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STATEMENT OF
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BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

STATE IMPLEMENTATION OF THE ALCOHOL, DRUG
ABUSE AND MENTAL HEALTH BLOCK GRANT



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Mr. Chairman and Members of the Committee;

We are pleased to be here today to discuss the implementation of the alcohol, drug abuse and mental health block grant. During the past year we have visited 13 states (California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington) to examine a wide range of issues that were of interest to your committee as well as other committees of the Congress. These states include a diverse cross section of the country and account for about 46 percent of the national alcohol, drug abuse, and mental health block grant appropriations and about 48 percent of the nation's population. Our draft report, which is currently being prepared, should be available soon to the Committee. Today, I would like to focus on our preliminary observations in four areas

- states acceptance of their expanded management role,
- funding trends in alcohol, drug abuse and mental health programs between 1981 and 1983,
- state policy decisions associated with block grant implementation, and
- perceptions about the block grant from state officials and interest groups.

Before discussing our observations, it would be useful to highlight the historical federal and state roles in administering the alcohol, drug abuse and mental health programs because of their influence on state block grant implementation.

In the mental health area, federal policy was to assist the start-up of community-based mental health centers with federal

support declining over time. As a result, most states were providing about two thirds of the overall financial support to community mental health centers when the block grant was enacted, and they had considerable influence over the direction of mental health programs. For example, California spent \$355 million for community mental health programs in 1981 compared with about \$18 million in federal categorical awards.

State agencies were also heavily involved in managing federal alcohol and drug abuse categorical programs. The drug programs funneled a major portion of their support through a single grant to state agencies which provided services in accordance with federally approved plans. Although most federal alcohol programs were project grants that by-passed the state, formula grants under one major program were made directly to and administered by the states.

This shared financial and administrative responsibility between the federal and state governments for alcohol, drug abuse and mental health programs provided an established planning and administrative framework for states to assume their expanded block grant management role and helps explain the absence of major state program policy changes.

STATES INVOLVED IN
MANAGING PROGRAMS SUPPORTED
WITH BLOCK GRANT FUNDS

All 13 states generally assigned alcohol, drug abuse and mental health block grant responsibilities to their state offices which had administered the prior categorical programs or

similar state programs. Thus, states found it necessary to make only limited organizational changes. Also, states were taking their management role seriously by establishing program requirements, monitoring grantees, providing technical assistance, collecting data, and auditing funds. These efforts were often integrated with ongoing state efforts for other related programs.

While we were not able to quantify any cost savings associated with managing alcohol, drug abuse and mental health programs using the block grant approach, there were indications of administrative simplification. According to state officials, the block grant enabled 7 of the 13 states to reduce the time and effort involved in preparing grant applications and reporting to the federal government, 5 to change or standardize their administrative requirements, and 8 to improve the planning and budgeting process.

States were also obtaining advice for making decisions on how to use block grant funds from several sources. In addition to conducting the mandated legislative hearings and preparing required reports on the intended use of block grant funds, all 13 states held executive hearings on some aspect of the program and 9 states used advisory groups. Many program officials reported that input from advisory committees, together with informal consultations, often had the most influence on program decisions. Also, program officials in nine states noted that legislatures had become more involved in program decisions under

block grants. In five states, the governor's level of involvement was also greater.

TRENDS IN OVERALL PROGRAM
FUNDING SHOW INCREASES
IN MOST STATES

The federal-state shared responsibility for financing alcohol, drug abuse, and mental health services helped ease states' transition to the block grant. However, it also made it very difficult to construct a complete picture of aggregate program funding in 1981 from state records because all federal mental health grants and many alcohol awards went directly to local entities, by-passing the states. Nevertheless, we were able to develop financial information for the 1981-83 period in 9 of the 12 states that began administering the block grant in October 1981, and in California which assumed responsibility for the block grant in July 1982 for the 1982-83 period.

Eight of the 9 states where complete data was available showed an increase in the total financial support for alcohol, drug abuse, and mental health programs. The increases varied considerably among the eight states, ranging from about 3 percent in Pennsylvania to about 24 percent in Texas. Only Kentucky showed a decrease in overall funding of about 8 percent during this period. Also, California decreased total financial support by less than one percent between 1982 and 1983. After adjusting for inflation, however, only 5 of the 10 states showed increases in total financial support.

The upward trend in total financial support for the program between 1981 and 1983 occurred during a period when federal

support declined about 21 percent nationally. This was primarily due to two key factors, (1) carryover funds from categorical awards and (2) increases in state funding.

The carryover funds from categorical grant awards were an important source of financial support for alcohol, drug abuse and mental health programs during 1982 because the prior categorical programs had project grants with awards that extended well into 1982. Therefore, many service providers were able to fund much of their 1982 operations with categorical funds. The availability of these funds reduced the amount of block grant funds that states had to spend if they chose not to increase funding above the 1981 levels.

For the nine states where complete data was available, categorical funds comprised about 70 percent of the total federal categorical and block grant funds used to support alcohol, drug abuse and mental health programs in 1982. Because categorical and block grant funding overlapped, the immediate impact of federal appropriation reductions was mitigated, and these states were able to carry about 60 percent of their 1982 alcohol, drug abuse and mental health block grant awards into 1983.

All nine states with complete data also increased their contribution to the overall alcohol, drug abuse and mental health program funding between 1981 and 1983. These increases ranged from 2 percent in Pennsylvania to 63 percent in Kentucky. For California, expenditures of state funds in 1983 were about one percent less than in 1982.

While the rise in state funds generally contributed to overall increases between 1981 and 1983, changes for each program component varied considerably. Total funding increased for mental health programs in 8 of the 9 states where complete data was available while remaining constant in one state. At the same time, total funding for alcohol programs increased in six states, remained constant in one and decreased in two. In contrast, drug abuse total funding decreased in six states and increased in three. The more frequent funding reductions in the drug area stem, in part, from states' heavier dependence on federal support to operate these programs.

LIMITED CHANGES MADE TO TYPES OF SERVICES

While trends in expenditures varied among the program areas, states did not make substantial changes to the kinds of services offered or to the network of service providers.

Generally, the services offered in 1983 were the same as those available under the categorical programs. However, five states reported that more emphasis was placed on alcohol prevention and early intervention programs. In the drug area, more emphasis was being placed on prevention activities in three states. In the mental health area, four states reported that more emphasis was being placed on outpatient programs for the chronically mentally ill, follow-up on patients released from mental institutions, and community-based residential care.

Alcohol, drug abuse and mental health services have typically been provided by non-profit organizations, hospitals, and

local governmental agencies. None of the 13 states had made changes in the types of organizations eligible for funds under the block grant, and the network of providers which had received the categorical grants remain the principal recipients of block grant monies. It appears that the long standing co-sponsorship of many of the same service providers, coupled with fairly stable funding enabled the states to maintain the structure of the service provider network.

CONSIDERABLE CHANGE OCCURRING
AT SERVICE PROVIDER LEVEL

Although the states made few policy changes affecting the types of services offered, a wide range of changes were occurring at the 47 service providers we visited. Each of these providers was unique. They had been in business for different lengths of time, served unique local needs, and were supported by different funding sources.

About two-thirds of the service providers had experienced total funding increases between 1981 and 1983. Typically the amount of federal funds had decreased while state and local funds increased. About half the providers had increased staffing levels where as the other half had staffing decreases. Only one provider had a constant level of staffing.

At most of the service providers visited, officials reported they were serving the same population groups which had been served under the categorical program. Also, about 60 percent of the providers told us that the number of clients served had increased whereas about 35 percent reported that

clients served had decreased. Again, as expected, providers offering drug services tended to experience decreases in the number of clients served more often than did alcohol or mental health providers.

In certain instances clinics were making operational changes to increase their income or adapt to expected cuts in both federal and state program support. For example, a large clinic in New York was buying the building it had occupied under a lease arrangement. That option offered a lower operating cost and the unused space could be rented out to increase income as well. Additionally, this New York clinic had raised its fee charged for methodone maintenance treatment from \$5.00 a week per client in 1981 to \$10.00 a week in 1983, although, according to clinic officials, those unable to pay were still provided services.

In another instance, a county clinic in Colorado chose to spin-off a clinic providing alcohol services in a rural area into a nonprofit organization. Officials believed that several services offered could be marketed profitably and the type of services and their geographic coverage could be expanded as well.

Not all clinics visited seemed to be coping with funding changes as well as these. For example, a community mental health center in Mississippi, saw its total funds reduced by about 40 percent between 1982 and 1983. According to center officials, staff had been reduced by about one half and the center was serving 22 percent fewer clients.

While a variety of changes were occurring at the service providers visited, they were not solely attributable to the block grant. Instead they resulted from an array of factors which influenced their operations including program dynamics and changes in other sources of funds.

OVERALL PERCEPTIONS OF
BLOCK GRANT DIFFER

Almost all state executive and legislative branch officials liked the increased flexibility and reduced administrative requirements offered under the block grant. Generally, they viewed it as a more desirable way to fund alcohol, drug abuse and mental health services than the prior categorical approach. On the other hand, about 49 percent of the interest group respondents tended to view the block grant as a less desirable funding approach while 26 percent viewed it as more desirable. The remaining 25 percent perceived no major difference.

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.

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