NASADAD National Association of State Alcohol and Drug Abuse Directors

March 2019

Substance Abuse Prevention and Treatment (SAPT) Block Grant

SAPT Block Grant Funding

- FY 2019: $1.858 billion
- FY 2018: $1.858 billion
- FY 2017: $1.858 billion
- FY 2016: $1.858 billion
- FY 2015: $1.820 billion
- FY 2014: $1.820 billion
- FY 2013: $1.710 billion (after 5% sequestration cut)
- FY 2012: $1.779 billion (Congress appropriated $1.8 billion, but HHS redirected $21.5 million to other programs)
- FY 2011: $1.783 billion
- FY 2010: $1.799 billion
- FY 2009: $1.779 billion

Overview

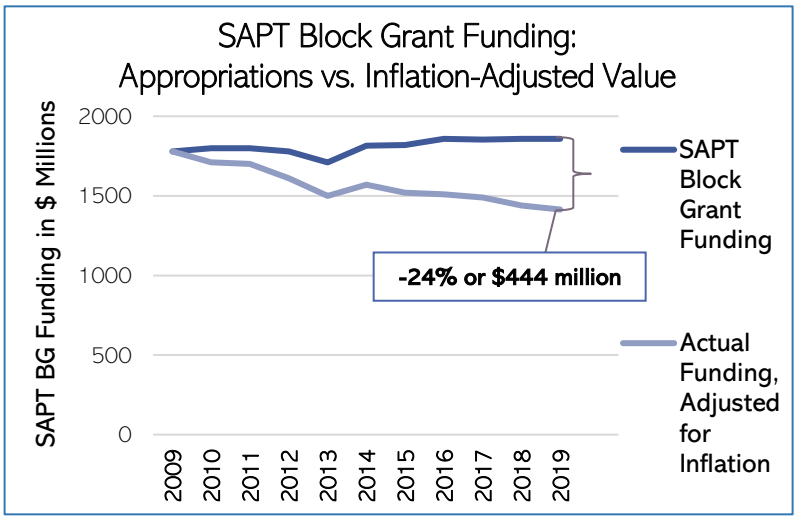
The Substance Abuse Prevention and Treatment (SAPT) Block Grant is distributed by formula to all States, Territories, Jurisdictions, and the Red Lake Band of Chippewa Indians (referred to as "States"). **It is the cornerstone of States' substance use prevention, treatment, and recovery systems**. The SAPT Block Grant is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS).

SAPT Block Grant Outcomes

The **SAPT Block Grant funds annually provide treatment services for 1.5 million Americans** (SAPT Block Grant Program Profile, 2018). At discharge from Block Grant-funded programs, 76% of clients demonstrate abstinence from alcohol use, and 57% are abstinent from illicit drug use. Additionally, of clients discharged from treatment, 89% have stable housing, and 93% have had no arrests.

Funding Decreasing Over Time

The SAPT Block Grant is a critical safety net program. **Over the past decade, SAPT Block Grant funding has not kept up with health care inflation, resulting in a 24% decrease in the real value of funding by FY 2019 (to $1.414 billion)**. As inflation increases, the actual purchasing power of the same funding decreases. In order to restore the SAPT Block Grant's 2009 purchasing power, Congress would need to allocate an additional $444 million for FY 2020. As States work to maintain their systems with fewer resources, the demand for services continues to rise. According to the latest National Survey on Drug Use and Health (NSDUH, 2018), past month use of illicit drugs has been on the rise over the past decade, increasing from 8.3% of individuals aged 12 or older in 2006 to 10.6% in 2017.



Financial Burden of Substance Use Disorders

According to NSDUH, in 2017, approximately 19.7 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year. During the same year, only 4 million received treatment for such a problem. As a result, over 16 million Americans needed but did not receive services for a substance use problem in 2017. The economic impact of SUDs is staggering. The National Institute on Drug Abuse (NIDA) estimates that **illicit drugs, alcohol and tobacco cost society roughly $740 billion every year**: $193 billion for illegal drugs, $249 billion for alcohol, and $300 billion for tobacco. Additionally, prescription opioid misuse and addiction costs us $78.5 billion per year.

Substance Use Disorders Represent Tiny Fraction of Overall Health Expenditures

According to SAMHSA's 2016 report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2014*, spending on SUDs decreased as a share of all healthcare spending from 2.0 percent in 1986 to 1.1 percent in 2002, and remained stable ever since. **Expenditures for substance use disorder services represented only 1.2% of all healthcare expenditures** in 2014. That translates to approximately $34 billion for SUDs vs. $3.2 trillion for all health expenditures.

Investments in Services for Substance Use Disorders Saves Money

In 2016, NIDA noted that for every dollar spent on substance use disorder treatment programs, there is an estimated $4 to $7 reduction in costs associated with drug related crimes. When healthcare costs are included, total savings can exceed costs by 12 to 1. Substance use prevention is also a cost-effective way to reduce the financial burden of substance misuse and SUDs. According to the Surgeon General's 2016 *Report on Alcohol, Drugs, and Health*, every $1 spent on effective, school-based prevention programs can save an estimated $18 in costs related to problems later in life.

SAPT Block Grant Produces Results

An independent study of the SAPT Block Grant, released in June 2009, found that the program was effective in:

1) Producing positive outcomes as measured by increased abstinence from alcohol and other drugs, increased employment, decreased criminal justice involvement, and other indicators;
2) Improving States' infrastructure and capacity;
3) Fostering the development and maintenance of State agency collaboration; and
4) Promoting effective planning, monitoring, and oversight.

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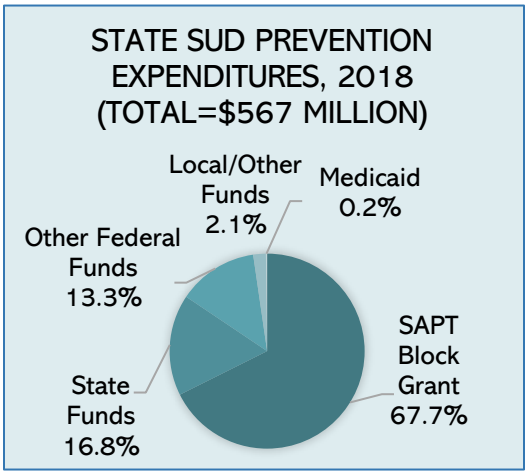
Prevention Matters: SAPT Block Grant Prevention Set-Aside

Federal statute requires States to direct at least 20% of SAPT Block Grant funds toward primary prevention of substance use. This "prevention set-aside" is managed by the Center for Substance Abuse Prevention (CSAP) within SAMHSA, and is a core component of each State's prevention system. On average, **SAPT Block Grant funds make up 68% of primary prevention funding in States** (SAPT Block Grant State Agency Reported Expenditures by Target Activity within Source of Funds, 2018). In 20 States, the prevention set-aside represents 75% or more of the State agency's substance use prevention budget. In 6 of those States, the prevention set-aside represents 100% of the State's primary prevention funding.



SAPT Block Grant and Vulnerable Populations

States using SAPT Block Grant funds must provide additional protections and/or funding for certain vulnerable populations that are identified in statute. Priority populations include: pregnant and parenting women, persons who inject drugs, individuals with or at risk for HIV/AIDS, and individuals with or at risk for tuberculosis (TB).

Pregnant and Parenting Women

Pregnant women must be given priority in treatment admissions, and those that are referred to the State for treatment must be placed within a program or have interim arrangements (e.g., education on communicable diseases, counseling on effects of substance use on the fetus, referral to prenatal care, etc.) made within 48 hours. Further, States are required to allocate a dedicated amount of SAPT Block Grant funds to support pregnant and parenting women.

Persons Who Inject Drugs

SAPT Block Grant funded treatment programs that serve persons who inject drugs must keep the State informed about their admissions capacity. This allows the State to monitor whether individuals are placed into treatment in a timely manner or provided with interim services if an opening is temporarily unavailable.

Individuals with HIV/AIDS

For States with AIDS infection rates of 10 or more per 100,000, early HIV intervention services must be provided to individuals undergoing SUD treatment. These services are to be available in the areas of the State with the highest disease burden. Early intervention services include pre-testing counseling, testing, post-testing counseling, and appropriate treatment.

Individuals with Tuberculosis (TB)

SAPT Block Grant funded treatment programs must directly (or through arrangements) make TB services available to everyone who receives treatment. TB services include counseling, testing, and clinically appropriate treatment.

SAPT Block Grant Funds Treatment Services: Prescription Drug and Heroin Use on the Rise (TEDS, 2016)

As noted below, over one-third (34.1%) of individuals admitted to treatment in the publicly-funded system cited heroin or prescription opioids as their primary substance of use in 2016. That year, admissions for heroin addiction exceeded admissions for alcohol alone as primary substance of use. In addition to the troubling increase in treatment admissions, opioid overdose deaths have also been on the rise; in 2017, over 47,600 Americans lost their lives to a prescription opioid or heroin overdose.

Primary Substance	% (estimate)
Heroin	26.2% (445,443)
Alcohol only	18.4% (312,497)
Marijuana	13.4% (228,391)
Amphetamines	10.6% (180,161)
Other Opiates	7.9% (134,085)
Cocaine (smoked)	3.0% (50,970)
Cocaine (other route)	1.9% (32,417)
PCP	0.3% (4,868)
Hallucinogens	0.1% (1,986)
Inhalants	0.1% (885)

Age at Admission	% (estimate)
12-17	3.9% (66,059)
18-24	14.3% (243,437)
25-29	18.2% (309,399)
30-34	16.3% (276,873)
35-39	12.4% (210,957)
40-44	8.7% (148,119)
45-49	8.9% (151,639)
50-54	8.3% (140,139)
55-59	5.4% (91,662)
60 and older	3.4% (58,364)

Race/Ethnicity	% (estimate)
White	62.2% (1,037,557)
Black/Afr American	16.7% (278,128)
Am Ind/AK Native	2.3% (38,666)
Asian/Pac Islander	1.0% (16,885)
Hispanic	13.4% (223,826)
Other	4.3% (71,916)

Gender	% (estimate)
Male	65.1% (1,104,318)
Female	34.9% (591,479)

Role of State Alcohol and Drug Agencies

NASADAD represents State alcohol and drug agency directors from the fifty States, the District of Columbia, and Territories. States work with counties and local communities to ensure that public dollars are dedicated to effective programs using tools such as: performance data management and reporting, contract monitoring, corrective action planning, onsite reviews, and technical assistance to community coalitions. State alcohol and drug agencies work with providers to use evidence-based prevention practices.

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Special thanks to Rick Harwood, Deputy Director, and Emily Diehl, Policy Intern, for their important contributions to this fact sheet.