

Substance Abuse Prevention and Treatment (SAPT) Block Grant

SAPT Block Grant Funding

- 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

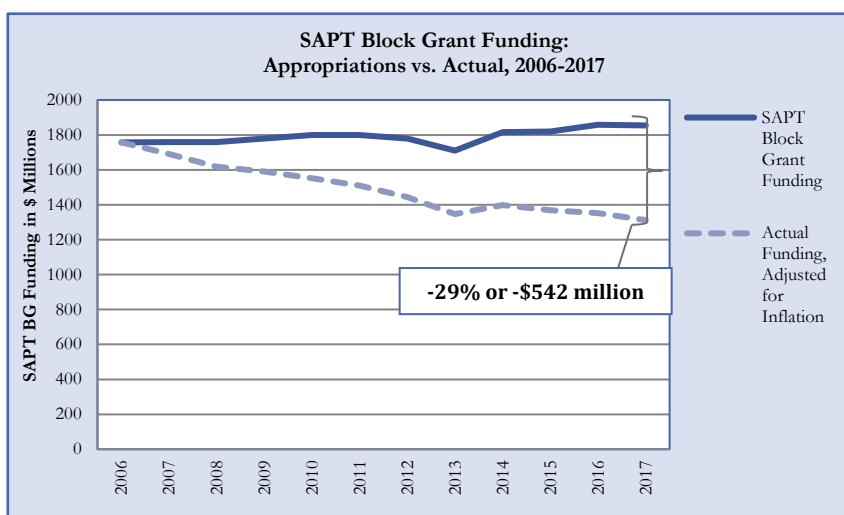
The Substance Abuse Prevention and Treatment (SAPT) Block Grant is distributed by formula to all States and Territories. **It is the cornerstone of States' substance abuse prevention, treatment, and recovery systems.** The SAPT Block Grant is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS).

SAPT Block Grant Outcomes

According to SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program Profile, **SAPT Block Grant funds annually provide treatment services for 1.5 million Americans.** At discharge from block grant-funded programs, 70% of clients demonstrate abstinence from illegal drug use and 83% are abstinent from alcohol 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 last 10 years, SAPT Block Grant funding has not kept up with health care inflation, resulting in a staggering 29% decrease in the real value of funding by FY 2017 (to \$1.312 billion).** As inflation increases, the actual purchasing power of the same funding decreases. In order to restore the SAPT Block Grant's 2006 purchasing power, Congress would need to allocate an additional \$542 million for FY 2018. As States work to maintain their systems with fewer resources, the demand for services continues to rise. According to the National Survey on Drug Use and Health (NSDUH), 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 10.1% in 2015.



Financial Burden of Substance Use Disorders

According to NSDUH, 21.7 million people aged 12 or older needed treatment for an alcohol or illicit drug use problem in 2015 (met criteria for abuse or dependence). During the same year, only 3 million received treatment for such a problem. As a result, over 18 million Americans needed but did not receive services for a substance use problem in 2015. The economic impact of substance use disorders is staggering. The **National Institute on Drug Abuse (NIDA) estimates that illegal drugs, alcohol, and tobacco cost society roughly \$700 billion every year** or \$193 billion for illegal drugs, \$224 billion for alcohol, and \$295 billion for tobacco.

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 substance use disorders decreased as a share of all health 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 health expenditures** in 2014. That translates to approximately \$34 billion for substance use disorders vs. \$3.2 trillion for all health expenditures.

Investments in Substance Abuse Saves Money

In 2006, the National Institute on Drug Abuse (NIDA) noted that for every dollar spent on substance use disorder treatment programs, there is an estimated \$4 to \$7 reduction in the cost of drug related crimes. With outpatient programs, total savings can exceed costs by 12 to 1. Substance abuse prevention is also a cost-effective way to reduce the financial burden of substance abuse and substance use disorders. 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

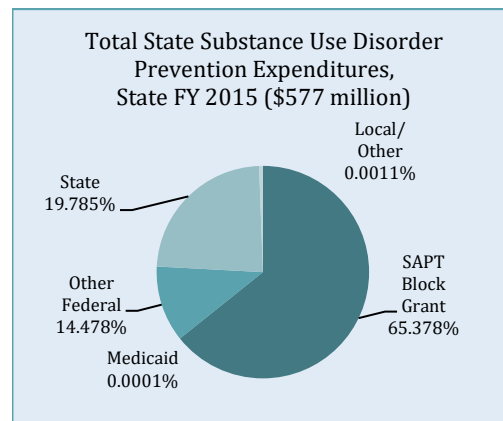
An independent study of the SAPT Block Grant, released in June 2009, found that the program was effective in:

- 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.

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 abuse. 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 65% of primary prevention funding in States and Territories**. In 18 States, the prevention set-aside represents 75% or more of the State agency’s substance abuse prevention budget. In 4 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, injection drug users, individuals with HIV/AIDS, and individuals with 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 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 HIV infection rates of 10 or more per 100,000, early HIV intervention services must be provided to individuals undergoing substance use disorder 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 tuberculosis 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, 2014)

As noted below, almost one-third (30.3%) of individuals admitted to treatment in the publicly-funded system cited heroin or prescription opioids as their primary substance of use. In 2014, admissions for heroin addiction exceeded admissions for alcohol alone as primary substance of use. According to NASADAD data, in 2015, 39 States reported an increase in treatment admissions for heroin. In addition to the troubling increase in treatment admissions, opioid overdose deaths have also been on the rise—in 2015, over 33,000 Americans lost their lives to a prescription opioid or heroin overdose.

Primary Substance	% (estimate)	Age at Admission	% (estimate)	Race/Ethnicity	% (estimate)
Heroin	22.1% (357,293)	12-17	4.8% (77,812)	White	62.3% (981,107)
Alcohol only	20.3% (327,694)	18-24	16.6% (268,319)	Black/Afr American	17.9% (281,403)
Marijuana	15.3% (247,461)	25-29	17.2% (276,860)	Am Ind/AK Native	2.5% (38,959)
Other Opiates	8.2% (132,387)	30-34	15.1% (242,742)	Asian/Pac Islander	1.0% (16,529)
Amphetamines	8.9% (144,427)	35-39	10.9% (175,051)	Hispanic	13.0% (205,564)
Cocaine (smoked)	3.6% (57,493)	40-44	9.4% (151,336)	Other	3.3% (51,648)
Cocaine (other route)	1.9% (30,017)	45-49	9.5% (153,383)		
PCP	0.3% (4,910)	50-54	8.5% (137,574)	Gender	% (estimate)
Hallucinogens	0.1% (1,864)	55-59	4.9% (79,559)	Male	66.4% (1,068,950)
Inhalants	<.05% (791)	60 and older	3.0% (48,211)	Female	33.6% (541,502)

Role of State Substance Abuse Agencies

NASADAD represents State substance use disorder agency directors from the fifty States, the District of Columbia, and the five U.S. 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 substance abuse agencies work with providers to use evidence-based prevention practices.

NASADAD Contact Information: Robert Morrison, Executive Director, (202)293-0090 or rmorrison@nasadad.org.
Shalini Wickramatilake-Templeman, Federal Affairs Manager, (202) 293-0090 or swickramatilake@nasadad.org.