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ABSTRACT

In response to a request by Congressman Henry Waxman, the General Accounting Office (GAO) examined the implementation of legislative requirements that states set aside a percentage of their Alcohol, Drug Abuse and Mental Health Services Block Grant funds for services to targeted populations, including women substance abusers and underserved mentally ill children and adolescents. GAO obtained data from state agencies; a total of 19 providers who delivered services to the targeted populations; and 278 state- and local-level interest groups involved in alcohol, drug abuse, and mental health issues in California, Colorado, Kentucky, Michigan, Mississippi, New York, Texas, and Vermont. The results revealed that the eight states studied used a variety of procedures to collect information about program needs. In most cases, states allocated their funds according to historical trends or to maintain existing service delivery systems, rather than relying on the results of their needs assessments. The federal requirements to set aside funds for targeted populations promoted a minimum level of spending for new or expanded services to target groups. In 40% of cases, the states increased their commitment to provide required services. In remaining cases, states addressed requirements by either using projects they had already planned or by passing the responsibility for the requirements to local service providers. (NB)

United States General Accounting Office

Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives

October 1987

BLOCK GRANTS

Federal Set-Asides for Substance Abuse and Mental Health Services

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-214417

October 14, 1987

The Honorable Henry Waxman
Chairman, Subcommittee on Health and
the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we examine the implementation of legislative requirements that states set aside a percentage of their Alcohol, Drug Abuse and Mental Health Services Block Grant funds for services to targeted populations. These funds are to be used specifically for new or expanded services to women substance abusers and underserved mentally ill children, adolescents, and other underserved populations.

As arranged with your office, we are sending copies of this report to other interested members, the Director of the Office of Management and Budget, the Secretary of the Department of Health and Human Services, and state officials and interest groups that participated in our review. Copies also will be made available to other interested parties who request them.

Sincerely yours,

Edward A Hensmore

for Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

Women substance abusers and certain underserved populations, including mentally ill children and adolescents, were targeted for services when the Congress amended the Alcohol, Drug Abuse and Mental Health (ADAMH) Services Block Grant in 1984. States, to receive their share of the block grant funds, must agree to set aside certain percentages of their allocations for the specified populations.

The Chairman of the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce asked GAO to examine two major issues:

- How states determined needs and made decisions on their uses of ADAMH block grant funds and
- How states implemented the set-aside provisions.

Background

The 1984 amendment to the ADAMH Block Grant required each state to set aside 5 percent of its grant allocations for new or expanded alcohol and drug abuse services for women, and 10 percent of its mental health program funds for new or expanded services to severely disturbed children and adolescents and comprehensive community mental health programs for underserved populations. The legislative history indicates that states could use services they had recently initiated or expanded for the target populations to comply with the set-aside. However, no specific time period was identified. The Department of Health and Human Services (HHS) has proposed these set-asides be eliminated when the block grant is reauthorized.

GAO's work was done between October 1986 and March 1987 in eight states: California, Colorado, Kentucky, Michigan, Mississippi, New York, Texas, and Vermont. These states were chosen according to geographic diversity and differences in programmatic approaches and size. Most of the work was done at state agencies. GAO also, however, visited a total of 19 providers that delivered services to the target populations in these states and surveyed 278 state- and local-level interest groups involved in alcohol, drug abuse, and mental health issues in these states.

The eight states organized their delivery of targeted services for the alcohol, drug abuse, and mental health program areas differently. Some had a single agency administering the program; others used two or three agencies. To facilitate the analysis, GAO treated each of the three program areas as a separate case. Therefore, the results are expressed in the context of 24 cases (8 states offering services in 3 program areas).

In fiscal year 1986, $469 million was allocated to all states under this program; $137.2 million (29 percent) of the funding went to the eight states in the GAO review in that year.

Results in Brief

The eight states studied used a variety of procedures to collect information about program needs. Some used structured, state-level procedures, but most used less formal approaches. In the majority of cases, states allocated their funds according to historical trends or to maintain existing service delivery systems, rather than relying on the results of their needs assessments.

The two 1984 requirements to set aside funds for women substance abusers and underserved mental health populations promoted a minimum level of spending for new or expanded services to these target populations in the eight states. The states used different strategies to respond to these requirements. In 40 percent of the cases, states increased their commitment to provide required services. In the remaining cases, states addressed the requirements by either using projects they had already planned or passing the responsibility for the requirements to local service providers.

Principal Findings

Assessing Program Needs and Allocating Resources

In all 24 cases, states reported they conducted some form of program needs assessment. In five cases, states conducted structured, state-level assessments, using models to predict needs. In the remaining 19 cases, state officials said they used a variety of less formal approaches, such as public hearings and historical trends.

GAO believes the needs assessment results were not the dominant force driving the allocation of funds among local service providers. In 14 of the 24 cases, GAO found that the predominant factor influencing state decisions on program funding allocation was the desire to maintain overall program stability (see page 15).

State Responses to Federal Set-Aside Requirements

States used different strategies to implement the federal requirements. In 10 of the 24 cases, states created new or expanded services specifically in response to the requirements, while in 9 cases they used new or

expanded programs that they had already planned to initiate (see page 18).

In the remaining five cases, states "passed down" the responsibility for implementing the set-aside requirements to counties or local service providers. In most of these cases, the states had not received increased allocations through the block grant formula changes and did not provide additional block grant funds to the counties or service providers. While statewide data were not available on how the requirements were implemented at the local level, the providers we visited all developed new services in response to the set-aside.

Of the 19 service providers GAO visited, 17 believed increased or better services were being provided for their communities. Among the most frequently offered services for women substance abusers were residential treatment and outpatient treatment and counseling. The most frequently offered mental health services included residential and day treatment programs for children and the chronically mentally ill (see page 22).

Reactions to the Possible Elimination of Set-Asides

Reactions to the possibility that the set-asides might be eliminated were mixed, depending on the type of respondent. State program officials in 22 of the 24 cases said they would continue funding for these services to the targeted groups even without the 1984 set-aside requirement because they shared similar goals. They also said that, once started, programs create a demand for a service level that is hard to discontinue.

Others were less optimistic. Only 4 of the 19 service providers visited by GAO believed their program would be continued if the set-aside requirements were removed. State and local interest groups surveyed were divided in their perceptions of their state's commitment to women's substance abuse programs and mental health programs for underserved populations. A majority of interest groups representing recipients or relatives or friends of recipients believed their state's commitment to services for the targeted groups would decrease if the federal set-aside provisions were eliminated. Conversely, a majority of interest groups representing service providers and/or local governmental units believed their state's commitment to services for the targeted groups would remain the same absent the set-aside provisions (see page 25).

Matter for Congressional Consideration

This review provides some insight into the use of set-asides in block grants to promote national objectives. If the Congress wants to emphasize certain issues nationally, set-asides in existing block grants can be used to accomplish this, under certain circumstances, without creating separate programs requiring their own federal and state administrative structures. However, to enhance state implementation the Congress should consider specifying the time period prior to the enactment of legislation during which states could count previously initiated services toward meeting the set-aside requirement.

Agency Comments

As requested, GAO did not obtain official comments from HHS, which is responsible for administering the block grant. However, HHS officials were advised of GAO's methodology and findings. These officials indicated they had no substantive problems with the findings presented in this report. States in the survey reviewed the summaries of primary data collected on their programs for factual accuracy.

Contents

Abbreviations

ADAMH	Alcohol, Drug Abuse and Mental Health Services Block Grant
HHS	Department of Health and Human Services

Introduction

In 1981, the Congress consolidated 10 grant programs for alcohol, drug abuse, and mental health services into the Alcohol, Drug Abuse and Mental Health (ADAMH) Services Block Grant. Under this block grant, administered by the Department of Health and Human Services (HHS), states assumed additional responsibilities for providing alcohol, drug abuse, and mental health services. Within certain statutory limits, states can determine program needs, set priorities, allocate funds, and establish oversight mechanisms.

In creating this block grant, the Congress established a number of constraints, including limits on states' discretion to transfer funds among the three program areas. Also, as a condition of receiving block grant funds, states must agree to use 20 percent of their alcohol and drug abuse allocations to fund prevention and early intervention programs designed to discourage abuse.

In 1984, we reported to the Congress on states' implementation of the block grant. The 13 states we reviewed then placed great importance on integrating the block grant with established state programs. States sought to maintain stability in their program priorities in the transition to block grants from categorical programs.

In the 1984 reauthorization, as modified by technical amendments in 1985, the Congress added two new conditions on states' use of block grant funds. States were required to:

- Use not less than 5 percent of their total block grant to initiate or provide new or expanded alcohol and drug abuse services for women, and
- Use not less than 10 percent of the mental health portion of their block grant for new or expanded services targeted to severely disturbed children and adolescents and for new or expanded comprehensive community mental health programs for underserved areas or populations.

The legislative history supporting the 1985 technical amendments clarified that states could use services they may have recently initiated or expanded to these target populations to comply with the federal requirements, even though these efforts may have begun prior to passage of the set-asides. However, no specific time period was identified.

In 1984, the Congress also changed the allocation formula and gave states more flexibility to shift their block grant funds among substance abuse and mental health services. The changes in the formula increased allocations for some states in fiscal year 1985 and left others with

unchanged allocations. When the ADAMH block grant was created, funds were allocated among states in proportion to the amounts allocated under the prior categorical grant programs. The new formula introduced in fiscal year 1985 based allocations to states on population and relative per capita income. Because these formula changes were controversial, however, each state was guaranteed to receive the same proportion of funds it received in fiscal year 1984, when total funding was $462 million. Only funding in excess of $462 million would be allocated by the new formula. In fiscal year 1985, the first year under the new formula, states received $490 million for the ADAMH program. Thus, $28 million (about 6 percent) was allocated under the new formula. Twenty-five states received the additional funding.[1]

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked GAO to examine how states (1) made funding decisions for their substance abuse and mental health programs and (2) implemented the 1984 set-aside requirements. The administration has proposed that all set-asides under this program be eliminated when the Congress reauthorizes it in 1987, arguing that states should have full flexibility in their decisions on the use of block grant funds.

We examined programs in eight states supported with ADAMH funds set aside for women's alcohol and drug abuse programs and for community mental health programs targeted to children and other underserved populations. These 8—California, Colorado, Kentucky, Michigan, Mississippi, New York, Texas, and Vermont—were among the 13 states surveyed in our 1983-84 block grant study. They were chosen according to geographic diversity and differences in programmatic approaches and size. ADAMH funding to these states comprised $137.2 million in fiscal year 1986, or 29 percent of total ADAMH funding. Our review focused on the 1986 program year as defined by each state, since that was the first year all eight states had implemented programs in response to the set-aside requirements.

Five of the eight states we visited received funding increases, ranging from 11 to 25 percent, as a result of the formula changes between fiscal years 1984 and 1985. Colorado, New York, and Vermont received no funding increases.

[1]In fiscal year 1986, the funding level was reduced to $469 million because of the Gramm-Rudman funding cuts. Thus, only $7 million was allocated under the new formula.

Nationwide, ADAMH block grant funds comprised about 17 percent of total federal, state, and local spending for alcohol and drug abuse programs, and about 9 percent of federal, state, and local spending for community mental health programs. The block grant contributed 18-29 percent of total federal and state funding for alcohol programs in our eight states, 12-75 percent of drug abuse program funding, and 1-30 percent for mental health programs (see table 1.1). We were unable to ascertain the full extent of local and private contributions.

Table 1.1: Federal and State Expenditures for Alcohol, Drug Abuse and Mental Health Services (Eight States, State Program Year 1986)

Dollars in millions

State/program	Total expenditures: Federal[a] and state	Total expenditures: Total ADAMH	ADAMH as a percent of total federal and state expenditures
California			
Alcohol	$52.4	$10.3	20
Drug	62.1	21.2	34
Mental health	475.9	15.9	3
Colorado			
Alcohol and drug[b]	16.5	4.1	25
Mental health	44.9	3.7	8
Kentucky			
Alcohol and drug[b]	7.5	2.7	36
Mental health	27.3	1.8	7
Michigan			
Alcohol and drug[b]	39.8	10.9	27
Mental health	161.3	4.3	3
Mississippi			
Alcohol	5.5	1.0	19
Drug	1.0	.6	58
Mental health	12.1	3.6	30
New York			
Alcohol	50.5	8.8	18
Drug	153.2	18.0	12
Mental health	1,324.1	9.2	1
Texas			
Alcohol and drug[b]	15.8	10.1	64
Mental health	95.2	9.3	10
Vermont			
Alcohol	2.2	.6	29
Drug	.7	.5	75
Mental health	22.6	2.1	9

[a]In some cases, this includes federal funds from programs other than the ADAMH block grant.

[b]Combined alcohol and drug abuse programs; these states did not differentiate expenditures between the two services.

We conducted our review at three levels: federal (HHS), state agencies, and local service providers. Also, we sent a questionnaire to substance abuse and mental health interest groups in these same states. Our field work was conducted between October 1986 and March 1987.

At HHS, we interviewed program officials in the Public Health Service and reviewed internal evaluation reports and other documents related to its administration of the block grant.

At the state level, we gathered information from state program officials responsible for administering the three program areas covered under the block grant—alcohol, drug abuse, and mental health—focusing on how states determined statewide program needs and how they implemented the 1984 set-aside requirements. We did not, however, assess whether states complied with the dollar minimums established in the statute because of (1) confusion states faced in understanding the requirements in the first year, (2) subsequent technical amendments that affected the set-aside computations, and (3) lack of federal regulations to provide guidance to the states. In addition, statewide data were lacking in states that passed the requirements down to local service providers to implement.

Variations among states in the administrative structure for these three program areas affected our presentation of results. In one of the eight states, the program areas were administered by a single agency; in five states, they were combined into two agencies—one for substance abuse and one for mental health; and in the remaining two states, they were administered by three separate agencies. To more clearly convey our results, we treated each program area separately; as a result, our analysis is presented in terms of 24 cases (3 program areas for each of the 8 states).

At the local level, we visited between one and three local service providers in each state that received funding under the two set-aside provisions. This helped us gain local-level perspectives on the delivery of set-aside services. We obtained information on services provided by a total of 19 service providers, selected according to their geographic, demographic, and service profiles.

We also conducted a questionnaire survey of 278 state and local interest groups in the eight states to obtain their perspectives of how their states implemented the set-aside provisions. National-level interest groups representing service providers and groups representing program client groups provided names of their state affiliates. We used these names to supplement lists of interest groups that we developed in our 1983-84 block grant review. In each state, we identified between 9 and 77 interest groups knowledgeable about their state's alcohol, drug abuse, and/or mental health programs, for a total of 278 groups. The questionnaires

were mailed out during January and February 1987. As of September 1987, we had received 161 responses (58 percent). Of these, 75 (47 percent) were knowledgeable about their state's alcohol services, 42 (26 percent) about drug abuse services, and 100 (62 percent) about mental health services (see table 1.2).[2]

Table 1.2: Distribution of Interest Group Respondents (by State)

State	No. of Respondents
California	50
New York	42
Texas	23
Kentucky	13
Michigan	11
Colorado	10
Mississippi	9
Vermont	3
Total	**161**

Our sample of eight states and the 19 service providers within these states was selected judgmentally, and the results are not intended to be projected to the nation as a whole. Likewise, our sample of interest groups in the eight states was not random, and results of the survey are not necessarily representative of all interest groups in those states. Our work was done in accordance with generally accepted government auditing standards.

[2]Respondents could answer more than one category, so the total number of responses exceeds 161.

States' Decisions on the Use of Block Grant Funds and Their Implementation of the Set-Aside Requirements

We examined the needs assessment and funding allocation processes for alcohol, drug abuse, and mental health programs in eight states. We then assessed the extent to which the 1984 federal set-aside requirements influenced state allocation processes for programs affecting women alcohol and drug abusers and mental health services for underserved populations. The following questions and answers present our findings.

How Are States Assessing Program Needs for Alcohol, Drug Abuse, and Mental Health Services?

In all 24 cases, states reported that they perform an assessment of program needs for their alcohol, drug abuse, and mental health services. State needs assessments consisted of a variety of activities; in 5 cases these activities were structured, and in 19 cases states reported using a less formal approach.

States used various procedures to collect information about program needs. Of the interest groups that responded to our survey, 52 percent felt their states did an effective job of identifying the need for services. States in five cases used structured, state-level processes. These involved the development of models to predict need, methodologies for assessing needs for specific types of services, or statewide aggregations of information that identified need in terms of populations or service elements. For example, Colorado's Alcohol and Drug Abuse Division officials used a computerized alcohol treatment needs model to predict statewide needs specifically for the alcohol program.

In the remaining 19 cases, state officials said that needs assessment activities were comprised of a variety of less formal approaches. According to the officials, activities included delegating needs assessment to the counties, relying on the state agency's institutional knowledge of needs, and various other informal techniques. Among the latter were reviews of statistical, demographic, and indicator data; polling of service providers and program clients; obtaining input through public meetings; and consideration of historical funding patterns.

For example, a Vermont state official said its substance abuse agency relied on the institutional knowledge of its staff and their knowledge of programs and new needs that arise. According to this official, needs were often determined through the interaction of a provider and the agency. In Mississippi, the Community Services Division director said the state did not perform a broad needs assessment on a regular basis. Rather, studies of specific needs were undertaken periodically. The division augmented these studies with needs data accumulated by others,

such as the University of Mississippi and the National Institutes of Mental Health.

What Are the Key Factors Involved in State Decisions on the Use of Block Grant Funds?

Maintaining program stability emerged as a key factor in state decisions on the use of block grant funds. Although states made some changes at both the program and service levels, they were generally reluctant to depart significantly from historically based funding patterns. Notwithstanding the various processes states used to assess needs, in 14 of the 24 cases we were unable to establish that the results of states' needs assessments were used in their allocation of resources among program areas or among service providers.

States did not significantly shift funding patterns in their use of block grant funds. This is shown most clearly in their responses to a specific 1984 provision giving them greater flexibility in using federal funds. In addition to creating the set-aside requirements in 1984, the Congress increased states' discretion to shift ADAMH funds between substance abuse and mental health programs by permitting them to reallocate up to 25 percent, rather than 15 percent, of their funding allocations between these two areas. Between 1984 and 1987, seven of the eight states did not use this increased flexibility to significantly change their allocations, as table 2.1 shows.

Table 2.1: Changes in Eight States' ADAMH Block Grant Allocations Between Substance Abuse and Mental Health Services (State Program Years 1984-1987)

State/program area	Changes in allocations (percents)[a] 1984	1985	1986	1987
California				
Substance abuse	66	67	67	67
Mental health	34	33	33	33
Colorado				
Substance abuse	51	51	51	51
Mental health	49	49	49	49
Kentucky				
Substance abuse	67	67	59	65
Mental health	33	33	41	35
Michigan				
Substance abuse	72	70	72	75
Mental health	28	30	28	25
Mississippi				
Substance abuse	26	30	30	30
Mental health	74	70	70	70
New York				
Substance abuse	76	76	76	76
Mental health	24	24	24	24
Texas				
Substance abuse	59	61	53	51
Mental health	41	39	47	49
Vermont				
Substance abuse	34	32	33	27
Mental health	66	68	67	73

[a]The minor shifts from mental health to substance abuse in several cases resulted from implementation of the women's substance abuse set-aside, which was calculated as a share of the entire block grant allocation. The more substantial shift in Texas was due to a state court order to increase spending for children's mental health services. Kentucky's 1986 shift was a one-time change related to state targeting of community-based programs for the chronically mental ill.

The lack of significant block grant funding shifts between substance abuse and mental health programs seems related to the following factors:

1. State agencies were reluctant to deviate from historical funding patterns because of formal or informal agreements among state agencies regarding allocation of block grant funds, according to state officials.

2. Block grant funds are only one source of program funds. States did shift program emphases for specific services within program areas in 14 of our 24 cases, but these initiatives often were funded using sources

such as state general funds, other block grants (notably, the social service block grant), or Medicaid funds. In most of these cases, the state legislature or governor initiated action to shift program emphases. For example, California's Mental Health Initiative, sponsored by the governor, led to a 57-percent increase in funding between 1984 and 1987 to support new local services. Legislatures in some states, such as Colorado and Kentucky, increased support for specific program services, including drug detoxification and driving-under-the-influence programs.

With regard to substate allocation of funds down to local providers, states in 14 of the 24 cases distributed the majority of their funds to maintain historical funding patterns or existing service delivery systems. In these cases, we did not find that the results of states' needs assessment processes were used in their substate funding allocation processes, except when these states received increased funding. For example, California's needs assessment for substance abuse services were conducted by its counties, but results of these studies were not routinely aggregated at the state level for use in allocating program funds. Instead, the major part of California's alcohol and drug funds were allocated on a historical basis to support the existing service delivery system. However, new federal or state funds were allocated using a needs-based formula.

In only 2 of the 24 cases was a majority of funds allocated through a needs-based formula, based on such factors as poverty levels, prevalence of substance abuse or mental health problems, and population. For example, Michigan allocated 98 percent of its substance abuse funds through a formula consisting of three components: (1) treatment funds, allocated according to poverty levels; (2) heroin funds, allocated to areas in accordance with a heroin prevalence study; and (3) prevention funds, allocated on the basis of population.

In the remaining eight cases, states used a combination of methods to allocate funds, including state priorities, county plans, service provider proposals, and documented needs. For example, in Kentucky, 85 percent of all state funds were allocated based on a mixture of priorities and restrictions set by its General Assembly, proposals submitted by service providers, and documentation of needs and historical allocations.

How Are States Implementing Federal Set-Aside Requirements?

The influence of the two federal set-aside requirements in creating new, or expanding existing, services varied among the eight states because they used different strategies to implement them. In 10 of the 24 cases, states created new or expanded existing services specifically in response to the requirements. In another nine cases, states used new or expanded services they had already planned to initiate for these target populations. In the remaining five cases, states passed the requirement down to the counties or local providers to implement. Because the five states did not have information on how each provider was implementing the requirement, we were not able to determine if new or expanded services were created throughout the state. The availability of additional federal money and states' prior involvement in providing services to targeted populations before enactment of the federal requirements enabled states not passing down the requirements to provide resources for the set-aside services without reallocating funds from other services.

The differing strategies used by the states determined whether the set-asides stimulated the creation of new or expanded services. In 10 of these cases, the states clearly created new or expanded services as a direct result of the requirements; 7 were substance abuse programs and 3 were mental health. Mississippi is a good example of a state that clearly created new women's substance abuse programs in response to the set-aside requirement. Prior to 1984, the state had no alcohol and drug abuse programs that provided services specifically for women. During 1986, the state spent about $160,000 (44 percent) of its set-aside funds to support four treatment programs and one halfway house for women with alcohol or drug problems. The halfway house had served 38 women since opening in May 1986 and referred another 29 women to other service providers. In the 14 months prior to the opening of the halfway house, the local community mental health center had to turn away 68 women for treatment.

California provided an example of new programs created in response to the mental health set-aside requirement. There, state officials allocated $1.5 million in set-aside funds in program year 1986 for 20 new projects for children, adolescents, and the underserved populations, including:

- a children's intensive day treatment service in Imperial County·
- an early childhood intervention project in Siskiyou County;
- a residential treatment program for severely disturbed adolescents (ages 16 to 21) in San Bernardino County; and
- an employment opportunity project for the chronically mentally ill in Los Angeles County consisting of a retail cookie business to provide

chronic psychiatrically disabled adults, ages 18-35, with practical paid vocational training and experience in an actual competitive work setting.

In each of the 10 cases in which states implemented new or expanded services, additional block grant funds were available (see table 2.2). These new funds allowed states to implement the services without reallocating funds from existing programs. In each case, the additional funds resulted from changes in the federal fund allocation formula. For example, California's mental health program received a $749,000 increase in federal block grant funds in program year 1986. This new money, along with block grant funds carried over from the prior year, precluded the need to take money from existing programs to start the new set-aside programs.

Table 2.2: How Eight States Implemented Set-Aside Requirements for the ADAMH Block Grant (1986)

State/program	Increased ADAMH grant (due to formula changes)	States created new or expanded services	States used previously planned projects	States passed requirements down to local providers
Kentucky				
Alcohol	•	•		
Drug	•	•		
Mental health	•		•	
Texas				
Alcohol	•	•		
Drug	•	•		
Mental health	•	•		
Mississippi				
Alcohol	•	•		
Drug	•	•		
Mental health	•	•		
Michigan				
Alcohol	•		•	
Drug	•		•	
Mental health	•		•	
California				
Alcohol	•	•		
Drug	•			•
Mental health	•	•		
Vermont				
Alcohol				•
Drug				•
Mental health			•	
Colorado				
Alcohol				•
Drug				•
Mental health			•	
New York				
Alcohol			•	
Drug			•	
Mental health			•	
Total cases	15	10	9	5

In another nine cases, states addressed the set-aside requirements by using new or expanded programs they had already planned to initiate for the target groups before the federal set-aside requirements were

adopted. For example, in 1983—the year before the passage of the set-aside requirements—Michigan's Department of Public Health had adopted a 5-year plan to address the needs of chemically dependent women, resulting in funding of nine women's projects in 1984. Implementation of the federal requirement for new or expanded services had no effect on their plans for women's programs. A state official said Michigan intended to continue funding the new or expanded services for women already addressed in their women's substance abuse plan.

New York State already had planned a number of projects to address set-aside objectives that had been routinely identified through the state's regular planning processes. The state designated these projects as meeting the set-aside requirements. Vermont implemented mental health programs for children—a set-aside target population—in response to a court order, rather than the set-aside requirements; these programs were initiated several months before passage of the set-aside.

In the remaining five cases, states passed the set-aside requirements on to their counties or service providers. Here, we were unable to determine whether new or expanded services were created across the state because states did not have information on how the local providers were implementing the set-aside requirements. We visited only a few of the providers in these states and found that they had, in fact, created new or expanded services that were stimulated by the set-aside.

In four of these cases, states had not received additional block grant funds through changes in the formula, and the states did not give their counties or service providers additional funds to meet the set-aside requirements. In Vermont, for example, the providers were expected to use 5 percent of their existing grants for new women's services. At least two existing local programs had reduced services to provide the new set-aside services. For instance, services to adult, white males were reduced in Champlain, Vermont, when therapy groups previously available to both males and females were expanded and limited to females to meet the set-aside requirement. California passed its drug set-aside requirements on to its counties, along with additional funds, but at the time of our visit, they lacked data to verify if the counties were meeting those requirements.

Services Increased or Improved, Providers and Interest Groups Say

Of the 19 service providers we visited, 17 believed increased or better services were being provided. Only 12 believed, however, that these services were being provided in response to the federal set-aside requirements. Six other providers maintained that the services would have been provided anyway, and one provider was unaware of the requirement. For example, a Kentucky mental health service provider said that the number one priority was to serve the chronically mentally ill, and while the set-aside resulted in additional funds, the service was not created due to the set-aside.

A majority of interest groups that focused on women's substance abuse services or services for the targeted underserved mental health populations believed their states had increased services to those groups since January 1985, as shown in table 2.3. But of those who were aware of the federal set-aside requirements, a majority did not believe the requirements had greatly stimulated the increased level of state activity.

Table 2.3: Views of Interest Groups on Levels of Services to Target Populations Since 1985[a]

Services for	Percentage of groups believing that New services were created	Existing services were expanded
Women alcoholics	51	60
Women drug abusers	53	51
Children, adolescents, and unserved or underserved populations or areas	54	50

[a]Number of respondents: 75 for alcohol, 42 for drug abuse, and 100 for mental health services.

What Types of Services Are Provided at the Local Level in Response to Set-Aside Requirements?

In the eight states, a variety of local services were provided in response to the federal substance abuse and mental health set-aside requirements. Current substance abusers and severely disturbed children and youth were the key segments of the target populations served. (Case studies of how individual states responded to the substance abuse and mental health requirements are detailed in apps. I and II).

The most frequently offered substance abuse services funded for women in the eight states were:

- residential treatment (group counseling and education),
- outpatient counseling and treatment,
- community outreach (education and training),
- identification and intervention with high-risk individuals (employee assistance and prevention education), and

- services to special populations (homeless, battered women, etc.).

Women substance abusers targeted for services included (1) current abusers, (2) those at high risk of abusing a substance (battered women, ethnic minorities, nurses), and (3) wives of alcoholics or addicts.

The most frequently offered mental health services provided in the eight states were:

- day treatment programs for children and the chronically mentally ill,
- residential treatment program for children and the chronically mentally ill,
- crisis intervention,
- case management services/social worker (includes referrals), and
- special programs (elderly, sexual abuse, suicide prevention).

Members of the mental health target populations most frequently served included (1) severely disturbed children and youth, (2) the chronically mentally ill, (3) the mentally ill homeless, and (4) victims of sexual abuse.

In the Opinion of State Officials, Should the Set-Aside Requirements Be Eliminated?

In a majority of cases, state officials favored elimination of the set-asides, most often because they had higher priority uses for block grant funds. But only 4 of the 19 providers we visited indicated there were other unmet local needs of higher priority than the set-aside services.

State officials favored eliminating the set-aside requirements in 14 of 24 cases. For example, California alcohol program officials said they preferred the increased flexibility that would result, and drug program officials believed the set-aside sometimes resulted in providing services that were inconsistent with other, higher priority needs they had identified. In New York, although state mental health officials said their program had not been adversely affected by the set-aside requirement, they feared possible inconsistency in the future between the set-asides and state priorities. Finally, Texas mental health officials said that, although the set-aside proved beneficial to the areas funded, they would rather use all block grant funds to support existing services and perform them better.

Of the remaining 10 cases, state officials in 7 favored continuing the set-asides, while officials in the remaining 3 did not specifically advocate either elimination or continuation of the set-asides. A Texas alcohol and

drug program official favoring set-asides said the women's set-aside requirement protected funding for alcohol and drug abuse programs for women from being redirected to other programs. In Mississippi, the set-aside was supported by a Department of Mental Health official as legitimizing the state's own mental health priorities that target services for children.

We asked the 19 local service providers if they saw unmet, higher priority needs in their communities other than those the set-asides targeted. Fifteen said no, and four said yes. In California, for example, the substance abuse program chief at Butte County Alcohol and Drug Services would assign substance abuse services for adolescents a higher priority, given that outpatient and prevention services were already available for women. He also would place a higher priority on services for blacks and Hispanics. In Colorado, the executive director of the Larimer County Mental Health Center believed that services for the homeless and mentally ill criminal offenders and vocational rehabilitation for the mentally ill were of higher priority than populations targeted by the set-aside.

Would States Continue Services to Populations Targeted Under the Federal Set-Asides If Requirements Were Eliminated?

As to whether services to targeted populations would continue in the absence of the federal set-asides, we received varied responses depending on the type of respondent. State officials in 22 of 24 cases said they would continue these services. Conversely, only 14 of 19 service providers visited believed their programs would be continued at current funding levels. Finally, interest group responses differed, according to whether they represented service providers or client/recipient groups.

Even without the federal set-asides, state officials in 22 of the 24 cases said they would continue some level of funding for these mandated services. The main reasons they gave were that (1) state and federal priorities and/or goals are generally the same, and (2) once started, programs create a demand for a service level that is hard to discontinue.

Other indicators, however, portend a less optimistic funding outcome. One measure of potential future state support is the presence of state dollars in services funded by the set-asides. In only 11 of the 24 cases did state officials say their states provided support for the set-aside services from their own revenues in 1986. Such support ranged from 10 percent in Mississippi to 92 percent in New York. Also, service providers were less optimistic than state officials about programs established under the set-asides. Only 4 of the 19 service providers we visited believed their programs would be continued if the funds they were

receiving to provide new or expanded services were no longer available or if the requirements on the states were removed.

Most interest groups familiar with the women's set-aside alcohol services and targeted mental health programs believed their state's commitment to these services would not be maintained if the federal set-aside requirement were eliminated (see table 2.4). However, a majority of the interest groups familiar with the women's drug abuse set-aside provision believed their states would continue to maintain their commitments to these services.

Table 2.4: Views of Interest Groups on Their State's Commitment to Target Populations in the Absence of Federal Set-Asides (By Type of Service)[a]

	Percent of groups saying that services would		
Services for	**Increase**	**Remain the same**	**Decrease**
Women alcoholics	0	46	55
Women drug abusers	0	65	35
Children, adolescents, and underserved populations or areas	2	45	53

[a]Number of respondents: 44 for alcohol, 23 for drug abuse, and 49 for mental health. These numbers differ from table 2.3 because some respondents said they were not familiar with the set-aside requirements.

We also analyzed these same interest group responses by type of respondent. A majority of interest groups (1) that were familiar with the set-asides and (2) whose memberships consisted of service provider organizations or local governmental units believed their state's commitment to continuing service to targeted groups would remain the same, even if the federal set-aside provisions were eliminated (see table 2.5). Conversely, a majority of interest groups whose memberships consisted of program recipients or friends or relatives of recipients believed that their state's commitments to continue providing services to targeted populations would decrease if the federal set-aside provisions were removed.

Table 2.5: Views of Interest Groups on Their State's Commitment to Target Populations in the Absence of Federal Set-Asides (By Type of Respondent)[a]

Interest groups	Percent of groups saying that services would		
	Increase	Remain the same	Decrease
Service providers:			
Alcohol	0	58	42
Drug	0	78	22
Mental health	0	54	46
Recipients/relatives:			
Alcohol	0	39	61
Drug	0	44	56
Mental health	4	48	48

[a]Number of respondents: 35 for alcohol, 18 for drug abuse, and 36 for mental health services. These numbers differ from the prior table because some respondents did not classify themselves as either service providers or recipients/relatives.

Conclusions and Matter for Congressional Consideration

If the Congress wants to emphasize certain issues nationally, setting aside funds in existing block grants accomplishes this without creating separate programs that require their own federal and state administrative structures.

The influence of federal set-aside requirements on state priorities, however, often depends on such factors as the presence of additional federal aid and states' prior level of involvement in delivering the targeted services. When new federal money was provided, states were more likely to create new or expanded services. In the absence of additional funds, however, states were less likely to create new or expanded services, but rather, designated already planned projects or passed down the requirements to local providers.

The set-aside requirements, as modified by the 1985 technical amendment, represent a reasonable approach for accommodating differing prior levels of state commitment to targeted services while assuring a minimum level of services to the targeted populations in all states. On one hand, states providing little or no prior funding for the targeted populations were stimulated to provide additional services to satisfy the set-aside. On the other hand, states already moving to provide new or expanded services above the minimum set-aside level would not have to increase their funding over and above what they had already planned. This recognizes the initiatives taken by states providing services prior to the passage of the federal requirements. It is also consistent with the block grant approach in providing states with flexibility to tailor the implementation of federal requirements to their own unique circumstances.

The ability of states to implement future set-asides could be enhanced, however, if the Congress more clearly defined new or expanded services. It could do so by establishing a national minimum level of services as was done by the 1984 amendments and by identifying a time period prior to the enactment of the legislation, during which states could count previously initiated services toward meeting the set-aside requirement.

Matter for Congressional Consideration

In reauthorizing the ADAMH or other block grants, the Congress may want to promote new or expanded services for target populations using the set-aside approach. Where this is an objective, we suggest the Congress consider specifying the time period prior to enactment of legislation during which states could count previously initiated services toward meeting the set-aside requirement.

Selected Case Studies of State Strategies Used to Implement the Women's Alcohol and Drug Abuse Set-Aside Requirement

Mississippi

Mississippi received an increase in ADAMH funds as a result of changes to the formula in 1984. The state implemented the set-aside provision by competitively awarding in September 1985 substance abuse funds to providers for new women's services. The acting department director believed the increased funding prevented service cutbacks that might have occurred as a result of the set-aside requirements. Mississippi uses a single state agency to administer its alcohol and drug abuse programs. Nearly 24 percent of its total program expenditures consist of ADAMH funds.

No previous programs were specifically targeted towards women's alcohol and drug abuse. Therefore, to meet the federal requirement, Mississippi set aside $232,000 for women's alcohol and drug abuse programs in fiscal year 1986—5 percent of its ADAMH award. Because these services did not get underway until midway through the year, only $160,000 was awarded to providers; the remaining $72,000 was carried forward to the next year to be used for women's services.

The state competitively awarded set-aside funds to six providers that included

- three mental health centers and one halfway house that used funds to offer day-treatment programs,
- a community mental health center that used funds to manage a four-bed halfway house, and
- a coed halfway house that used funds to hire an outreach worker.

According to Mississippi's state alcohol and drug abuse services director, the day-treatment programs for substance abuse offered women intensive out-patient services with child care—a type of service that existing residential programs did not offer. Residential treatment was often not available to women in certain parts of the state because only 7 of the state's 15 mental health centers operated halfway houses that accept women. The director of the service provider organization that managed the new four-bed halfway house in Hattiesburg told us that, in the 14 months before the new halfway house opened, he had to refer 68 women seeking treatment to halfway houses in other locations. From the opening in May 1986 to the end of the fiscal year, he said, the new halfway house treated 38 women, while 29 were referred elsewhere because the house was full.

The set-asides were beneficial and should be continued, officials of the Mississippi Department of Mental Health told us. Women are an underserved population, the acting department director said, and the department would continue funding women's programs at the current level even if the set-aside requirement were removed.

New York

New York received no increase in its allocation as a result of the formula changes in 1984. The state designated programs already planned to meet the federal set-aside requirement. It administered alcohol and drug abuse programs through two separate agencies, the Division of Alcoholism and Alcohol Abuse and the Division of Substance Abuse Services. ADAMH money made up about 13 percent of total federal and state funding for these programs in 1986.

Officials in both divisions viewed the set-aside requirement as an administrative burden that had no effect on the state program. To respond to the requirement, they identified programs that qualified as being new or expanded as an after-the-fact exercise, allocating $1.1 million to qualifying programs identified by counties through the state's normal planning process.

Because of the process by which the state allocated funds, most service providers were unaware the requirement existed. For example, a local service provider we visited in Erie County did not know its community residential treatment facility for women was used by the state to meet the federal set-aside requirement.

A state official, pointing out that the set-aside requirement coincided with the state's priorities, saw no purpose served by it. For example, drug abuse program officials said that 30-40 percent of the clients for these programs were women, and the state already provided specific services for homeless and mentally disturbed women and women with children. Therefore, the officials believed the requirement needlessly limited state flexibility.

Vermont

Neither did Vermont receive an increase when the federal formula changed in 1984; generally it passed the federal set-aside requirement down to local providers to implement. Vermont had a combined alcohol and drug abuse program. Unlike most other states, Vermont delivered some services directly, but about three-quarters of its 1986 program funds were allocated to local service providers.

For the most part, Vermont did not reallocate resources to meet the federal set-aside requirement. Instead, the state required its local service providers to spend at least 5 percent of their block grant allocations for new or expanded services, without providing additional funding. It also established a center for battered women. Thus, a total of $174,525 (24 percent of total substance abuse spending) was spent on women's services in program year 1986 in response to the set-aside requirement. A state substance abuse official pointed out that, prior to the federal requirement, Vermont already had established increased services to women as a state priority. For example, it had already planned the battered-women's center and had instructed state service providers to pay special attention to the needs of women, though not with specific programs or funding amounts. The set-aside requirement did influence local spending for women's programs. For the first time, a specific dollar amount was earmarked in providers' contracts for increased women's services. For example, the Champlain Drug and Alcohol Services program had earmarked $9,600 of its $244,700 contract for increased women's services.

Because additional federal funds did not accompany the new requirement, some local providers had to reallocate resources to meet the new requirement. For example, the director of the Champlain program, which instituted therapy groups for nurses and prison inmates' wives, said they had to cut back services to other groups, particularly white males, to establish the new women's services. On the other hand, another provider we visited, the Addison Counseling Service, which instituted specialized therapy groups for women, said women would have been served without the requirement, but not in specialized groups. According to these providers, these local women's programs would be continued if the set-aside requirement were removed. However, the programs would have to compete with other programs for funding.

State officials favored repeal of the set-asides on principle. They considered set-asides contrary to the intent of block grants, which was to maximize states' flexibility. Although the current requirements had only an administrative impact on state program priorities, they feared future set-asides might interfere with their funding decisions.

Selected Case Studies of State Strategies Used to Implement the Mental Health Set-Aside Requirement

California

California received an increase in ADAMH funds due to the 1984 formula changes; its Department of Mental Health implemented the set-aside requirement by soliciting proposals for new services. ADAMH funds comprised about 3 percent of the department's total mental health expenditures in program year 1986.

The department already had established increased children's services as a state priority and had increased state funding for local programs, with special consideration for children's services, by $40 million in state program year 1985-86. Its goal was to have a quarter of each county's mental health budget dedicated to children's services. To implement the federal set-aside requirement, California solicited proposals from local providers for about $1.6 million (10 percent of the mental health portio of California's fiscal year 1986 block grant funds) in new mental health services. It received 289 proposals to address the needs of the targeted population and funded 20, using the increases the state received as a result of the 1984 formula changes.

The projects were independent of existing programs. For example, one Los Angeles project provided chronically disabled adults with paid vocational training and work experience in a retail cookie business. In another case, an information and referral center created in San Diego provided a telephone network and a central office for information, referral, and mutual support for families and friends of severely mentally ill persons.

California's Department of Mental Health program director said the set-aside requirement did not influence state mental health priorities, because the federal requirement was not in conflict with the state's own priorities. For example, the department had identified, as a longstanding priority, services to children and youth, persons with chronic mental illness, and the elderly. The official expected this emphasis to continue, even if the set-aside requirement were repealed. He hoped that the congressional reauthorization would contain as few set-asides as possible, believing that some other states, operating under rather serious funding constraints, should be allowed maximum flexibility in the use of these funds.

Kentucky

Kentucky, which received a 25-percent increase in it ADAMH allocations as a result of formula changes in 1984, implemented the set-aside by designating programs the state had already planned to undertake.

ADAMH funds comprised about 7 percent of Kentucky's total federal and state mental health spending in program year 1986.

During 1985, Kentucky began targeting programs specifically to the chronically mentally ill. When the federal mental health set-aside requirement was implemented in 1986, Kentucky did not create separate programs but defined the state's initiatives as meeting the federal requirement. The state reviewed proposals from its 14 community mental health centers and approved 17 projects totaling about $744,000 in ADAMH funds, well in excess of the $184,000 required by the set-aside provision. The state funded additional projects for the chronically mentally ill totaling about $803,000 in state funds. The 17 ADAMH-funded projects included 4 for crisis care, 7 for case management, 3 for residential treatment, and 3 for education and consultation.

In 1987, Kentucky continued its efforts to serve the chronically mentally ill. ADAMH funds totaling about $430,000 were provided to continue the 17 projects started in 1986, and $62,000 in ADAMH funds were used to start new projects for the same population. The state also used about $136,000 in ADAMH funds for children's projects and about $2 million in state funds for children, adolescents, and underserved groups.

In Kentucky, we visited a crisis stabilization project supported with set-aside funds and coordinated by Seven Counties Services, Inc., one of the state's 14 community mental health centers. The project goal was to provide an alternative to hospitalization by providing assistance to clients to enable them to remain outside the hospital. ADAMH funding was $65,000 in program year 1986. In program year 1987, ADAMH funding support under the set-aside remained the same, but in addition the state contributed $247,000. The effects included increased hours of service to the targeted chronically mentally ill adults, more in-home services, and increased staff. Three full-time employees were assigned to the crisis project.

The mental health set-aside requirement coincided with Kentucky's overall mental health plans and had not caused problems because the state exceeded the set-aside requirement with additional ADAMH and state funds. Mental health advocates in Kentucky responding to our survey generally believed that, even if the federal set-aside requirement were eliminated, the state would continue its commitment.

Texas

In 1985, Texas received an increase under the 1984 formula changes. It implemented the set-aside requirement by speeding up the creation of several projects the state would probably have eventually undertaken anyway. About 10 percent of the state's mental health program budget consisted of ADAMH funds.

Texas allocated $700,000 of its 1986 ADAMH funds and $1.4 million in state funds for new and expanded projects to serve children. A state program official said the set-aside requirement probably provided the impetus for two projects: (1) expanding an existing alternative family support project for emotionally disturbed and mentally disabled children and (2) establishing a specialized day-treatment project for aggressive and violent emotionally disturbed adolescents. He believed the projects would eventually have been funded without the set-aside requirement. In the previous four years, the state had increased funding for community mental health programs in response to a lawsuit against the state.

We visited the Johnson County Mental Health/Mental Retardation Center, which Texas designated as meeting the 10-percent mental health set-aside requirement. According to the executive director, the center's creation greatly expanded existing services such as family counseling and support services to county residents. In program year 1986, the first year of the set-aside program grant, the center served 388 clients. This compared with 100 clients served the previous year by the county's outreach clinic, which had been the only local source of services. Funds from the federal set-aside comprised almost 70 percent of the center's 1986 expenditures. If ADAMH funding were withdrawn, the director believes mental health services in the county would return to their previous level.

Although the state's Deputy Commissioner of Mental Health felt that the set-aside benefited the areas served by the new and expanded projects, she believed it did not benefit the state as a whole. The state would prefer using its block grant funds to reinforce existing services rather than creating more programs, she said, because the constant creation of new programs would spread agency resources too thin.

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