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**SUBSTANCE ABUSE AND
MENTAL HEALTH**

**Reauthorization Issues
Facing the Substance Abuse
and Mental Health Services
Administration**

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Substance Abuse and Mental Health: Reauthorization Issues Facing the Substance Abuse and Mental Health Services Administration

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to assist the Subcommittee in its deliberations on the reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA, with an operating budget of \$1.9 billion in fiscal year 1996, is the Department of Health and Human Services' (HHS) lead agency for substance abuse and mental illness prevention and treatment. The work of this agency has been deemed critically important to our nation's efforts to address and reduce the problems related to substance abuse and mental disorders. My testimony today focuses on SAMHSA's role in (1) coordinating its efforts with federal agencies involved in related research or services; (2) measuring the results of its programs or activities, particularly in light of the fact that most of its funds are used to support services provided by States and by local grantees; and (3) monitoring the impact of the transition to managed health care on individuals with mental disorders and substance abuse problems.

The observations I present today are based on our past and ongoing work at HHS as well as on conversations with SAMHSA officials and officials at other agencies that are engaged in substance abuse and mental health-related activities.

In summary, SAMHSA faces three important challenges in the current environment. First, given the many different, yet related, federal agency activities in the areas of substance abuse and mental health, it is especially important that SAMHSA communicate and coordinate its efforts with agencies involved in similar or complementary activities. Second, under the Government Performance and Results Act (GPRA), SAMHSA will have to show that its funds are used efficiently and effectively. This will present a particular challenge for the agency because most of its funds are used to support services provided by states and local grantees. Finally, the move to managed care in the private and public sectors affords potential opportunities for SAMHSA to improve the coordination of care, yet it has risks, given the financial pressures to control costs and health plans limited experience in setting capitation rates for mental health and substance abuse services. These are issues that deserve SAMHSA's careful attention.

Background

It is estimated that 52 million Americans annually experience a mental health or substance abuse problem and about half obtain treatment.¹ Many factors, including perceptions of the need for treatment, account for many people not getting care. In addition, insurance coverage has generally been more limited for mental health than for physical health services. For this reason, public sector (federal and state) resources have provided an important safety net for individuals unable to afford the care available in the private sector, and we now have a sizable public sector investment in mental health and substance abuse services. Private sector resources (for example, managed behavioral health plans) have grown, however, particularly as more employers have offered mental health and substance abuse benefits. Nonetheless, many Americans continue to face barriers in obtaining access to mental health and substance abuse services.

In October 1992, the Congress established SAMHSA under Public Law 102-321 to strengthen the nation's health care delivery system for prevention and treatment of substance abuse and mental illnesses. Before 1992, the major federal substance abuse and mental health delivery services and research activities were combined under one agency, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). In the 1992 legislation, the Congress created SAMHSA to administer the services portion of ADAMHA and transferred its research components to the National Institutes of Health (NIH) to be carried out by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health.

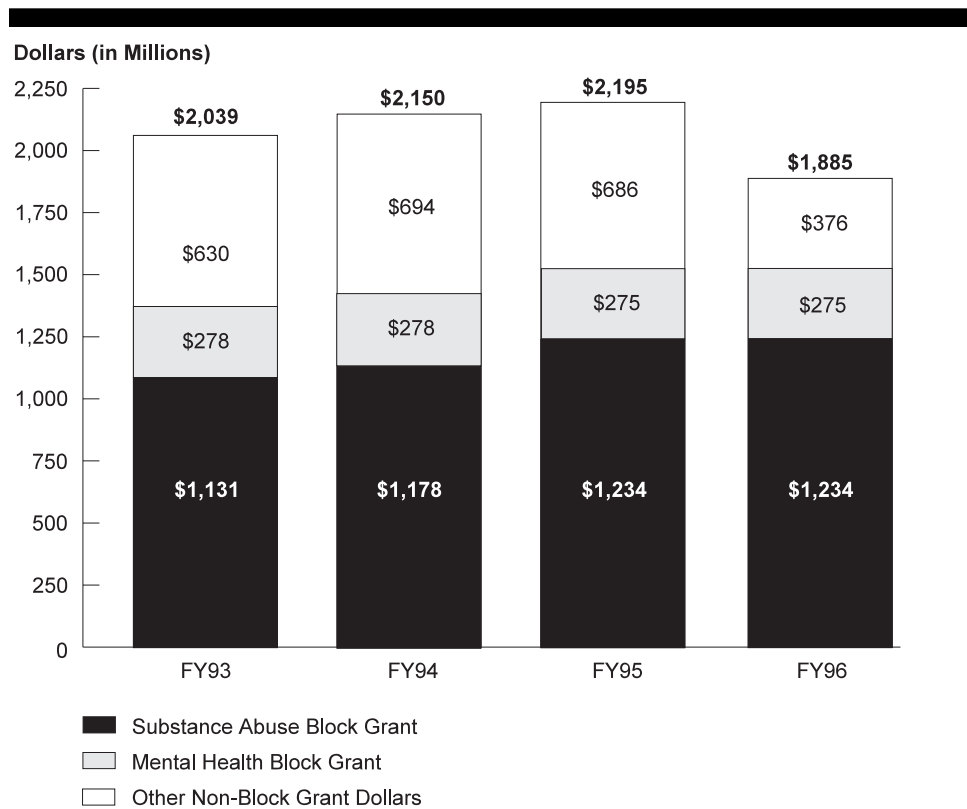
Since 1992, SAMHSA's budget has remained relatively stable at about \$2 billion each year. Most of this amount has been in the form of block grants to states and local governments. In fiscal year 1996, these grants totaled \$1.2 billion for substance abuse prevention and treatment services and \$275 million for mental health services. Combined, these block grants accounted for about 80 percent of SAMHSA's budget (see fig. 1). These funds go directly to states and local organizations, which have broad discretion in how best to use them, within federal guidelines. The remainder of SAMHSA's budget—\$376 million in fiscal year 1996—supports program management; data collection, analysis, and dissemination; and a wide array of demonstration efforts through the Knowledge Development and Application (KDA) program. The KDA program, as described in HHS' fiscal year 1998 budget, supports community organizations and other grantees with funding for well-defined demonstrations and other efforts that help

¹Institute of Medicine, National Academy of Sciences, Managing Managed Care: Quality Improvement in Behavioral Health (Washington, D.C.: National Academy of Sciences, 1997).

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promote strategies to reduce drug use by youth and increase the knowledge base about issues such as managed care and early childhood problems.

Figure 1: Amount of SAMHSA's Total Budget Authority Devoted to Block Grants, Fiscal Years 1993-96



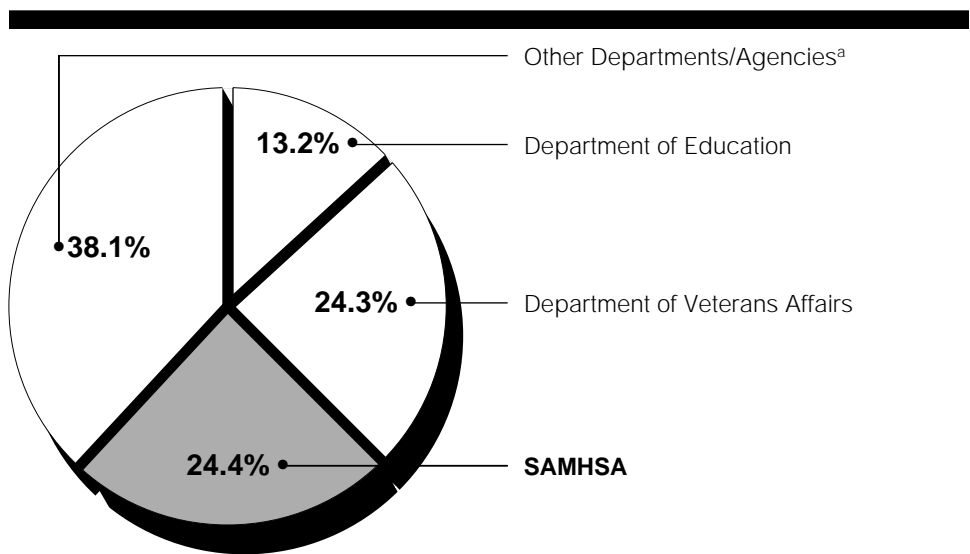
Most of SAMHSA's \$1.9 billion budget—75 percent in fiscal year 1996, or \$1.4 billion—funded substance abuse prevention and treatment services. SAMHSA's drug abuse budget authority, although sizable, represented only about one quarter of the federal government's drug abuse prevention and treatment budget in fiscal year 1996 (see fig. 2).² The Department of Veterans Affairs devoted a similar level of resources, while the Department of Education, the next largest supporter of these services, provided about half the level of funding of the other two agencies. Over a

²The federal government's drug abuse prevention and treatment budget is prepared by the Office of National Drug Control Policy (ONDCP). SAMHSA's budget authority in ONDCP's budget is \$1.084 billion for fiscal year 1996. This amount excludes SAMHSA funding for alcohol-only programs.

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dozen other agencies with varying roles and responsibilities share in funding similar or related activities under their respective missions, goals, and objectives.³

Figure 2: Agencies' Share of Federal Funding for Drug Abuse Prevention and Treatment, Fiscal Year 1996



Notes: Total funding is \$4.4 billion. Funding for alcohol-only prevention and treatment programs is not included.

^aOther agencies include the Departments of Defense, Justice, and Labor.

Source: ONDCP, *The National Drug Control Strategy, 1997: FY 1998 Budget Summary*, (Washington, D.C.: ONDCP, Feb. 1997).

Coordination Is Important to Program Results and More Efficient Use of Federal Funds

Given the number of federal agencies with related responsibilities in the area of mental health and substance abuse services, SAMHSA is presented with a particular challenge as well as an opportunity to coordinate activities and promote the development of effective linkages. While we recognize that ONDCP has lead responsibility for coordinating federal drug abuse supply and demand reduction activities, SAMHSA, nevertheless, has responsibility for coordinating its efforts with agencies involved in similar or complementary activities.

³Drug and Alcohol Abuse: Billions Spent Annually for Treatment and Prevention Activities (GAO/HEHS-97-12, Oct. 8, 1996).

The relationship between SAMHSA and the NIH institutes that once were a part of ADAMHA is an important partnership to maintain. The NIH research institutes support the development of new knowledge and technologies in prevention and treatment of substance abuse and mental illness. Linkages between researchers and practitioners are critical for new research initiatives to be grounded in real world problems and for new programmatic initiatives to reflect current knowledge in the field. Since one of SAMHSA's major goals is to support the application of innovative treatment and prevention approaches, working with the research institutes to identify projects that could serve as models for innovation is very important. There are probably many such opportunities for collaboration across agencies.

SAMHSA also has the opportunity to work with agencies such as the Departments of Veterans Affairs and Justice that serve populations in which mental health and substance abuse problems are great. Despite the value of such relationships, we found that in the past, SAMHSA, along with NIDA and NIAAA, had no process to link its expertise with that of the Indian Health Service (IHS),⁴ an agency that serves a population in which abuse of alcohol and other substances is a major problem. We recommended that IHS and the other HHS agencies work together to develop a plan to address substance abuse-related problems among Indian populations. In 1996, HHS developed and implemented such a plan, which should help it strategically allocate limited federal resources to address a major public health problem in IHS service areas.

Emphasis on Accountability for Meeting Program Goals Is Essential

Another major challenge for SAMHSA is to measure how well its programs are working. Given that most of SAMHSA's dollars are distributed to states through its block grant program, the agency faces the additional challenge of balancing the flexibility it affords states to set priorities on the basis of local need against its own need to hold the states accountable for achieving SAMHSA's goals. While this may have always been a daunting task, the passage of GPRA in 1993 now requires SAMHSA, along with other federal agencies, to show that the use of their funds is yielding results.⁵

Under GPRA, every major federal agency—and, in many cases, organizations within each agency—must now answer some basic

⁴Indian Health Service: Basic Services Mostly Available: Substance Abuse Problems Need Attention (GAO/HRD-93-48, Apr. 9, 1993).

⁵Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

questions: What is our mission? What are our goals, and how will we achieve them? How can we measure our performance? How will we use performance information to improve? GPRA forces federal agencies to shift their focus from such traditional concerns as staffing and activity levels to a single overriding concern: results.

Specifically, GPRA directs agencies to consult with the Congress, obtain the views of other stakeholders, and clearly define their missions. It also requires agencies to establish long-term strategic goals as well as annual goals linked to the strategic goals. Agencies must then measure their performance according to their goals and report to the President and the Congress on their success. In addition to ongoing performance monitoring, agencies are expected to identify performance gaps in their programs and to use information from these evaluations to improve programs.⁶

GPRA requires that federal agencies develop strategic plans for a period of at least 5 years and submit them to the Congress and the Office of Management and Budget (OMB) no later than September 30, 1997. These plans must identify the agencies' long-term strategic goals and describe how the agencies intend to meet these goals through their activities and resources. GPRA also requires agencies to submit an annual performance plan to OMB that links the strategic goals in their plan to managers' and employees' daily activities. This plan should include the annual performance goals for the agencies' programs as listed in their budget, a summary of the resources to conduct these activities, the performance measures that will gauge the progress toward those goals, and a discussion of how the performance information will be verified.

Recognizing this challenge, HHS is transforming its SAMHSA block grants into Performance Partnership Grants (PPG). Under PPG, an arrangement between the state and federal governments will be negotiated that identifies specific objectives and performance measures in terms of outcomes, processes, and their capacity to be achieved over 3 to 5 years. This appears to be a promising strategy because it gives states greater control over their funding decisions while encouraging them to accept greater accountability for results.

One of the many difficulties in implementing PPGs, however, will be developing and reaching agreement with individual states on their measures of performance. A panel of experts, convened by the National

⁶Executive Guide: Effectively Implementing the Government Performance and Results Act (GAO/GGD-96-118, June 1996) and Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

Research Council at the request of HHS, was asked to recommend a set of performance measures for ten public health areas of concern that states and the federal government could use to negotiate PPG agreements and monitor performance. Included in these areas of concern are substance abuse, mental health, chronic disease, and sexually transmitted diseases. The panel's final report on this first phase of its work is expected to be released by mid-June 1997. A final report on the second phase of the study, which will include recommendations for improving state and federal surveys and data systems, is expected to be released by the end of calendar year 1998. Consequently, implementation of PPGs will occur later than fiscal year 1998, as earlier projected.

Issues in the Transition to Managed Behavioral Health Care

Another challenge facing SAMHSA is its role in restructuring public sector mental health and substance abuse services, given the growth of the private sector managed behavioral health care industry. The forces driving the move to managed care for physical health services are also in operation in the mental health specialty sector. Employers' concerns about the high costs of mental health and substance abuse services have prompted them to adopt a number of managed care strategies. According to HHS, about 60 percent of Americans with private insurance were enrolled in a managed behavioral health plan in 1995. Similarly, the public sector, through the Medicaid program—which is administered by the Health Care Financing Administration (HCFA)—has looked to managed care to improve access to a comprehensive range of services while also reducing costs. As states have enrolled increasing numbers of Medicaid beneficiaries in managed care plans, they have found themselves having to make choices about payment and care arrangements for mental health services. While some states are integrating behavioral health and physical health services into a single managed care program, others are either fully or partially carving out mental health benefit packages under separate contractual arrangements.

The move to managed care, particularly when driven by pressures to control costs, has raised concerns about access to and quality of mental health and substance abuse care. Managed care has the potential to improve access to a comprehensive range of benefits for a population with multiple and chronic behavioral health care needs; yet it also has risks, given financial incentives to limit costs and the health care system's limited experience in setting capitation rates for services needed by this population. People with mental health and substance abuse problems may need a combination of different types of care, such as outpatient services,

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inpatient hospital care, and long-term institutional or residential care. SAMHSA has established an Office of Managed Care, which funds a project that is monitoring the impact of the transition to managed care on public mental health and substance abuse providers and the people served. In addition, SAMHSA is supporting a number of managed care policy and demonstration grants that focus on specific issues or populations, such as people who are homeless or seriously mentally ill or who live in rural communities. Knowledge gained through these efforts should be useful in working with HCFA to develop oversight and performance standards for Medicaid's move to mental health managed care. Given the major transitions occurring in health care delivery and financing of physical and mental health services, it will be important for SAMHSA to continue to give attention to developments in the field.

Mr. Chairman this concludes my statement. I will be pleased to answer any questions you or Members of the Subcommittee might have.

Contributors

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