,264	5,235	3,159	3,368	46	30	25
Massachusetts	69,004	73,972	80,380	22,430	20,495	18,448	33	28	23
Michigan[b]	30,428	32,100	32,533	11,453	11,011	11,150	38	34	34
Mississippi	9,292	10,387	10,122	5,935	5,633	4,538	64	54	45
New York[a,b]	129,068	144,972	143,793	39,048	43,587	38,438	30	30	27
Pennsylvania	135,857	132,613	131,636	31,264	31,437	24,922	23	24	19
Texas	47,959	52,069	58,829	22,927	18,762	21,920	48	36	37
Vermont	8,064	8,613	9,284	4,435	4,413	3,852	55	51	41
Washington	34,922	42,220	38,621	11,830	13,316	7,917	34	32	20

[a]Represents state fiscal year data.

[b]Represents substance abuse programs only.

APPENDIX II

CHANGES IN FEDERAL ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ALLOCATIONS TO STATES

1980-83

(in thousands)

State	Total federal allocations				Changes in allocations									
					1980-82		1980-83		1981-82		1981-83		1982-83	
	1980	1981	1982	1983	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
CA	$ 62,675	$ 53,645	$ 41,196	$ 44,368	$ (21,479)	(34)	$ (18,307)	(29)	$ (12,449)	(23)	$ (9,277)	(17)	$ 3,172	8
CO	9,709	8,122	6,349	7,095	(3,360)	(35)	(2,614)	(27)	(1,773)	(22)	(1,027)	(13)	746	12
FL	32,645	29,158	22,445	24,345	(10,200)	(31)	(8,300)	(25)	(6,173)	(23)	(4,813)	(17)	1,900	8
IA	2,873	1,982	2,029	2,321	(844)	(29)	(552)	(19)	47	2	339	17	292	14
KY	5,860	3,924	3,322	3,702	(2,538)	(43)	(2,158)	(37)	(602)	(15)	(222)	(6)	380	11
MA	26,281	22,466	17,025	18,476	(9,256)	(35)	(7,805)	(30)	(5,441)	(24)	(3,990)	(18)	1,451	9
MI	22,875	15,796	13,095	14,143	(9,780)	(43)	(8,732)	(38)	(2,701)	(17)	(1,653)	(10)	1,048	8
MS	5,113	5,292	3,960	4,540	(1,153)	(23)	(573)	(11)	(1,332)	(25)	(752)	(14)	580	15
NY	58,830	48,218	37,779	40,617	(21,051)	(36)	(18,213)	(31)	(10,439)	(22)	(7,601)	(16)	2,838	8
TX	24,469	19,051	16,798	18,299	(7,671)	(31)	(6,170)	(25)	(2,253)	(12)	(752)	(4)	1,501	9
VT	5,091	4,394	2,911	3,355	(2,180)	(43)	(1,736)	(34)	(1,483)	(34)	(1,039)	(24)	444	15
WA	11,407	9,994	8,382	9,093	(3,025)	(27)	(2,314)	(20)	(1,612)	(16)	(901)	(9)	711	8
National total	$625,141	$540,962	$428,095	$468,000	$(197,046)	(32)	$(157,141)	(25)	$(112,867)	(21)	$(72,962)	(13)	$39,905	9

APPENDIX III

1981-83

DOLLAR AND PERCENTAGE CHANGES IN TOTAL FUNDS

FOR ALCOHOL ABUSE PROGRAMS

(in thousands)

State	Total 1981 alcohol abuse funds	Percentage of total 1981 ADAMH funds[a]	Total 1982 alcohol abuse funds	Percentage of total 1982 ADAMH funds[a]	Total 1983 alcohol abuse funds	Percentage of total 1983 ADAMH funds[a]	1981-83 change in alcohol abuse funds		Change in percent of total ADAMH funds 1981-83
							Amount	Percent	
CA[b]	$46,433	9	$40,095	7	$40,599	7	$ 504[c]	1	0[c]
CO	14,098	27	14,188	27	14,217	27	119	1	0
FL[d]	17,867	20	20,079	21	18,521	20	654	4	0
IA[b]	6,645	54	7,207	55	8,218	58	1,573	24	4
KY	8,639	27	7,791	26	6,868	23	1,771	(21)	(4)
MA	23,851	33	24,518	31	25,583	31	1,732	7	(2)
MI	23,257	(e)	28,635	(e)	27,250	(e)	3,993	17	(e)
MS[f]									
NY[b]	95,561	(e)	110,913	(e)	114,730	(e)	9,169	20	(e)
PA	28,357	13	30,587	14	31,150	14	2,793	10	1
TX	5,257	8	5,684	9	11,320	15	6,063	115	7
VT	2,307	15	2,002	13	2,290	14	(17)	(1)	(1)
WA[d]	13,692	34	13,628	28	13,450	29	(242)	(2)	(5)

[a]See table 2.1 on page 14 for total ADAMH funds in each state.

[b]Represents state fiscal year data.

[c]Since California did not accept the block grant until July 1982, these changes represent the difference between SFY 1982 and SFY 1983.

[d]Does not include funds from other sources.

[e]Percent not known since data from these states represent substance abuse programs only.

[f]Mississippi's total program funds could not be readily separated into ADAMH program components.

APPENDIX IV

1981-83

DOLLAR AND PERCENTAGE CHANGES IN TOTAL FUNDS

FOR ALCOHOL ABUSE PROGRAMS

(in thousands)

State	Total 1981 drug abuse funds	Percentage of total 1981 ADAMH funds[a]	Total 1982 drug abuse funds	Percentage of total 1982 ADAMH funds[a]	Total 1983 drug abuse funds	Percentage of total 1983 ADAMH funds[a]	1981-83 change in total drug abuse funds		Change in percent of total ADAMH funds 1981-83
							Amount	Percent	
CA[b]	$ 57,152	10	$ 52,993	10	$ 51,979	10	$(1,014)[c]	(2)	0[c]
CO	4,487	9	14,159	8	4,059	8	(428)	(10)	(1)
FL[d]	14,320	16	14,390	15	14,426	15	106	1	(1)
IA[b]	3,001	25	2,712	21	2,797	20	(204)	(7)	(5)
KY	3,164	10	2,544	9	2,550	9	(614)	(19)	(1)
MA	9,083	12	8,448	11	8,129	10	(954)	(11)	(2)
MI	27,420	(e)	27,704	(e)	33,316	(e)	5,896	22	(e)
MS[f]									
NY[b]	131,764	(e)	156,829	(e)	157,413	(e)	25,649	19	(e)
PA	30,451	14	31,314	14	30,992	14	541	2	0
TX	10,284	17	9,387	14	8,361	11	(1,923)	(19)	(6)
VT	817	5	978	6	921	5	104	13	0
WA[d]	4,375	11	4,008	8	4,387	9	12	(g)	(2)

[a]See table 2.1 on page 14 for total ADAMH funds in each state.

[b]Represents state fiscal year data.

[c]Since California did not accept the block grant until July 1982, these changes represent the difference between SFY 1982 and SFY 1983.

[d]Does not include funds from other sources.

[e]Percent not known since data from these states represent substance abuse programs only.

[f]Mississippi's total program funds could not be readily separated into ADAMH program components.

[g]Less than 1 percent.

APPENDIX V

1981-83

DOLLAR AND PERCENTAGE CHANGES IN TOTAL FUNDS FOR MENTAL HEALTH PROGRAMS

(in thousands)

State	Total 1981 mental health funds	Percentage of total 1981 ADAMH funds[a]	Total 1982 mental health funds	Percentage of total 1982 ADAMH funds[a]	Total 1983 mental health funds	Percentage of total 1983 ADAMH funds[a]	1981-83 change in total mental health funds		Change in percent of total ADAMH funds 1981-83
							Amount	Percent	
CA[b]	$436,713	81	$457,704	83	$455,887	83	$(1,817)[c]	(d)	0[c]
CO	32,726	64	33,613	65	34,834	65	2,108)	6	1
FL[e]	58,127	64	61,751	64	61,217	65	3,090	5	1
IA[b]	2,622	21	3,221	24	3,057	22	435	17	1
KY	19,964	63	19,417	65	19,918	68	(46)	(d)	5
MA	39,578	55	45,691	58	49,071	59	9,493	24	4
MI[f]									
MS[f]									
NY[f]									
PA	160,025	73	161,304	72	164,050	72	4,025	3	(1)
TX	45,837	75	49,822	77	56,503	74	10,666	23	(1)
VT	12,073	80	12,948	81	13,805	81	1,732	14	1
WA[e]	22,567	55	31,576	64	28,514	62	5,947	26	7

[a]See table 2.1 on page 14 for total ADAMH funds in each state.

[b]Represents state fiscal year data.

[c]Since California did not accept the block grant until July 1982, these changes represent the difference between SFY 1982 and SFY 1983.

[d]Less than 1 percent.

[e]Does not include funds from other sources.

[f]Data obtained in these states are not comparable to data obtained in other states.

APPENDIX VI

INTEREST GROUP RESPONSES TO QUESTIONS CONCERNING BLOCK GRANT IMPLEMENTATION FOR ADAMH

Table 1
Change in the Level of ADAMH Interest Group Activity

	Percent increase	Percent same	Percent decrease	No. of respondents
With state program officials	37	53	10	181
With state legislature	31	63	6	177

Table 2
ADAMH Interest Group Satisfaction With State Methods of Facilitating Public Input Into ADAMH Decisions

Hearings	Percent satisfied	Percent dissatisfied	No. of respondents
Degree of advance notice	40	42	168
Number of hearings held	40	25	161
Time, location of hearings	46	29	164
Avail. of information prior to hearings	26	52	167
Time allotted to block grants at hearings	47	24	152
Timing of hearings relative to states' allocation decisionmaking process	29	48	157
Comments on state plans			
Avail. of copies of state plan of intended expenditures	40	43	163
Length of comment period on state plan	36	39	151

Hearings	Percent satisfied	Percent dissatisfied	No. of respondents
Comments on state plans (continued)			
Timing of comment period relative to states' allocation decisionmaking process	31	47	151
Opportunity to comment on revised plans	25	56	147
Advisory committees			
Role of advisory groups	39	36	130
Composition of advisory groups	40	37	129
Informal contact			
Accessibility of state officials for informal contact on block grants	65	15	157

Table 3
Degree of Satisfaction With State Responses to Issues of Great Concern to ADAMH Interest Groups

	Percent satisfied	Percent dissatisfied	Percent neutral	Total no. of respondents
Need to maintain or increase funding for specific services	42	42	15	111
Need to maintain or increase funding for protected groups	31	48	20	83
Need to maintain or increase funding for geographic areas	30	40	30	67

Table 4
Did Changes Made by States Have a Favorable or Adverse Effect on Individuals or Groups Represented by ADAMH Interest Groups?

Percent favorable	Percent adverse	Percent unsure/no effect	Total no. of respondents
28	47	25	159

Table 5
Are Block Grants a More or Less Desirable Way of Funding ADAMH Programs Than Were Categorical Grants?

Percent more desirable	Percent equally desirable	Percent less desirable	Total no. of respondents
26	25	49	178

0876J.

AN EQUAL OPPORTUNITY EMPLOYER

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

U.S.MAIL

SPECIAL FOURTH CLASS RATE
BOOK

L.E
+ADPS