FUNDING FAMILY-CENTERED TREATMENT FOR WOMEN WITH SUBSTANCE USE DISORDERS

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

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Funding Family-Centered Treatment for Women With Substance Use Disorders

Prepared for:

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About This Series

As part of its commitment to ensure that people have access to effective treatment and supportive services that promote their recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) has prepared two papers on family-centered treatment for women with substance use disorders. *Family-Centered Treatment for Women With Substance Use Disorders—History, Key Elements and Challenges* introduces, defines, and discusses the concepts and implementation challenges of an evolving family-centered treatment approach for women with substance use disorders. The companion paper, *Funding Family-Centered Treatment for Women With Substance Use Disorders*, identifies and discusses potential sources of funding for comprehensive family-centered treatment and provides suggestions for how States and substance abuse treatment providers can strengthen their overall financing strategies.

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Funding Family-Centered Treatment for Women With Substance Use Disorders

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I. INTRODUCTION

A. Overview

Research on women and substance use disorders shows that relationships, especially with family and children, play an important role in women's substance use, treatment, and long-term recovery. It follows then—and ample evidence supports this premise—that women benefit from comprehensive treatment that addresses their needs in the context of these relationships. But translating research into practice is not always easy. To advance the field of women's treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) has prepared a two-part series on family-centered treatment for women with substance use disorders.

The first paper, *Family-Centered Treatment for Women With Substance Use Disorders—History, Key Elements and Challenges* (Werner, Young, Dennis & Amatetti, 2007), examines the role of family in the context of treatment for women with substance use disorders and expands the earlier CSAT Comprehensive Substance Abuse Treatment Model for Women and Their Children (Comprehensive Model) to include older children, fathers, husbands, and other family members. It presents a continuum of family-based services and introduces, defines, and discusses the concepts and implementation challenges of this evolving approach to addressing substance use disorders. Chief among these challenges is how treatment providers can fund the model's array of recommended clinical treatment and community support services—not only for women but also for children and other family members. This companion document, *Funding Family-Centered Treatment for Women With Substance Use Disorders*, seeks to address this difficult issue.

Treatment providers often rely on short-term or sole source funding strategies to provide a broad range of services. As demonstration projects end and new Federal and State funding priorities shift, providers have to expand to multiple sources of funding. There is a growing need to find ways of financing programs to make them sustainable.

Yet many States, communities, and providers find it difficult to identify, much less coordinate, all available funding. As Griffin (2003) so aptly puts it, understanding funding is "a bit like plumbing. *Complicated* plumbing. Picking out the main pipes, seeing where they begin and end, is easy. Following all the twists and turns, their back-ups and reverse flows and feeder systems and bypass valves, is hard" (emphasis in original). The existing treatment gap is, in part, associated with the difficulty States and providers have in adequately financing treatment programs (Mark et al., 2005). But it is also related to the need for effective partnerships at many different levels: among the various community organizations that serve women with substance use disorders and their children and families, between State and local government agencies and officials, between service providers and State and local policymakers, and between the public and private sectors.

CSAT's family-centered treatment model assists providers in identifying discrete elements of the model and making their own assessments of how to finance the elements through available funding streams. For some elements, such as medical care, funding will be more available and sufficient to cover the cost of service delivery. Other elements that have traditionally been considered outside the realm of core substance abuse treatment, such as mental health, family supports, and many children's services, may not be as easily funded.

Providers will have to use flexible and diversified funding strategies—which are contingent on establishing effective working partnerships with other community organizations—to cover these services while they demonstrate to funders and other service systems why these components are critical in the comprehensive model of care. Providers will likely have to pursue an incremental, long-term, collaborative approach to planning, building, and sustaining the full array of services outlined in the model. Such an approach is all the more essential given that Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds—the funds most under the control of the treatment system—represent only 8 percent of all public dollars spent on substance abuse treatment nationally and, on average, less than half of a Single State Agency's (SSA's) substance abuse treatment expenditures (Mark et al., 2007; Office of National Drug Control Policy, 2006).

B. Purpose and Organization of This Paper

This funding paper is intended to help substance abuse treatment providers, State substance abuse agencies, and their collaborating service systems and providers identify and better understand potential sources of funding for comprehensive family-centered treatment and strengthen their overall financing strategies. More specifically, this paper does the following:

- Provides necessary background and context (e.g., information on the program and funding landscape, definition of funding terms) to inform providers' efforts
- Identifies and describes major funding streams that support substance abuse treatment and related services for women and their children and families
- Highlights the experiences and insights of one organization, SHIELDS for Families, in developing an effective comprehensive services financing strategy
- Provides a set of concrete, next-step starting points for both providers and State agencies seeking to provide and fund comprehensive services

The paper is divided into six sections. After this Introduction (Section I), Section II provides important *starting points, background, and context* for providers. Much of Section II focuses on the importance of knowing and incorporating the needs of communities and clients into funding decisions and the need for and challenges associated with multiple and integrated funding streams.

Section III provides an *overview of the primary sources of Federal funding*, with an emphasis on the large pools of Federal formula or block grant funding that can be used

for substance abuse treatment and related support services for women and their children and families. Section IV discusses *State-funding issues* and general sources (e.g., tobacco settlement funds) that treatment providers can use.

Section V discusses the *role and importance of the private sector* in supporting comprehensive treatment. It briefly discusses two private-sector funding sources in particular—foundations and private health insurance—that treatment providers may wish to consider.

Section VI concludes with a set of *next steps and recommendations* for treatment providers and State agencies as they seek to develop and implement strategies to secure funding for comprehensive services.

Throughout this paper, the experiences and insights of one organization, SHIELDS for Families, in developing an effective comprehensive services financing strategy are highlighted. These lessons, which emerged from an interview with Dr. Kathryn Icenhower, Executive Director of SHIELDS, are highlighted in *Advice From SHIELDS* boxes. SHIELDS was chosen because of its wealth of experience and success in securing, managing, and sustaining multiple funding sources; implementing a broad array of services for women, children, and families; and achieving positive outcomes for the individuals and families they serve. Appendix A contains a more detailed description of SHIELDS.

It is important to underscore that fiscal context always matters. The information and suggestions in this paper are made with the awareness that in most States, fiscal constraints—including increased competition for existing dollars and funding levels that may fluctuate from year to year—are very real and significant factors affecting the provision of comprehensive family treatment services. These constraints make it all the more important to have a well-balanced array of funding that does not rely on any single source, but spreads the responsibility for supporting effective treatment programs across multiple funding streams.

II. ESSENTIAL BACKGROUND AND CONTEXT

A. Before You Get Started—Taking Stock of Your Program and Community

Before providers complete that next Request for Proposal (RFP) or search Grants.gov for that next funding opportunity, it is imperative they first take stock of not only their program but also the larger community services system. This need for upfront planning is based on an important premise: In today's economic landscape, any future increases in available treatment dollars will likely be incremental or occur in funding streams that providers have not traditionally leveraged for substance abuse treatment and related support services, such as IV-E Child Welfare Services (see Section III), special State funds (see Section IV), and private health insurance providers (see Section V). Some traditional funding streams have remained relatively constant or increased only slightly. For example, the SAPTBG has increased about 10 percent over the last 8 years, from approximately $1.6 billion in 2000 to $1.76 billion in 2008 (Substance Abuse and Mental Health Services Administration, 2001, 2008a).

At first glance, the absence of any infusion of new, external funds directly targeted to substance abuse treatment and related support services may seem problematic because comprehensive programs for women and their children and families (in comparison to standard services) can require additional funds. Yet, on closer examination, treatment providers will likely find good news—substantial sums of funding are already embedded in the community. The key is for providers to better understand these existing funding streams, specifically:

- How they flow into their communities
- How they are currently allocated among different service providers
- How they might be *better* allocated to meet the needs of women with substance use disorders and their children and families
- What is needed to tap into those existing resources

Along with an increased understanding of the community's funding landscape, providers must have a keen sense of the community's and target population's needs and the current service delivery environment.

The questions below are designed to help providers gain this fundamental knowledge base as they seek to provide more comprehensive service delivery and improve treatment effectiveness.

(1) *Who are my clients and what are their needs?*

Although this may seem like a simple question to answer, client populations and needs may undergo subtle shifts over time in response to policy changes or other factors. Providers need to ensure they have a thorough and accurate understanding of, and can correctly prioritize, their clients' clinical treatment and supportive service

needs to answer the fundamental question of "financing for what?" For instance, a program may determine that its clients' most critical needs are mental health services for the women, developmental services for the children, and employment services for the fathers. This information on priority needs is then used to shape a targeted financing strategy.

> ***Advice From SHIELDS***
>
> *Rather than simply "follow the funding," providers must instead let their families' needs drive their funding decisions. Funding that does not fit clients' priority needs is not an appropriate target.*

To obtain this knowledge, providers can conduct a variety of activities, including case reviews, surveys or focus group discussions with current clients, exit interviews with clients who are being discharged, or followup with former clients to find out what services were the most and least useful and needed but not received. These activities can be modest in scale (i.e., feasible) and still provide practical information from front-line staff and clients. For instance, a case review could entail selecting a given month and reviewing the first 10 cases entering treatment to identify service needs. Or a "focus group" discussion could be conducted with program managers and clinicians at regularly scheduled staff meetings.

(2) *What services do we currently provide to meet clients' needs, and where do we fall short? What about others in the community that serve our clients?*

By comparing clients' priority needs with existing program services, treatment providers can identify any significant gaps in service delivery. Treatment agencies need to look at whether they are providing the adequate level of structure and intensity of clinical treatment, in addition to the necessary support services, along the full continuum of care for these women and their children and families. In other words, does the program provide the adequate level, duration, intensity, and range of services to meet clients' needs and achieve the desired outcomes?

In assessing current services, treatment providers should also consider the efforts of others in the community. Given the broad range of needs that women with substance use disorders and their children and families typically have, they are likely to be clients of other community service systems (e.g., child welfare, criminal justice, mental health). To serve clients in the broadest context, effective collaboration with other agencies on the basis of clients' needs and overlapping caseloads is needed (Center for Substance Abuse Treatment, 2000).

The clinical treatment and support services outlined in the CSAT family-centered treatment paper (see Werner et al., 2007) may serve as a useful framework for program managers and clinicians to discuss what services are most important to the women, children, and families they serve.

(3) *What funding and other resources in the community are currently used to fund these services?*

Once armed with an understanding of the services provided, substance abuse treatment providers must ask:

- What funding and other resources support these services?
- Are those resources sufficient to achieve intended outcomes?
- How can the agency's resources be combined with others to achieve greater impact?

The best way to answer these questions is to (1) create an inventory of what other resources and services already exist in the community and the total level of public and other dollars flowing into the community to support those services, (2) chart how those existing funds are allocated among service providers, and (3) identify who controls them.

At first, this matrix of funding may be preliminary or rough in nature, but in time it should lead to a complete and detailed inventory that includes all sources in the community that fund treatment, the levels they fund, and the populations they serve (for resources on map spending see Armstrong et al., 2006; Children and Family Futures, 2003). Some States, notably Arizona, compile this inventory annually (see Section IV of this paper for more information). In most sites, however, a comprehensive inventory may not be available from either State or local funders, and an agency may need to begin with only those sources closest to its own mission. Still, this is an essential start because the best preparation for seeking new funding is a solid information base on current funding and how it enhances or limits provision of services.

Typically, financing discussions focus on new sources of funding rather than the far greater amount of resources *already in the community.* Having knowledge of the community's institutional funding base will enable providers to move beyond a vague wishful-thinking "theory of resources"[1] that considers only new, outside, and often narrowly defined or categorical funding requiring new administrative functions. Armed with this baseline funding knowledge, providers can focus on leveraging existing dollars effectively.

To properly document the funding landscape, however, providers need to decipher the complexity of the community's budgeting and decisionmaking process and untangle the underlying politics and other issues that drive it. Budgets for issues affecting women with substance use disorders and their children are often buried in other categories, such as maternal and child health, mental health, employment, family support, child care and development, and developmental disabilities.

(4) *To what extent can we tap into these existing sources? What partnerships need to be established?*

> ***Advice From SHIELDS***
>
> *Remember that not all collaborations are equal. To ensure partnerships are effective, they must be driven by clients' and families' needs and move beyond the rhetoric of collaboration to shared decisionmaking, outcomes, and accountability.*

Substance abuse treatment providers should operate under the assumption that it is neither feasible nor effective for their organization alone to provide everything that their clients need. Each agency must confront decisions about which services they should and can provide and which services need to be accessed through collaborative partnerships in their community. Through the resource inventory and mapping process, treatment providers can discover available services provided by others that will benefit their clients. Treatment providers might find that these other community organizations and agencies are already serving their clients or, at the very least, might be better equipped than they are to deliver a particular service. The key is to identify potential collaborators in the service network, initiate discussions about which service providers have the capability and capacity to offer which services, and develop an interconnected service delivery system that reflects the clients' and community's needs. Hayes, Flynn, and Stebbins (2004) stress: "Lack of knowledge and understanding of concurrent service delivery systems, competition among programs and services, and duplication of effort can hurt the short- and long-term success of coordinated initiatives."

In addition to establishing partnerships with other community organizations, treatment providers must develop close connections with their local and State policymakers and government officials, who have a major role in funding decisions. Keep in mind that Federal funds typically flow through State governmental agencies and often cannot be accessed directly by local providers.

For a substance abuse treatment provider to successfully advocate that its clients deserve additional or more intensive community services to meet their needs, it must show that its program is effective, can leverage other resources, and is part of an integrated services effort. The issue of effectiveness cannot be overemphasized. Any discussions and negotiations for client services—whether with other service providers or State and local policymakers—must include conversations about outcomes, including cost savings to other systems and the community. For instance, substance abuse treatment providers need to be able to show how their treatment program increases family reunification rates and decreases criminal offenses, thereby providing savings to the foster care and criminal justice systems.

Establishing effective partnerships that embrace and agree on a long-term financing strategy does not happen overnight. Negotiating funding based on outcomes is often a multiyear process and may entail difficult conversations and decisions, such as the

need to redirect funds away from ineffective programs. (Redirection as a financing strategy is discussed further in Section D below.)

(5) *Should we—can we—offer the service ourselves? With our own staff or outside contractors?*

During resource mapping and in discussions about who is best equipped to provide given services, the treatment organization may identify significant unmet service needs, shortcomings in existing service delivery methods, and/or significant barriers to tapping into existing resources. This may lead to the conclusion that providing certain services in-house will best meet clients' needs. If this is the case, the organization will need to discuss and strategize internally to decide the extent to which it wants and can provide onsite services. This internal planning and decisionmaking should address questions such as Do we have the appropriate facilities, technology, licensing, qualified staff, and prior experience? How will we accommodate the growth in our budget and programs? Should we use our own staff, employ additional staff, or bring in outside contractors? If we contract out, what are the expected savings, benefits, and programmatic outcomes? Do the contractors share our program's values and philosophy regarding women's treatment?

Advice From SHIELDS

Since its inception in 1991, SHIELDS for Families has continually responded to the needs of community—and its funding reflects that. It has grown from an organization with $300,000 and 10 employees to one with a $15 million budget and more than 40 funding sources, 260 employees, and more than 20 programs. While many services (e.g., HIV/AIDS education) are provided through strategic community partnerships involving a wide range of other types of service providers, SHIELDS also has chosen to take the lead on certain services (e.g., family preservation, housing) that no one else in the community could adequately provide.

Bigger is not always better. Smaller treatment providers, in particular, may realize that to be most effective, they may have to do "less, but better." In other words, by serving fewer women better with higher dosage efforts, they may be able to provide longer term and more intensive and comprehensive services—and achieve better treatment outcomes—than programs that diffuse resources more broadly and less intensively.

B. A Broader Look at the Larger Program and Funding Landscape: The Importance of—and Challenges Associated With—Multiple and Integrated Funding Streams

The questions outlined above are intended to help providers better understand the community or local conditions in which they are working. This detailed perspective is vital and essential, but a wider lens is also needed. Providers must understand certain fundamentals about women's substance abuse treatment programming and the larger funding structures.

The CSAT Family-Centered Treatment Model emphasizes two key factors: comprehensive services and continuum of care. Although these two goals are connected, it is important to distinguish between them. *Comprehensive services* encompass the broad array of services (e.g., substance abuse treatment, medical care, mental health services, parenting education, child care, life skills, job training, developmental services, housing) that women with substance use disorders and their children and families need to address their multiple and complex needs. The *continuum of care* refers to the amount of structure and intensity needed by women and their children and families at different points—outreach, engagement or pretreatment, treatment, retention, aftercare, ongoing recovery—in the woman's care. Throughout the continuum of care, however, women and their children and families may receive comprehensive services.

To provide comprehensive services across an appropriate continuum of care, treatment providers, in general, have to secure multiple funding streams. The more structured and intensive the care is along the continuum, the broader the array of funding streams needed. The more committed an agency is to providing comprehensive family services, the more mastery it needs of all the relevant funding streams that can support not only women but also their children and families.

Closely intertwined with the above point, is that no single agency, on its own, has adequate funding sources to achieve comprehensive outcomes of individual, child, and family well-being. Because a consortium of agencies (substance abuse treatment, child care, health, education, employment, and others) will most likely provide the array of recommended services, multiple funding streams that flow into these various agencies must be connected. In short, interagency funding streams are a critical element of effective substance abuse treatment financing.

Yet many service providers are unsure how to explore new financing strategies beyond traditional (and comfortable) categorical funding or earmarked revenues, unsure how to move toward a broader funding portfolio that includes a host of public and private sources, and unsure how to engage in collaborative activities for fear they might jeopardize "their own" funding streams.

Several issues affect the ability of programs to both obtain multiple funding sources and connect interagency funding streams. These barriers exist at several different levels: from the Federal level (e.g., constraints imposed by categorical funding) to the State level (e.g., competing priorities and demands among agencies) to the individual treatment provider level (e.g., limited capacity or lack of facility licensing to identify, secure, and manage multiple funding streams).

For example, determining whether to provide services directly or to negotiate for services with outside agencies is a critical decision, but at times it may be made based on a limited understanding of other agencies' funding streams. When it comes to the complexities of multiple funding streams and a comprehensive view of how they fit together, staff knowledge and experience are usually limited. Staff members typically specialize in a specific program area and may have indepth understanding of only major funding

streams, such as Medicaid or the SAPTBG requirements. In addition, at both the State and the local levels, each service system often sees the other's funding streams as difficult to access, and each views its funding as overcommitted and possibly threatened by collaboration. This self-protective attitude may lead to misunderstandings over whose money should cover which services: yours, mine, or ours?

For instance, when substance abuse treatment providers partner with child welfare services (CWS) agencies, there is sometimes an unspoken concern among substance abuse treatment providers that, if CWS agencies improve their ability to identify substance abuse among families in the child welfare system, then CWS will "come after our money." Some treatment providers, however, recognize that better identification of families with substance use disorders who are involved in the child welfare system may actually result in either an increase in substance abuse funding or an allocation of CWS funding to pay for the caregiver's treatment and services for the children, as has happened in some States and localities.

Another obstacle arising from competition among different agencies is the question of which agency "takes credit" for a client. This barrier highlights the continuing need to change the way that agencies are acknowledged for their contributions to a client's overall recovery; it points to the benefit of developing cross-agency outcomes that are negotiated among the various agencies serving the client and with the funders that support these agencies.

Understanding these and other barriers that affect a State's, community's, or treatment provider's ability to provide comprehensive services is a critical first step in developing a diversified and effective funding response.

C. Providing Comprehensive Services and an Appropriate Continuum of Care—Tradeoffs and Tensions From an Administrative and Organizational Perspective

An underlying—and often unspoken—tension exists among the recognized need to provide comprehensive services across the full continuum of care, the tradeoffs and costs required to implement such practice, and the current state of readiness and willingness of most organizations and communities to make this happen.

Barriers to Providing the Appropriate Level of Services

Despite an acknowledged need for research demonstrating positive outcomes associated with comprehensive treatment programs for women and their children, current financing arrangements often pressure providers to reduce lengths of stay and intensity of services (Cartwright & Solano, 2003). Categorical and other funding often does not enable treatment agencies to provide the adequate level, duration, or intensity of services to ensure positive outcomes. Specialized treatment programs or services for women are vulnerable to budget cuts, as the broader range of services targeted to women's needs typically results in higher rates of patient costs (Grella, Joshi, & Hser, 2000). In fact, discretionary funding available through RFPs is sometimes still allocated to the lowest

bidders, without quality of services being appropriately reviewed and factored into funding decisions.

To ensure the availability of sufficient effective services, programs may need to secure additional layers of funding from existing or additional sources. For example, programs that do not have funding to provide aftercare or continuing care services to women and their children may fall short in educating about relapse prevention, resulting in treatment readmission. Although on the surface readmission may seem like a positive action, this revolving-door effect may actually result in higher overall costs because of women being readmitted to ineffective and underfunded treatment. Some have observed, in fact, that low-dosage programs create high turnover caseloads ***and*** lower overall outcomes.[2] This is an issue of program quality as well as funding resources.

Tracking the Effectiveness of Comprehensive Services—Building the Link Between Outcomes and Management Information Systems

Comprehensive programs also require more extensive administrative overhead in at least two areas: collection and analysis of outcomes data and financial management of multiple funding streams. It is not widely recognized that the two topics are closely linked.

> ***But How Can We Find Time To Do All That Work?***
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> *Without question, a multisource funding strategy takes time that small agencies may not have. Some providers have responded to this challenge by working through their provider associations to pursue RFPs and grant updates jointly, sharing in the costs of staffing they cannot afford separately. Other providers, such as those in Arizona, have worked with State agencies to obtain annual inventories of prevention and treatment funding that help guide decisionmaking. A sustainability plan takes work, but it may be the only guarantee that an agency will survive beyond ad hoc grant chasing.*

Establishing an outcomes-based system requires substantial staff time and other resources to collect, enter, track, and analyze data and then translate that knowledge into service improvements. It also involves investing organizational resources to obtain and maintain an adequate management information system. Yet documenting the effectiveness of these more comprehensive programs is all the more critical to justify multiple funding from multiple funders. It can make the case for realignment of priorities and redirection of funds away from the least effective programs to those with proven results.

Outcome data have become a "must have" rather than a "nice to have" component of treatment programs. As former SAMHSA Administrator Charles G. Curie noted, "Increasingly, policymakers and budget planners at all levels—Federal, state, local, and private—are basing funding decisions on outcome data." To increase the availability of meaningful outcome data, SAMHSA has created National Outcome Measures (NOMs). SAMHSA and the States hope to bring all States to full NOMs reporting by the end of fiscal year (FY) 2007 (Substance Abuse and Mental Health Services Administration, 2005b). As of March 2008, for the substance abuse treatment NOMs, all States are reporting the client count domain of retention and the access/capacity NOMs, while a

range of 31 to 45 States are reporting on the other five defined treatment NOMs (abstinence, employment status, number of arrests, living arrangement and length of stay in treatment). Thirty States are reporting on all defined substance abuse treatment NOMs. Several of the treatment measures are still in development (Substance Abuse and Mental Health Services Administration, 2008b). (More information on NOMs is available at http://www.nationaloutcomemeasures.samhsa.gov.)

Documenting the effectiveness of expenses incurred from providing both more intensive levels of care and more comprehensive programming requires advanced data systems and outcomes analyses that many programs currently do not have the capacity (i.e., resources) or capability (i.e., knowledge or expertise) to implement.

When it comes to financial management of multiple funding streams, costs are incurred not only to seek out grants but also to maintain and administer them. Each funding stream typically has its own match rates, data collection and reporting requirements, and cost allocation rules; these inconsistencies can discourage providers' efforts to provide comprehensive services. As a result, programs that seek to align funding from multiple sources and agencies will need to develop a solid financial management plan and likely have to invest resources in an exceptional management information and cost-accounting system that enables them to allocate, track, and report on treatment expenditures (Lind, 2004; see also Hayes, 2002).

Advice From SHIELDS

At SHIELDS, "we automated everything from day one." Because managing all fiscal and programmatic requirements is a significant challenge, "one of the first things we look at is what it takes to administer a grant." Still, SHIELDS sometimes alters its funding strategy midstream if, in hindsight, the management and administrative difficulties prove to be too overwhelming and costly for the organization.

A key element of SHIELDS's success is hiring and retaining high-quality staff with administration and management expertise—indeed, its most junior administrator is a 14-year veteran of the organization. The agency strongly advises other providers to strengthen their client and financial tracking capabilities.

This close link between outcomes evaluation and client/fiscal management information systems becomes vital to the organization. Without an adequate outcomes infrastructure that can track costs or services received by clients, neither reports to funders nor evaluation of outcomes can be done in sufficient depth to justify the funding. The two data efforts—client outcomes and agency costs by services—must be connected. In doing so, an organization's potential to seek new funding is greatly strengthened by its ability to "tell a story" about how current funds are used, for which clients, with what results, and at what costs. That "story" must be communicated effectively both internally (to fundraising and development staff) and externally (to current and prospective funders and other systems of care in which clients are involved). Effective internal communication requires that fundraising and development staff work closely with information technology and evaluation staff. In an organization that focuses on its future and engages in long-term planning, these parts—development, evaluation, and information technology—are all

integrated. This internal synergy, in turn, enables development staff to easily convey the program's results to funders and others in the community and more successfully make the case for funding.

The bottom line: In the short run, developing an integrated service delivery system is more expensive and time consuming, and capacity building incurs more overhead costs. In the long run, however, an established integrated network maximizes use of funds, reduces duplication of services, increases positive treatment outcomes, and contributes to an organization's overall sustainability (Center for Substance Abuse Treatment, 2000).

D. The Movement Toward Unified Financing—What Is It? What Does It Seek To Achieve?

To create and sustain an integrated and flexible continuum of care for women, children, and families, States and communities are using unified fiscal planning. Unified fiscal planning is shorthand for a variety of available financing strategies critical to supporting comprehensive service programs. Commonly used strategies include decategorization, pooled funding, blended funding, braided funding, wraparound, and refinancing (Crocker, 2003). Often these terms are used interchangeably or without clear meaning. These and other terms as used in this paper are defined below.[3]

Strategies To Increase Funding Flexibility[4]

- *Decategorization.* Decategorization is a Federal- or State-level strategy used to reduce or eliminate constraints imposed by existing categorical funding streams. It creates more flexibility by removing narrow eligibility requirements and restrictive allocation rules. In return for increased flexibility is often greater accountability for outcomes. The downside to decategorization is that it usually requires State legislative action and overcoming strong, vocal constituencies that oppose combining programs or directing funding to other designated populations. One method of decategorization is to establish a "master contract" between a funding agency with fiscal and administrative responsibility for several categorical programs and a service delivery provider. This type of service agreement facilitates more comprehensive, responsive, and coordinated service delivery (Lepler, Uyeda, & Halfon, 2006). (See box, Increasing Funding Flexibility—Selected State Practices, for two case examples from New York.)

- *Pooled or Blended Funding.* This strategy, which may be implemented at the State or local level, is used to formally combine a portion of funds from several agencies or sources into a single, unified funding stream. For example, State officials may combine a portion of Federal block grant and other State funds into a block grant to counties and other local entities.[5] A new funding structure is often developed to administer and allocate the funds to the participating agencies based on negotiated contracts. An advantage to blended funding is that local grantees have the authority to prioritize their funding allocations and can use funds as they see fit to achieve project goals. Pooled dollars can be used to

support activities such as collaboration, coordination, and program planning that are not directly reimbursable through specific Federal categorical programs. In addition, blending multiple streams into a single stream can reduce reporting burdens. The challenge, however, is that agencies may be reluctant to contribute to a blended pool for fear of losing control over "their money." Hayes, Flynn, and Stebbins (2004) note, "Attempting to blend separate funding streams is fundamentally about bridging the differing philosophies and priorities that led to the creation of categorical streams in the first place."

- *Braided Funding.* Braided funding is generally used by an individual agency or program to obtain and weave together multiple funding sources to create and support needed comprehensive services. Resources are coordinated to maximize capability, efficiency, and effectiveness, but various categorical requirements remain intact and funds must be used for their original intent. Although braided funding is less flexible than pooled or blended funding, the funding sources remain distinct and resources can be tracked more closely. The downside is that braided funding entails more sophisticated and extensive fiscal accounting, which only large provider agencies may be equipped to handle.

- *Wraparound.* Wraparound is a process in which clients receive a full range of services to meet their needs. Behar (1986) introduced the term two decades ago, defining wraparound as a way to "surround multi-problem youngsters and families with services rather than with institutional walls, and to customize these services." The process should be an interagency, community-based, collaborative approach and entail flexible service delivery approaches and flexible funding (Burns & Goldman, 1999). Maximum funding flexibility is needed to respond to the dynamic nature of families and their shifting situations and needs. The difficulty is that wraparound typically has been implemented for categorically defined populations, which results in restricting funding to that one group. Given the multiple needs of some children of people who abuse substances, wraparound could potentially address developmental and other issues in a preventive manner.

Increasing Funding Flexibility—Selected State Practices

- *New Mexico*: The Behavioral Health Purchasing Collaborative, created by State legislation, blends State and Federal funding for substance abuse, mental health, criminal justice, child welfare, and Temporary Assistance for Needy Families (TANF). One of its primary tasks is to improve access, quality, and value of mental health and substance abuse services (Perlman & Dougherty, 2006).
- *New York:* The State's first master contract, implemented in 1991 and still in effect, was with the Door, a nonprofit, comprehensive youth development organization. It combined seven categorical contracts from three State government agencies (Office of Alcoholism and Substance Abuse Services, Department of Health, and Division for Youth) into one contract totaling $1.4 million. A second master contract, the Consolidated Child and Family Health Grant, which has been in effect since 1997, combined seven categorical Federal and State grants into a master contract totaling $3.4 million to provide a wide range of health and supportive services for children and their families (Lepler et al., 2006).
- *Washington*: The Comprehensive Program Evaluation Project (CPEP), also known as Safe Babies, Safe Moms, seeks to improve the health and welfare of women with substance use disorders and their young children. Under CPEP, the Department of Alcohol and Substance Abuse, Economic Services Administration, Children's Administration, Medical Assistance Administrations, Research and Data Analysis, and Department of Health braid funding to provide inpatient substance abuse treatment through community-based treatment agencies, as well as housing support services (Washington State Department of Social and Health Services, 2002).
- *Wisconsin*: Wraparound Milwaukee provides services to children with serious mental health and emotional needs at immediate risk of placement in a residential treatment center, juvenile correctional facility, or psychiatric hospital. Funds are pooled from the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the State Division of Heath Care Financing (which operates Medicaid). Wraparound Milwaukee, acting as a public care management entity, oversees the management and disbursement of those funds (Milwaukee County Health and Human Services, n.d.). In addition, Milwaukee implemented the Wisconsin Support Everyone's Recovery Choice (WIser Choice) program as part of a complete redesign of the county's substance abuse treatment system. The WIser Choice system streamlined the number of substance abuse intake points and implemented uniform program criteria and assessment protocols to establish standardized patient placement criteria and facilitate payment authorization for services. WIser Choice braids together multiple sources of existing funding (e.g., Access to Recovery grant funding, TANF, SAPTBG funds, State community aids, local tax levy) to support a single point of entry and single coordinated case plan. The three Central Intake Units identify a client's eligibility for multiple programs, prioritize which funding source to tap, and authorize payment for services. The automated system allows workers to develop individualized funding plans and can be expanded to include additional funding sources.
- *Wyoming:* The 21st Century State Incentive Grant braided $17 million in funds from the State Incentive Grant, the 21st Century Community Learning Centers, Safe and Drug-Free Schools, and the Tobacco Settlement Trust Fund into a single alcohol, drug, and tobacco prevention initiative for youth. The effort involved 26 grantee communities in 23 counties; the Wyoming Department of Education serves as the fiscal manager (Wambeam, Pruden, Anderson, & Feldman, 2006).

Strategies To Maximize Revenues

- *Leveraging*. Leveraging is a strategy to maximize Federal funding by taking greater advantage of Federal programs that provide matching funds contingent on State, local, or private spending. Expenditures must be on allowable activities as defined in the Federal statutes. This may entail designating current State or local spending to be eligible to draw down new Federal matching funds (see box below on Florida's example) or spending new State or local dollars to qualify for the maximum share of Federal funding. For local entities seeking to receive leveraged funds, a key challenge is to obtain commitments from the State, which is typically the recipient of these dollars.

> ***Creating a More Effective Matching Funds Strategy— How Florida Sought To Better Leverage Federal Funds***
>
> Several years ago, the State of Florida recognized it needed to do a better job of drawing down available Federal matching funds. The State determined it missed out on an estimated $900 million in Federal matching funds because of a lack of State and local matching funds. In response, the Governor of Florida signed into law the Local Funding Revenue Maximization Act in 2003. The act allows private donations from State and local charities, such as the United Way, community foundations, and businesses, to be certified as local matching funds and counted as part State spending required to draw down Federal funds for local prevention services and child development programs. Some Florida counties have developed long-term revenue maximization strategies that take advantage of the legislation, whereas others have expressed interest but require more information on the logistics of implementing such a strategy (Carasso & Bess, 2003; Technical Assistance Collaborative, Inc., 2004).
>
> In addition, in 2005, the Florida Legislature authorized a bill (SB 2600) to develop a local matching program to fund new specialized substance abuse services (community detoxification, intervention, community support) using local county tax funding (Abbott, Bryant, Daigle, & Engelhardt, 2006).

- *Refinancing.* Refinancing is a specialized form of maximizing the use of available Federal entitlement funds (e.g., Medicaid, Title IV-E Child Welfare) to pay for services currently financed with public State and local funds. States aggressively pursue these monies, typically by increasing program eligibility rates and expanding coverage. The new Federal funds are used to pay for existing standard services being covered by State general funds or other local revenue. The freed-up State and local funds are then shifted to other programs, which may include comprehensive service initiatives (Orland, Danegger, & Foley, 1995). It is critical to note that the additional Federal funds are not used to reduce current spending, but rather are used to invest in more and enhanced services (Center for the Study of Social Policy, 2001). Major challenges with refinancing include its complexity, difficulty in securing agreement on how refinanced funds will be used, and ensuring the freed-up money remains in the desired service system (e.g., substance abuse treatment, maternal and child health). The potential and form of

refinancing may be affected by pending changes in Federal entitlement programs—in particular, Medicaid.

- *Administrative claiming.* Administrative claiming is a form of refinancing that makes use of available child welfare (Title IV-E) and Medicaid (Title XIX) administrative funds to cover case management, outreach, eligibility determination, program planning, service coordination, and other administrative activities associated with enhancing access to services. Administrative claiming is based on a match of local funding and therefore entails accounting for local spending on administrative activities allowable under a State's federally approved plan. Arizona, for example, reported that the increased use of Title IV-E Administrative Claiming and Medicaid targeted case management (TCM) would reduce the FY 2006 operating budget of its Department of Children, Youth and Families by $900,000 (Arizona Legislature Joint Legislative Budget Committee, 2005). Missouri has used the IV-E administrative claiming process to increase funding for its juvenile courts (Barlow, 2000). A significant benefit of these funds is that, once received, they become State monies that are free of Federal restrictions and can be spent for any State-approved purpose. The State agency and local communities can agree to channel these funds back into the community for reinvestment in community programs for women with substance use disorders and their children and families. It should be noted that the Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, imposes new limits on the claiming of Federal administrative funds under Title IV-E and Medicaid.[6] The impact of DRA on States' use of administrative claiming to maximize revenue is unknown at this time.

Strategies To Optimize the Efficiency of Existing Resources

- *Redeployment.* Redeployment acknowledges the benefits of prevention by moving funding from higher cost remedial services to lower cost prevention and early intervention programs and services. Redeployment can be thought of as a strategy to address the "you can pay me now or pay me later" dilemma, in which the latter is the more costly option. For example, providing substance abuse treatment services to women of child-bearing age *before* they get pregnant or, at minimum, during the earliest possible stage of their pregnancy increases the likelihood of positive birth outcomes and reduces the much more extensive costs associated with meeting the health, developmental, socioemotional, educational, and other needs that an infant exposed to substances may have over the course of its lifetime.

- *Reinvestment.* This strategy is related to redeployment but takes efficiency efforts further by identifying the cost savings generated by effective programs and reinvesting those savings to support new or expanded services. Reinvestment acknowledges that it costs less to invest in producing good results among children and families than it does to treat the effects of bad results. In short, reinvestment rewards effective programs or initiatives by not only allowing them to "keep what

you save" but also giving them the flexibility in designing services that are most responsive to local client needs. In Maryland, for example, local collaboratives that have documented success in helping families stay together are authorized to use funds appropriated for out-of-home care to provide in-home services to at-risk families to prevent out-of-home placement.

- *Redirection.* Redirection is part of a longer term way of thinking about State and local funding. It involves identifying the least effective programs that are receiving funds and redirecting those resources to programs that are more effective and have documented results. In doing so, "new" resources are freed up in amounts that are likely greater than what is available from typical Federal or State sources. For example, if a State spends, on average, approximately $33 million of its State funds on substance abuse prevention and treatment,[7] redirecting the least effective 10 percent of that total would have the same effect as obtaining more than $3 million in "new" funds. Redirection will require candid and difficult community discussions (as discussed below), but it is also one of the best solutions to counter the often-voiced protest: "We can't do that without new money."

E. An Additional Word About Redirecting Funds

Reshaping the way existing dollars are spent is arguably one of the most ambitious efforts to improve financing (Hayes, Flynn, & Stebbins, 2004), while promoting quality by encouraging use of evidence-based programs. Yet, as previously mentioned, negotiations with other community-based service providers and policymakers about funding strategies need to address the difficult issue of redirecting funds away from less effective programs to those that have proven outcomes (including cost-benefit savings) for women, their children and families, and the community.

Parenting programs, for example, represent a possible opportunity for redirecting funds. Several evidence-based parenting skills training curricula (e.g., Strengthening Families Program, Nurturing Families) have been extensively evaluated and recognized as best practices. Funds for substance abuse treatment programs for women and their children should target those that have implemented proven parenting curricula or curricula based on a sound theoretical approach, as opposed to a curriculum that has not been rigorously evaluated or proved to result in positive outcomes.

It is important to note that redirection is not an argument that certain types of services or programs should be eliminated. The goals of these programs may be right on target, but flaws in their design and implementation have resulted in limited effectiveness. If the overall program goals remain important to the community, then funding should be redirected to a program that has documented it is more effective and works.

A first step to successful redirecting requires assessing the full array of available programs and funding in the community and identifying which agencies and funding

streams are best poised for change and inclined to respond to incentives and stimulus (e.g., facts and figures, public and political will) for genuine collaboration.

Redirection can result in three important gains: more financial resources for the most effective programs (that may be currently underfunded or at risk of shutting down due to lack of sustainable funding), more political capital to support the sustainability and replication of those programs, and, most important, increased program capacity to serve more women, children, and their families. Ignoring or overlooking redirection as a viable strategy to maximize existing funding may cause grantees to devote disproportionate time and energy to trying to secure limited, short-term, and highly competitive grant funding.

F. Summary

This section has provided treatment providers with background information and context that are essential to developing an effective comprehensive services funding strategy. It stressed the importance of providers knowing their clients and communities and building collaborative partnerships to enhance service delivery and leverage available funding. It also identified key barriers to managing multiple funding sources and providing comprehensive services across the continuum of care. Finally, it highlighted several funding strategies to increase funding flexibility, maximize revenues, and improve the efficiency of existing resources.

The next section identifies the main Federal funding streams that potentially can be used to support substance abuse treatment and related services for women with substance use disorders and their children and families.

III. PRIMARY FEDERAL FUNDING SOURCES

A. Information on Expenditures and Primary Funders

To help providers develop effective financing strategies, it is important to provide background on the complex and evolving substance abuse treatment funding system. Substance abuse treatment programs are not financed in the same way as other health programs. Unlike other health programs, the majority of treatment programs are supported with public funds. Spending for substance abuse treatment—in comparison with other health services—is often more centralized and shaped by government decisions, and therefore more influenced by matters of direct public policy (Meara & Frank, 2005).

Financing of substance abuse treatment entails major public participation at Federal, State, and local levels of government. Public substance abuse treatment programs have usually relied on three funding sources: the Federal SAPTBG, Medicaid reimbursement, and State General Funds. Today, these customary funding sources are supplemented by other potential funding sources, most of which are at the Federal level (e.g., TANF, IV-E Child Welfare Services, Social Services Block Grant [SSBG], discretionary grant projects). Additional spending comes from State and county earmarked taxes, fines and fees, and other sources. Most provide funding for substance abuse treatment within the context of other services, such as job training, child protective services, or criminal justice (Center for Substance Abuse Treatment, 2000).

Federal Funding—A Basic Introduction

There are essentially four types of Federal and State programs:

- *Entitlement programs*. Open-ended, uncapped appropriations that provide funding to serve all children and families that meet the program's eligibility criteria (e.g., Medicaid, Title IV-E).
- *Formula (or block) grants*. Capped appropriations that provide a fixed amount of funding to States or localities based on established formulas, which vary from grant to grant and require a State match. Formulas are usually tied to population characteristics (e.g., TANF).
- *Discretionary grants*. Capped appropriations for specific project grants awarded on the basis of competitive applications. Growing numbers of discretionary grant programs (e.g., Head Start) require collaborative efforts by a consortium of community agencies and organizations.
- *Direct payments*. Capped appropriations that support direct financial assistance to individual beneficiaries who satisfy eligibility requirements (e.g., Supplemental Security Income [SSI], Section 8 housing).

Source: Hayes, Flynn, & Stebbin, 2004

From 1993 to 2003, there have been important shifts in substance abuse treatment funding. National expenditures increased from $15 billion to $21 billion yet, as a percentage of all health, fell from 1.8 percent to 1.3 percent. Public payers also grew in importance relative to private payers. For instance, public payers made up 68 percent of

total substance abuse financing in 1993, but by 2003, this figure rose to 77 percent (with States administering 58 percent of the funding). Nationwide, Medicaid accounted for approximately 23 percent of all public dollars spent on substance abuse treatment, while other State and local government funding composed about 52 percent of all public spending. SAPTBG represented an estimated 8 percent, and other Federal Government spending contributed another estimated 12 percent of total public spending. Medicare accounted for the remaining 6 percent of public payers (Mark et al., 2007).

In looking at private payers, nearly half (45 percent) of private substance abuse expenditures came from private insurance. However, when you consider private insurance as a percentage of all (public and private) substance abuse expenditures, it accounted for only 10 percent in 2003, down from 14 percent in 1993. (This followed a more substantial decline in private insurer spending from 26 percent in 1990 to 14 percent in 1993.) In contrast, private insurance payments made up 37 percent of all health care expenditures in 2003 (Mark et al., 2007).

The settings in which substance abuse treatment services are provided also differ from other health services; this situation has implications for how funds are used to pay for services (Meara & Frank, 2005). Recent data show a trend in the movement away from inpatient hospital care. In 1993, 41 percent of expenditures went for inpatient care, compared with 21 percent in 2003. In contrast, outpatient care increased from 34 to 49 percent. Expenditures for residential care also increased modestly during this period, from 20 to 23 percent (Mark et al., 2007). Such trends are important because they affect the extent to which the necessary range of services and appropriate levels of care are available to individuals with substance use disorders and their children and families.

B. Organization and Purpose of This Section

As the above data show, much of the funding for substance abuse treatment services comes from the public sector, from both the Federal and State governments. At the Federal level, these funds come from numerous complex programs that flow through several separate Federal agencies. This section is a guide to and brief overview of nearly 30 Federal programs and the specific opportunities they provide for funding treatment services and activities for women and their children and families.

This section focuses on the large pools of Federal funding such as block grant and other formula grant programs. Federal discretionary grant programs are mentioned briefly at the end. Major sources of State funding, such as State General Funds, alcohol and tobacco taxes, and tobacco settlement funds, which can be used for substance abuse treatment services are discussed in Section IV; private funding sources are addressed in Section V.

What follows in this section are summary tables that provide snapshots of some of the primary Federal funding programs and allowable uses of those funds. These summary tables are organized according to the three primary types of services outlined in the CSAT Comprehensive Model: clinical treatment services for parents/adults (e.g.,

counseling and education, screening and assessment, treatment planning), clinical treatment services for children and youth (e.g., therapeutic child care, developmental services), and clinical and community support services for individuals and families (e.g., family support, parenting and child development education, transportation, housing assistance).

To provide a more complete picture and help providers understand both the opportunities and the constraints associated with each primary Federal funding program, a more extensive narrative description of each funding source follows the summary tables. It is recommended that the information provided in the summary tables and the narratives be considered together to obtain the most accurate understanding of a given funding source. In addition, the narrative section includes additional funding programs not included in the summary tables (e.g., IV-E Foster Care, IV-E Adoption Assistance), which are not intended as a primary funding source for substance abuse treatment for parents.

*The summary snapshots indicate the allowable **potential** uses of these Federal funds for substance abuse treatment and related support services. However, the way these funds are actually used varies tremendously from community to community, governed in large part by State and local priorities, policies, politics, economics, leadership, and other extenuating factors. As discussed in Section II, treatment providers must have a thorough understanding of not only their community's funding landscape but also their community's and target population's needs, the current service delivery environment, and the community's budgeting and decisionmaking process.*

Because many funding decisions occur on an individual State-by-State basis, substance abuse treatment providers are strongly encouraged to check with the designated State agency for administering certain funds to learn more about how they might be used and whether certain services are allowable and covered by their State's approved plan for the applicable program. It is also important to look at any specific planned use of funds in the context of the individual Federal program's statutory purposes and limitations and cost allocation requirements.

The tables and narrative descriptions were compiled based on information from a variety of sources: the Catalog of Federal Domestic Assistance, grant program announcements, authorizing legislation, administering agency Web site program descriptions, and other related funding reports and literature.[8] In addition, representatives from various Federal agencies (e.g., SAMHSA and the Administration for Children and Families [ACF], including ACF's Office of the Assistant Secretary for Planning and Evaluation and Children's Bureau) reviewed selected information for accuracy.

C. At a Glance: Summary Tables on Primary Federal Funding Sources and Potential Allowable Substance Abuse Treatment and Related Support Services for Adults with a Substance Use Disorder and Children and Families Affected by a Parent's or Caregiver's Substance Use Disorder

Table 1. Primary Federal Funding Sources and Potential Allowable Substance Abuse Treatment and Related Support Services for Adults

Major Federal Funding Source	Service														
	Supports Substance Abuse Treatment	*Outreach*	*Screening*	*Assessment*	*Substance Abuse Counseling and Education*	*Crisis Intervention*	*Treatment Planning*	*Detox*	*Pharmacotherapy*	*Drug Use Monitoring*[1]	*Medical Care*	*Mental Health*	*Trauma/Violence Services*[2]	*Case Management/ Care Coordination*	*Continuing Care*
Substance Abuse Prevention and Treatment Block Grant (SAPTBG)	●	●	●	●	●	●	●	●[3]	●	●		●[4]	●	●	●
Temporary Assistance for Needy Families (TANF)	● nonmedical aspects		●	●	●		●	●[5]				●	●	●	
Medicaid[6]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Workforce Investment Act Adult Program			●	●	●		●					●		●	●[7]
Community-Based Child Abuse Prevention Program[8]		●	●	●		●									
Child Welfare Services IV-B, Subpart I			●	●		●						●	●	●	●
Promoting Safe and Stable Families IV-B, Subpart 2	●		●	●	●	●						●		●	
Developmental Disabilities Basic Support And Advocacy Grants											●	●			
Community Mental Health Services Block Grant	●[9]	●	●	●		●					●	●	●	●	
Community Services Block Grant[10]						●								●	

[1] Drug use monitoring may encompass toxicology testing or other means (e.g., verification of treatment attendance) to monitor an individual's compliance with his or her treatment case plan.
[2] Trauma-specific services include individual and group services that directly address the impact and effect of trauma on people's lives and facilitate recovery and healing from sexual, physical, and emotional abuse. There are a number of different service models, but most are cognitively behaviorally based, stress safety first, and address trauma within the context of substance abuse.
[3] Important caveat: SAPTBG funds cannot be used for inpatient hospital substance abuse programs, except when such treatment is a medical necessity and the individual cannot be treated in a community-based, nonhospital, residential treatment program. In most instances, it can only pay for social setting detoxification.
[4] SAPTBG funds can be used to screen and assess for mental health issues but not to provide direct mental health services; direct services would be covered under the Community Mental Health Services Block Grant.
[5] TANF funds may be used for social model/setting detoxification but not for medical model detoxification that usually occurs in an inpatient hospital setting and is closely monitored by medical personnel.
[6] As of January 2007, the Federal Medicaid program will pay for screening and brief intervention programs for alcohol and drug addiction.
[7] Workforce Investment Act funds may be used to provide "followup services."
[8] Community-Based Child Abuse Prevention Program funds can be used for outreach, screening, and assessment if it is intended as part of a child abuse prevention effort.
[9] CMHS Block Grant funds can be used to support integrated treatment services for individuals with co-occurring mental health and substance use disorders.
[10] The use of Community Services Block Grant (CSBG) funds for such services may be allowable if the intended purpose is the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals to become fully self-sufficient.

Table 1. Primary Federal Funding Sources and Potential Allowable Substance Abuse Treatment and Related Support Services for Adults															
Major Federal Funding Source	**Service**														
	Supports Substance Abuse Treatment	*Outreach*	*Screening*	*Assessment*	*Substance Abuse Counseling and Education*	*Crisis Intervention*	*Treatment Planning*	*Detox*	*Pharmacotherapy*	*Drug Use Monitoring*[1]	*Medical Care*	*Mental Health*	*Trauma/Violence Services*[2]	*Case Management/ Care Coordination*	*Continuing Care*
Maternal and Child Health Services Block Grant – Title V	●	●	●	●		●			●	●	● prenatal care	●		●	
Social Services Block Grant	●	●	●	●	●	●	●	●	●		● [11]	●	●	●	●
Title V – Community Prevention Incentive Grants	●														
Family Violence Prevention and Services	● [12]	●	●	●	●	●						●	●	●	
Housing Opportunities for Persons with AIDS	●	●		●	●	●	●	●	●		●	●	●	●	●
HIV Care Formula Grants	●	●	●	●	●	●	●	●	●		●	●	●	●	●
Project for Assistance in Transition from Homelessness	●	●	●	●								●		●	
Residential Substance Abuse Treatment for State Prisoners	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● [13]

[11] Under the Social Services Block Grant (SSBG), medical care (other than family planning services, rehabilitation services, or initial detoxification of an individual who is dependent on alcohol or drugs) is not allowed unless it is "an integral but subordinate part" of an allowable social service. ACF's Office of Community Services uses the Uniform Definitions of Services, as established in Title XX, to determine allowable expenditures under SSBG. These are available on the SSBG Web site at http://www.acf.hhs.gov/programs/ocs/ssbg/procedures/unifdef.html.

[12] Family Violence Prevention and Services State Grants may be used for substance abuse prevention and referrals to substance abuse treatment.

[13] Aftercare could include both parent and children's services, if such services are part of the overall treatment program.

Table 2. Primary Federal Funding Sources and Potential Allowable Services for Children and Youth Affected by a Parent or Caregiver with a Substance Use Disorder

Major Federal Funding Source	*Service*										
	Intake	*Screening*	*Assessment*	*Care Planning*	*Residential Care*	*Case Management*	*Therapeutic Child Care*	*Substance Abuse Education and Prevention*	*Medical Care and Services*	*Developmental Services*	*Mental Health and Trauma Services*
SAPTBG		●	●	●	●	●	●	●	●	●	●
TANF					●	●	●	●			●
Community-Based Child Abuse Prevention Program[14]		●	●	●		●			● referrals to	● referrals to	
Child Abuse and Neglect State Grants	●	●	●			●					●
Child Welfare Services IV-B, Subpart I		●	●	●		●	● therapeutic foster care (capped $)				
Promoting Safe and Stable Families IV-B, Subpart 2		●	●	●	●		● therapeutic foster care	●		● referrals to	● [15]
Child Care and Development Fund/Child Care and Developmental Block Grant							●				● [16]
Medicaid/Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT)	●	●	●	●	●	●		● [17]	●	●	●
State Children's Health Insurance Program (SCHIP)		●	●			●		● [18]	●	●	●
Individuals with Disabilities Education Improvement Act (IDEA)		●	●	●		●	● [19]		● medical exam	●	●
Developmental Disabilities Basic Support and Advocacy Grants									●	●	●
Community Mental Health Services Block Grant		●	●	●		●	●	●	●		●

[14] Community-Based Child Abuse Prevention Program funds can be used for these services if they are intended as part of a child abuse prevention effort.
[15] Title IV-B funds permit States to establish two-generation intervention models to provide parent–child mental health and behavioral interventions for families with young children.
[16] States have used the 4 percent quality set-aside, State-appropriated, and/or TANF funds to finance early childhood mental health consultation in child care settings.
[17] Also supports substance abuse treatment for children and adolescents.
[18] Also supports substance abuse treatment for children and adolescents.
[19] Individuals with Disabilities Education Improvement Act Part C and IDEA Pre-school grants only; not IDEA Part B funds.

Table 2. Primary Federal Funding Sources and Potential Allowable Services for Children and Youth Affected by a Parent or Caregiver with a Substance Use Disorder											
	Service										
Major Federal Funding Source	*Intake*	*Screening*	*Assessment*	*Care Planning*	*Residential Care*	*Case Management*	*Therapeutic Child Care*	*Substance Abuse Education and Prevention*	*Medical Care and Services*	*Developmental Services*	*Mental Health and Trauma Services*
Community Services Block Grant[20]											
Maternal and Child Health Services Block Grant – Title V		●	●	●		●	●	●	●	●	●[21]
Social Services Block Grant		●	●	●	●	●	●	●	●	●	●
Chafee Foster Care Independence Program		●	●			●		●	●[22]		●
Juvenile Accountability Incentive Block Grants		●	●	●		●		●[23]			●
Title V – Community Prevention Incentive Grants[24]		●	●	●		●		●			●
Family Violence Prevention and Services				●[25]		●		●			●
HIV Care Formula Grants		●	●			●		●	●		●

[20] The purpose of the CSBG program is to provide assistance to State and local communities for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals to become fully self-sufficient. The authorizing legislation does not identify specific services to be funded; States have flexibility to use CSBG funds to provide services that address employment, education, income management, housing, nutrition, emergency services, and health. Check with your State CSBG administrator for more information and see the accompanying narrative CSBG profile in this section of the report for examples of how States have used CSBG funds to serve families affected by substance use disorders.

[21] Can pay for such services, including individual, group, and family therapy, but most exclude inpatient/outpatient care.

[22] The Foster Care Independence Act gives States the option of extending Medicaid to young people ages 18–21 who are transitioning from foster care.

[23] These funds can also be used for substance abuse treatment and juvenile drug court programs.

[24] Title V—Community Prevention Incentive Grants can fund "early childhood programs," but this is not defined.

[25] Care planning could be supported in the context of custody and visitation planning.

Table 3. Primary Federal Funding Sources and Potential Allowable Support Services for Individuals and Families Affected by Substance Use Disorders

Major Federal Funding Source	***Service***											
	Primary Health Care	*Life Skills*	*Parenting and Child Development Education*	*Family Programs and Family Strengthening*	*Vocational, Educational Remediation, and Support*	*Employment Readiness and Support*	*Linkages With CWS, TANF, and Legal*	*Housing Support Services*	*Recovery Community Support Services (including faith-based organization support)*	*Child Care*	*Transportation*	*Recreational Services*
SAPTBG	●		●	●	●	●	●	● (group homes)	●	●	●	●
TANF	●[26]	●	●	●	●	●	●	●	●	●	●	●
Medicaid	●	●		●		●	●	●	●		●	
Workforce Investment Act Adult Program[27]		●			●	●	●	●	●	●	●	
Child Abuse and Neglect State Grants	●											
Community-Based Child Abuse Prevention Program[28]			●	●					●			
Child Welfare Services IV-B, Subpart I			●	● (reunification)		●	●	●	●	●	●	
Promoting Safe and Stable Families IV-B, Subpart 2		●	●	●	●	●	●	●	●	● (including respite care)	●	●
Child Care and Development Fund/ Child Care and Developmental Block Grant										●		
EPSDT	●											
SCHIP	●											
IDEA		●[29]	●[30]		●						●	●
Developmental Disabilities Basic Support and Advocacy Grants	●			●	●	●	●					

[26] Can be used to support pre-pregnancy and family planning.
[27] Allowable supportive services are *not* limited to select examples highlighted in the law (e.g., transportation, child care, dependent care, housing); these decisions are left to State and local discretion.
[28] Community-Based Child Abuse Prevention Program funds can be used for these services if they are intended as part of a child abuse prevention effort.
[29] Social skills and daily living skills training for children.
[30] Individuals with Disabilities Education Improvement Act Part B and C funds, not pre-school grants.

Table 3. Primary Federal Funding Sources and Potential Allowable Support Services for Individuals and Families Affected by Substance Use Disorders

Major Federal Funding Source	***Service***											
	Primary Health Care	*Life Skills*	*Parenting and Child Development Education*	*Family Programs and Family Strengthening*	*Vocational, Educational Remediation, and Support*	*Employment Readiness and Support*	*Linkages With CWS, TANF, and Legal*	*Housing Support Services*	*Recovery Community Support Services (including faith-based organization support)*	*Child Care*	*Transportation*	*Recreational Services*
Community Mental Health Services Block Grant	●	●	●	●	●	●		●	●	●	●	● [31]
Community Services Block Grant[32]												
Maternal and Child Health Services Block Grant – Title V		●	●	●					●	● (respite)	●	● [33]
Social Services Block Grant	●	●	●	●	●	●	●	●	●	●	●	●
Chafee Foster Care Independence Program	● [34]	●			●	●		●	●	●	●	●
Juvenile Accountability Incentive Block Grants		●	●	●	● for youth	● for youth	●		●			
Title V – Community Prevention Incentive Grants			●	●	● education for children				●			●
Family Violence Prevention and Services		●	●	●	●	●	●	● immediate shelter		●	●	
Housing Opportunities for Persons with AIDS	● adult only	●			●	●	●	●	●	● [35]	●	
HIV Care Formula Grants	●	●			●	●	●	●	●	●	●	
Project for Assistance in Transition from Homelessness	● referral to				● referral to	● referral to		● (limited)	● peer support			
Residential Substance Abuse Treatment for State Prisoners	●	●	●	●	●	●	●	●	●			

[31] Therapeutic recreation for children with serious mental and emotional disorders (Bazelon Center for Mental Health Law, 2003)
[32] The purpose of the CSBG program is to provide assistance to State and local communities for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals to become fully self-sufficient. The authorizing legislation does not identify specific services to be funded; States have flexibility to use CSBG funds to provide services that address employment, education, income management, housing, nutrition, emergency services, and health. Check with your State CSBG administrator for more information and see the accompanying narrative CSBG profile in this section of the report for examples of how States have used CSBG funds to serve families affected by substance use disorders.
[33] Therapeutic recreation for children (Bazelon Center for Mental Health Law, 2003)
[34] Chafee funds can be used for preventive health activities (including smoking avoidance, pregnancy prevention, nutritional education).
[35] Housing Opportunities for Persons with AIDS funds can be used for day care while an individual is in eligible HOPWA activities, not while working.

D. Descriptions of Primary Federal Funding Sources

This section provides an overview of each funding source that includes the purpose of funding program, type of funding provided and any matching or maintenance of effort (MOE) requirements, how funds flow and are managed, eligibility requirements, how funds may be used for substance abuse treatment and related support services, important restrictions, and special issues of note. The discussion is limited to the most essential pieces of information.[9]

Major funding sources are grouped according to the following categories:

- Sources for substance abuse treatment and related support services for parents/adults
- Sources for children's services
- Sources that can be used more generally for services for parents/adults, children, and/or families
- Sources for specific populations of adults and/or children (e.g., individuals with HIV/AIDS)

These categories should not be considered mutually exclusive; indeed, that the population breakdowns are not discrete is further evidence of the complexity of the funding landscape for comprehensive services for women and their children and families.

MAJOR FEDERAL FUNDING SOURCES FOR SUBSTANCE ABUSE TREATMENT AND RELATED SUPPORT SERVICES FOR PARENTS/ADULTS

- Substance Abuse Prevention and Treatment Block Grant
- Medicaid
- Temporary Assistance for Needy Families
- Workforce Investment Act Adult Program

1. The Substance Abuse Prevention and Treatment Block Grant

Responsible Federal Agency. SAMHSA, U.S. Department of Health and Human Services (DHHS).

General Description/Overview. SAPTBG accounts for approximately 40 percent of all public substance abuse prevention and treatment funds that flow through the SSAs (U.S. Department of Health and Human Services, 2003). The overall goal of SAPTBG is to support a national system of substance abuse treatment and prevention programs and services.

Type of Funding. SAPTBG is an annual formula grant awarded to States; allotments are based on weighted population factors. State matching funds are not required, but States

must continue to expend a certain level of State funds (i.e., State MOE) to be eligible for these grants. Funding for FY 2007 was approximately $1.76 billion; the FY 2008 enacted budget was also approximately $1.76 billion.

How Funds Are Managed. To receive SAPTBG funds, the 50 States and the U.S. Territories must submit an annual application that details how they will expend the Federal funds, demonstrate compliance with SAPTBG requirements, and maintain State expenditures at a specified level. Each SSA is responsible for delivering these Federal funds to counties and individual providers. More than 10,500 community-based organizations receive SAPTBG funding from the States (Substance Abuse and Mental Health Services Administration, 2006).

Eligible Populations. All individuals are eligible to receive services covered by SAPTBG funds; there are no income restrictions. However, States must expend amounts from each SAPTBG award for the following set-asides:

- Primary prevention for individuals who do not require substance abuse treatment (at least 20 percent)
- HIV early intervention services (5 percent)
- Pregnant and parenting women (equal to or greater than a State's FY 1994 expenditures). Pregnant women and women with dependent children also receive priority admission preference

Use of Funds. In general, States have broad flexibility in using SAPTBG funds for a full range of substance abuse prevention and treatment services, including assessments, child care, job training and retention, medical care, mental health services,[10] domestic violence services, child abuse prevention, food, transportation, family support and reunification services, adoption support services, pregnancy prevention and family planning, youth development activities, relationship/marital counseling, and postpermanency services (Hutson, 2004; Lind, 2004).[11]

There are, however, some statutory requirements regarding pregnant and parenting women and intravenous drug users. Programs for pregnant women and women with dependent children must include: (1) the delivery of or referral for primary medical care for women, (2) the delivery of or referral for primary pediatric care for children, (3) the provision of gender-specific substance abuse treatment, (4) therapeutic interventions for children, (5) child care, (6) case management, and (7) transportation. Intravenous drug users must be provided with tuberculosis counseling, testing and treatment services, and early intervention services for those at risk of contracting HIV disease.

How Substance Abuse Treatment Providers Can Leverage These Funds

Only public or private nonprofit entities are eligible to receive SAPTBG funding. The SSA develops and enforces treatment standards and is responsible for establishing contracting, reimbursement, credentialing, and monitoring requirements. Treatment programs should contact the appropriate SSA for more information.[12]

Important Restrictions. SAPTBG funds may ***not*** be used for the following activities: (1) inpatient hospital substance abuse programs, except when such treatment is a medical necessity and the individual cannot be treated in a community-based, nonhospital, residential treatment program; (2) to make cash payments to recipients; (3) to purchase or improve land; (4) to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; (5) to purchase major medical equipment; (6) to provide financial assistance to any entity other than a public or nonprofit private entity; or (7) to provide individuals with hypodermic needles or syringes.

Of Special Note. Beginning in FY 2008, the SAPTBG application will be restructured to collect data, including NOMs,[13] that better reflect how States are managing and improving their substance abuse treatment systems. The State Outcomes Measurement and Management System will standardize operational definitions and outcome measures, link records to support pre- and post-service comparisons, and be used to develop benchmarking strategies.

2. Medicaid

Responsible Federal Agency. Centers for Medicare and Medicaid Services (CMS), DHHS.

General Description/Overview. The Medicaid program finances health insurance for qualifying beneficiaries (see Eligible Populations below). Within broad Federal guidelines and CMS oversight, each State administers its own program; establishes eligibility standards; determines the type, amount, duration, and scope of services; and sets the rate of payment for services. Thus, Medicaid varies considerably from State to State. Substance abuse treatment services are largely considered optional services the State may elect to cover.

Type of Funding. Medicaid is an open-ended entitlement for States financed by State and Federal funds. States must provide matching funds to receive Federal funds. The level of State-matching funding varies and is based on a number of factors. In some States, counties contribute to a portion of a State's cost. The Federal match may range from 50 percent to 83 percent; it varies from State to State and from year to year. In FY 2007, Congress will spend approximately $192 billion on Medicaid; FY 2008 Federal outlays are estimated to be $204 billion (Office of Management and Budget, 2007).

How Funds Are Managed. Federal funds must go to a designated State Medicaid Agency, which also varies from State to State. In most States, Medicaid funds do not follow to the SSA for substance abuse.[14] Providers should contact their State's department of health and human services for more information.

Eligible Populations. Medicaid eligibility varies by State and is based on income, age, participation in other Federal programs, and pregnancy status. In general, all covered individuals fall into three categories: children and their parents, the elderly (ages 65 and

over), and individuals with permanent disabilities. For pregnant women and children younger than 6, Federal law requires a minimum income ceiling of 133 percent of the Federal poverty level; for children between ages 6 and 18, the minimum is 100 percent of the poverty level. For other population groups, States may establish their own income standards. In the past, States could apply for a waiver to cover other population groups.[15] With the passage of DRA, States can now submit State plan amendments instead of waivers to CMS, thereby quickening the approval process. DRA also requires documentation of citizenship for most new applicants and current beneficiaries at redeterminations.

The discussion on use of funds below focuses on services for adults. The use of Medicaid and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for children, the child health benefit package of Medicaid, are discussed below in Major Federal Funding Sources for Children's Services.

Use of Funds. Medicaid funds are used to provide both mandatory and optional services. States must provide 12 mandatory services, but the service categories below are ones under which a mental health or substance abuse service may be delivered (Robinson, Kaye, Bergman, Moreaux, & Baxter, 2005):

- Inpatient medical hospital services (excludes substance abuse specialty care for adults)
- Outpatient medical hospital services
- Rural health clinic services
- Federally qualified health center services
- Physician services (including psychiatrists)

Optional services under which States can establish coverage of mental health and substance abuse services can include (Robinson et al., 2005):

- Clinic services
- Other rehabilitation services
- Other licensed practitioner services (e.g., psychologists, psychiatric social workers)
- TCM
- Inpatient hospital services for individuals younger than 22
- Home- and community-based services

Recently, two new Medicaid reimbursement codes were added for insurance claims, and in January 2007 the Federal Medicaid program began paying for screening and brief intervention services for alcohol and drug addiction. Before this change, Medicaid did not have a defined set of substance abuse treatment services that were reimbursable at the Federal level. Rather, substance abuse treatment provided under Medicaid has been largely a State discretionary program, with States determining the type, duration, and scope of treatment services in their State plans. As a result, different States have different levels of coverage. States without a specific substance abuse State plan can receive

reimbursement if the treatment is provided under a Medicaid services category that qualifies for Federal matching funds. For example, in most States, detoxification provided as a part of a general inpatient hospital treatment is reimbursable under Medicaid (Rubinstein, 2002). Substance abuse treatment providers that are considering targeting their programs to the Medicaid population should check their State's coverage and payment rates to determine financial feasibility and, if needed, explore other funding options in greater depth (Center for Substance Abuse Treatment, 2006).

All but two States (Arkansas and Mississippi) cover at least a limited package of substance abuse services for adults; most all define their substance abuse coverage in the optional medical service categories because of their flexibility (Robinson et al., 2005). For instance, under the "other rehabilitation" benefit, covered services include those that restore basic life skills necessary to function independently in the community, redevelopment of communication and socialization skills, and family education and other family services exclusively related to the treatment or rehabilitation of other covered individuals. Services under the "clinic services" option must be rendered onsite in the clinic and under the direction of a physician (except for individuals who are homeless). One benefit of clinic services is that they can assist in screening for substance use problems, brief intervention, referral to the specialty system, and coordination of physical health problems for treatment of health complications. (For an extensive discussion on the types of services States provide under Medicaid, see Robinson et al., 2005.)

Many States use Medicaid to provide TCM, which Federal law defines as services that will assist individuals eligible under the State Medicaid plan in gaining access to needed medical, social, educational, and other services (Armstrong et al., 2006). Allowable case management services are understood to include assessments to determine service needs, development of a specific care plan, referrals and related activities to help the individual obtain needed services, and monitoring and followup (Smith, A.D., 2005). DRA imposes several changes regarding case management. First, it clarifies what is meant by case management in the context of the medical assistance definition, which may limit the scope of permissible TCM services. Second, case management services for children in foster care will no longer qualify for Medicaid reimbursement. And third, DRA requires States to bill other funding sources that are "legally obligated" to pay for TCM services first, before charging Medicaid. However, bills have been introduced in both the House and Senate that would place a 1-year moratorium on several DRA-imposed changes to Medicaid regulations, including those affecting rehabilitative services and TCM. The moratorium is intended to give Congress time to determine whether the rules are in line with congressional intent of DRA and are in the best interest of Medicaid beneficiaries.[16]

Other services that Medicaid can cover include child abuse prevention services, family support and family reunification services, adoption support services, mental health services, pregnancy prevention and family planning, and youth development activities (Hutson, 2004).

During the 1990s, five States (Maryland, Massachusetts, New York, South Carolina, and Washington) expanded services for pregnant women with substance use disorders using

Medicaid waivers initiated as demonstration projects. Projects varied widely but included the following components: outreach, screening and assessment, case management to link women with appropriate services, expanded Medicaid coverage for treatment and an enriched package of support services provided during treatment, and efforts to better integrate prenatal care and substance abuse treatment systems (Howell et al., 1998). Recently, under the Health Insurance Flexibility and Accountability initiative, other States have implemented waivers to expand Medicaid eligibility generally for pregnant women and higher income parents (Coughlin, Long, Graves, & Yemane, 2006; see also Artiga & Mann, 2005). Still other Medicaid waivers, such as Vermont's Global Commitment to Health waiver implemented in 2005, strengthen integration of community-based mental health and substance abuse treatment systems, among other things (American Public Human Services Association, 2005). States in which a significant portion of births are covered by Medicaid may use this situation as an opportunity to review prenatal coverage of screening for substance use disorders that may affect both mothers and their children.

How Substance Abuse Treatment Providers Can Leverage These Funds

To be paid for Medicaid reimbursable services, a substance abuse treatment agency must be an authorized Medicaid provider. Providers should contact the SSA responsible for the administration of Medicaid in their State to find out the process and requirements and what types of substance abuse treatment services their State plan covers.

A treatment agency certified as a Medicaid provider can position the program to obtain patients from other public-sector referral sources, such as social services and criminal justice. In some States, the criminal/juvenile justice system and drug court administrators often favor providers eligible for Medicaid reimbursement because some offenders' treatment can then be billed to Medicaid (Center for Substance Abuse Treatment, 2006).

Important Restrictions. A significant limitation of using Medicaid for substance abuse treatment for adults is the Institutions of Mental Disease (IMD) exclusion, which applies to alcohol, drug abuse, and mental health inpatient facilities. It prohibits Medicaid reimbursement of any services delivered in an institution with more than 16 beds that treats "mental diseases," which applies to most residential substance abuse treatment programs. For clients between ages 22 and 64 whose payment source is Medicaid, the IMD exclusion significantly limits access to the more intensive models of substance abuse treatment, which are often indicated for the most severely addicted clients. The two types of inpatient facilities most clearly affected are State and county mental hospitals and private psychiatric hospitals.

Despite the IMD exclusion, a number of States and localities have found ways to work within the existing rules to make residential-like substance abuse treatment services eligible for Medicaid reimbursement. For example, to avoid size limits, facilities with more than 16 beds can be legally divided into a number of smaller facilities with 16 or fewer beds. Moreover, smaller psychiatric hospitals can merge with larger general hospitals to create a general hospital with a large psychiatric "wing" (U.S. Department of Health and Human Services, 1999). A study highlighting the experiences of seven States

(Delaware, Maryland, Massachusetts, Oregon, Rhode Island, Tennessee, and Vermont) that waived the IMD exclusion under their Section 1115 waivers found that States used their waivers to incorporate mental health inpatient facilities, but (with the exception of Vermont) excluded substance abuse IMDs. In Delaware, Massachusetts, and Oregon the IMD exclusion applies to both mental health and substance abuse services; for the other four States (Maryland, Rhode Island, Tennessee, and Vermont) it applies only to mental health services (The Lewin Group, 2000).

Of Special Note. Most States now require Medicaid-eligible individuals to enroll in a managed care program, which has had both positive and adverse effects for individuals seeking substance abuse treatment.[17] Benefits may include increased access to treatment and primary health care, improved continuity of care, decreased hospitalization, and emphasis on early intervention and community-based programs. Problems include emphasis on prior approval requirements, medical necessity criteria, utilization review by unqualified case managers, and limited provider networks.

DRA resulted in other important changes to Medicaid, which could have conflicting results regarding eligibility and access to care. For instance, States may now restructure coverage through the use of a "benchmark" or "benchmark equivalent" plan (rather than a defined benefits package) and impose cost-sharing and premiums for Medicaid-covered benefits and services for certain groups. However, States also now have increased flexibility and use of home and community-based services. (For a more extensive discussion on implications of DRA, see Bazelon Center for Mental Health Law, 2006; National Governors Association, 2006; Rosenbaum & Markus, 2006; Rubin, Halfon, Raghavan, Rosenbaum, & Johnson, 2006.)

3. Temporary Assistance for Needy Families

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The TANF program replaced the Aid to Families with Dependent Children (AFDC) program in 1996, in accordance with the Personal Responsibility and Work Opportunity Reconciliation Act. TANF is the primary source of funding for State welfare reform initiatives. It provides assistance to States to provide an array of support and services consistent with the program's overall objectives (1) to assist needy families with children so that children can be cared for in their homes; (2) to reduce dependence by promoting job preparation, work, and marriage; (3) to reduce and prevent out-of-wedlock pregnancies; and (4) to encourage the formation and maintenance of two-parent families. On February 8, 2006, President George W. Bush signed into law DRA, which reauthorized TANF through 2010.

Type of Funding. TANF is a formula grant program in which each State receives a lump sum of funding based on its historic expenditures for welfare. Base funding for State and tribal family assistance is $16.5 billion annually. While the reauthorization eliminates some additional funding available under TANF (e.g., bonuses for high-performing States, supplemental funds for States with high population growth or high poverty rates), it

includes $150 million for project grants to support the promotion of healthy marriage and responsible fatherhood that is not included in the base total. TANF is categorized as mandatory fixed funding and therefore not subject to the yearly appropriations process. Like they must do for SAPTBG, States must contribute a specified amount of State funds each year through the annual MOE cost-sharing requirement.[18] The State MOE requirement is approximately $10 to $11 billion annually (Hutson, 2004). States must renew their funding status every 2 or 3 years by submitting their TANF plan to DHHS.

How Funds Are Managed. Federal funds go to the designated State agency certified by the Governor. Some States make policy and program decisions at the State level, whereas others leave most decisionmaking to the local or county level.

Eligible Populations. Assistance is limited to needy families with children, as defined by each State. In general, States have broad flexibility in setting eligibility requirements and can choose to vary eligibility criteria by TANF-funded program. For example, a State could have different eligibility requirements for cash benefits from those for child care assistance. In that way, low-income working families that may no longer be eligible for cash assistance could still receive child care assistance or other support services such as substance abuse treatment while working (National Governors Association, n.d.). In fact, the U.S. Government Accountability Office or GAO (formerly known as the U.S. General Accounting Office) estimated that at least 46 percent more families than are counted in the reported TANF caseload are receiving services funded with TANF/MOE funds (U.S. General Accounting Office, 2002). Individuals convicted of drug-related felonies are prohibited for life from receiving benefits under TANF and Food Stamp programs, unless a State modifies or opts out of this exclusion. A recent GAO review found that 32 States had laws exempting some or all convicted drug felons from the ban on TANF (U.S. Government Accountability Office, 2005).

Work is a mandatory activity for families receiving TANF, although States have some flexibility in determining what activities count toward work requirements and may choose to exempt certain individuals (e.g., victims of domestic violence, individuals with developmental disabilities) from work requirements. (See Of Special Note below for a related discussion on work requirements and the implications of reauthorization.)

Use of Funds. States have broad flexibility over the use of grant funds, so long as TANF-funded initiatives meet the statutory purposes of the program outlined above. TANF can fund a range of clinical treatment and support services, including child care, transportation, job training and education, domestic violence services, case management, vocational rehabilitation, mental health services, and parenting training. States adopting a family-centered approach can also use TANF funds to support what Johnson and Knitzer (2006) refer to as "two-generation strategies" (e.g., family counseling, family support activities, intensive home visiting) that involve both the parents and the children and provide more benefits for both generations, relying on the conviction that the best prevention for children is effective treatment for their parents.

The majority of States have, at some point, used TANF funds for substance abuse treatment services (see How States Have Used TANF Funds for Substance Abuse Treatment and Supportive Services below). TANF funds can be used for nonmedical aspects of substance abuse treatment services, such as screening and needs assessments for residential child care, that are performed by counselors, technicians, social workers, and others not in the medical profession and not provided in a hospital or clinic (U.S. Department of Health and Human Services, 1999). For instance, funds may support Family Resource Centers, which bring together a range of health and human service providers into one central community-based, multiservice center that serves the whole family. Unfortunately, because States are required to submit only information on how they spend TANF funds in broad programmatic categories (e.g., basic assistance, child care, employment, training), it is impossible to obtain a complete and detailed accounting at the national level of the various services funded with TANF resources (Parrott et al., 2007).

How States Have Used TANF Funds for Substance Abuse Treatment and Supportive Services

A 2002 survey of State TANF agencies by the Legal Action Center (2002) indicated that 41 of 44 responding States (including the District of Columbia) had used TANF funds for substance abuse treatment. In FY 2002 specifically, 27 of 44 States invested TANF funds in substance abuse treatment.

Although State spending averaged $5 million, most States spent a very small percentage—on average, a little more than 1 percent of total TANF funding—on substance abuse treatment. While nearly all (93 percent) of these 27 States said they had invested Federal TANF funds in treatment, less than half (44 percent) invested State MOE funds. Eleven States (41 percent) reported using both Federal and State MOE funds.

Among the 27 States, most used TANF funds for screening, assessment, and diagnosis (24 States); case management (23 States); nonhospital residential treatment (20 States); outpatient treatment (18 States); and detoxification (13 States). Four States used TANF funds for education and prevention, whereas only two used funds for housing and employment services. Only one State reported using TANF funds for each of the following services: consultation with staff and employers, monitoring, care coordination, transitional services, and "other" (not specified).

To maximize use of TANF, it is important for States to know that their MOE funds are State (not Federal) controlled. As such, States that have a separate State program that serves TANF-eligible families are not subject to important Federal restrictions (see below) (Capitani, Holguin-Pena & Hercik, 1999; Legal Action Center, 1999). In addition, States may transfer a portion of their TANF funds to the Child Care and Development Block Grant (CCDBG) and SSBG. The potential advantage of this approach is that transferred funds become subject to the rules of CCDBG, SSBG, or both and are no longer subject to certain TANF restrictions regarding substance abuse treatment. (These two funding sources are also discussed in this report.)

How Substance Abuse Treatment Providers Can Leverage These Funds

The ability of treatment providers to tap into available TANF funding varies depending on the nature of their State's system. For instance, in a county-administered State like California, funds are dispersed through the county social services departments, some of which may choose to use a competitive bid process or select from a contracted list of providers.

To meet the goals of TANF, State plans may specify work readiness activities that include substance abuse or mental health services for a recipient to become self-sufficient. If the State plan does not include work readiness activities for these services, providers may need to meet with their TANF officials about making administrative or State legislative changes to use TANF for these services. Providers should contact their State TANF or substance abuse agency or both for more information on how their State defines these activities and distributes TANF funds to meet work participation and employment-related goals.

Important Restrictions. TANF funds cannot be used to provide medical services (except prepregnancy and family planning services). However, the TANF final rule leaves it to States to determine which services are medical and which are not. States that define medical services as any Medicaid-covered service may limit their flexibility in using TANF funding (Rubinstein, 2002). In addition, no more than 15 percent of any State grant may be spent on administrative costs, exclusive of certain computerization and information technology expenses.

Of Special Note. TANF reauthorization under DRA resulted in important changes regarding substance abuse treatment and work participation requirements. The TANF Final Rule (released February 5, 2008, and effective October 1, 2008) redefines what types of activities may be counted toward work participation rates. It indicates that while substance abuse treatment is considered an allowable work activity under the category of job search and job readiness, it is generally no longer allowable under the community services or job skills training categories.[19] Furthermore, treatment or therapy must be determined to be necessary by a qualified medical or mental health professional and supervised by the TANF agency or other responsible party on an ongoing basis. States may only count the work portion hours of an individual's participation in a treatment program—for example, an individual living in a halfway house may count those hours spent on assigned, supervised, documented work responsibilities for the benefit of all the residents (e.g., preparing meals, housecleaning). State expenditures on treatment can count toward meeting a State's basic MOE expenditure. The statutory time limitations that apply to job search and job readiness assistance (no more than 6 weeks, or 12 weeks for qualifying States, in the preceding 12-month period and no more than 4 weeks consecutively) still apply. However, to give States more flexibility in providing job search and job readiness assistance, an hourly equivalent for purposes of the 6-week (or 12-week) limit has been adopted.[20] The implications of these changes remain to be seen.

Although work participation requirements for States (in terms of percentages of families participating in activities and the minimum number of hours a family must work to be counted as participating) remain the same, DRA makes significant changes to how the

caseload reduction credit is calculated (Administration for Children and Families, 2006c). Among the changes, States will now receive credit only for future caseload reductions, rather than for reductions that have occurred since FY 1995. As a result, States will have to obtain significant increases in their participation rates to meet the new standards (Congressional Research Service, 2005). In addition, the new law requires that families receiving assistance under Separate State Programs (SSPs)—programs that receive no Federal TANF funding but only State funding that counts toward the State's MOE—are now subject to the Federal work participation requirements. Before reauthorization, States had the flexibility of using SSPs to assist families who had significant barriers to employment, who were attending educational programs that lasted for more than 12 months, or for whom the Federal work requirements were otherwise unsuitable. Many States also provided assistance to two-parent families through SSPs to avoid fiscal penalties if they did not meet the applicable 90-percent participation rates (Greenberg & Parrot, 2006).

4. Workforce Investment Act Adult Program

Responsible Federal Agency. Employment and Training Administration, U.S. Department of Labor.

General Description/Overview. The Workforce Investment Act of 1998 (WIA), which went into effect in July 2000, reformed the Nation's workforce development system and changed the way employment and training services are delivered at the local level. It consolidated more than 60 Federal programs into three separate funding streams for the Youth, Adult, and Dislocated Worker Programs. WIA was designed to create workforce investment strategies that emphasized individual choice, local control, and performance-based participation for service providers. A central component of WIA was the creation of a system of one-stop career centers to provide individuals with easy access to employment and job training services.

> *Please note: The information that follows refers only to the **WIA Adult Program**, which provides funding for workforce investment activities that increase the employment, retention, and earnings of participants and increase their occupational skill attainment.*

Type of Funding. The WIA Adult Program is a statutory formula grant program. The allocation formula has remained largely the same as it was under the Job Training Partnership Act of 1982 (JTPA), which WIA eliminated. Whereas WIA serves all adults, JTPA served certain target populations. As a result, the allocation formula is narrowly focused on States' relative shares of excess unemployment, unemployment in Areas of Substantial Unemployment, and adults with low incomes (U.S. General Accounting Office, 2003).

How Funds Are Managed. In most cases, funds are provided to a State's workforce agency (i.e., the State labor department or State employment security agency). The States, in turn, allocate funds by formula to the approximately 600 Workforce Investment

Boards (WIB), the local decisionmaking entities. The act establishes State and local WIBs; the latter are appointed by local elected officials. Each State and local WIB must submit to the Governor or local elected official a comprehensive 5-year plan for its workforce investment systems. FY 2007 funding for adult employment and training activities is approximately $864.4 million.

Eligible Populations. All adults ages 18 and older, regardless of income, are eligible to receive basic services. Adults with low incomes and recipients of public assistance receive priority for training and other more intensive services.

Use of Funds. WIA authorizes the provision of three levels of service: core, intensive, and training. Services covered include job search and placement assistance, development of individual employment plans, counseling and career planning, and occupational and basic job skills training. WIA funds can be used for supportive services—but not actual substance abuse treatment—for those participating in core, intensive, or training services and are unable to obtain supportive services from other available programs. Supportive services may include, but are not limited to, transportation, child care, and housing assistance. How WIA funds are used and what portion goes to supportive services is left to State and local discretion.[21]

Core services (which all participants are eligible to receive) include the following:

- Job search and placement assistance
- Labor market information
- Initial assessment of skills and need
- Information about available services
- Followup services to help customers keep their jobs

Intensive services are provided to individuals who cannot obtain employment through core services. If funds are limited, legislation requires that welfare recipients and individuals with low incomes receive priority for the following intensive services:

- Comprehensive assessments
- Development of individual employment plans
- Group and individual counseling
- Case management
- Short-term prevocational services

For individuals who cannot secure employment through intensive services, the one-stop career centers offer training services directly linked to job opportunities in their local area. These services include the following:

- Occupational skills training
- On-the-job training
- Entrepreneurial training
- Skill upgrading

- Job readiness training
- Adult education and literacy activities in conjunction with other training

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Providers need to understand how their clients can access the services provided through their local WIB. Often substance abuse treatment clients require vocational assistance to secure employment and become self-sufficient. This service and funding stream is a prime opportunity for a treatment provider to partner with the WIB to ensure clients get access to these vocational, supportive, and employment-related services rather than duplicate these services with their resources. Providers should contact their State or local WIB.[22]

Important Restrictions. None of note.

Of Special Note. The law creating WIA expired in September 2002, and since then Congress has passed temporary extensions while working to reauthorize the program. WIA continues to operate under a continuing resolution while Congress works to resolve the specific parameters of a reauthorized program. In past congressional sessions, provisions allowing for participation by faith-based organizations have served as an obstacle to reauthorization. Progress on reauthorizing WIA is not expected until sometime well into 2008 (Wisconsin Technical College System, 2008).

MAJOR FEDERAL FUNDING SOURCES FOR CHILDREN'S SERVICES

- Child Abuse and Neglect State Grants
- Community-Based Child Abuse Prevention Program
- Title IV-E—Foster Care
- Title IV-E—Adoption Assistance
- Child Welfare Services—State Grants, Title IV-B, Subpart 1
- Promoting Safe and Stable Families, Title IV-B, Subpart 2
- Child Care and Development Fund and the Child Care and Developmental Block Grant
- Early and Periodic Screening, Diagnostic, and Treatment Program and Medicaid
- State Children's Health Insurance Program
- State Court Improvement Program
- Individual with Disabilities Education Act
- Developmental Disabilities Basic Support and Advocacy Grants

1. Child Abuse and Neglect State Grants

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. This grant program assists State agencies in improving their child protective services systems, including the intake, screening, assessment, and investigation of child abuse and neglect reports; training of child protective services workers and mandated reporters; development of child abuse risk and safety assessment tools and protocols; and programs and procedures for child abuse and neglect prevention, identification, and treatment.

Type of Funding. This is a formula grant program with no State matching requirements. Allocations are based on the population of children younger than 18 in each State. States must submit a 5-year plan and assurance that they are operating a statewide child abuse and neglect program that meets certain programmatic requirements. Congress appropriates these funds annually; FY 2007 funding is approximately $27 million.

How Funds Are Managed. The child protective services State Liaison Officers manage these funds; the officers typically reside within the State's child welfare services administrative office. Each State is required to establish at least three citizen review panels to receive Child Abuse and Neglect State Grants Program funding.

Eligible Populations. Services are provided to all children who have been abused and neglected and their families. There is no income or other eligibility requirement.

Use of Funds. Funds can be used for a variety of child welfare services, with a focus on child abuse and neglect prevention and treatment. States may use the funds for 1 or more of the 14 purposes specified in the authorizing legislation. The following are examples of how States have used funding:

- Intake, assessment, screening, and investigation of abuse and neglect reports
- Case management, ongoing case monitoring, and delivery of services and treatment for children and their families
- Developing, improving, and implementing risk and safety assessment tools and protocols
- Developing, strengthening, and facilitating staff recruitment and training
- Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions
- Enhancing collaboration among public health agencies, the child protection system, education, and private community-based programs to provide child abuse and neglect prevention and treatment services and to address the health needs, including mental health needs, of children identified as abused or neglected

Although substance abuse treatment providers cannot access these funds directly, they need to be aware of this important source of support, given the prevalence of parents with substance use disorders who are involved in the child welfare system and the need to create more effective linkages between substance abuse and child welfare services. A 2006 GAO study found that 39 of 40 States contacted are concerned with the level of services provided to children and families, and mental health and substance abuse services ranked highest among States' concerns about the level of services children and families receive (U.S. Government Accountability Office, 2006).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Treatment providers need to recognize that many of this grant program's purposes are activities that they often perform with clients who are involved in child welfare services (e.g., intake, assessment, case management). Many jurisdictions have created partnerships in which substance abuse treatment agency staff members conduct the specific assessment for substance use disorders while child welfare staff members maintain responsibilities for the child abuse/neglect risk and safety assessments. These may be professionals with substance abuse treatment expertise who are hired from the treatment agency or the treatment agency staff outstations. These partnerships include a variety of staffing configurations with substance abuse treatment staff co-located at child welfare offices or courts. In some cases, services are provided through a contract between the child welfare and substance abuse treatment administrations; in others, the child welfare system hires the treatment staff directly as a child welfare employee.

Important Restrictions. None of note.

Of Special Note. This program, which was reauthorized by the Keeping Children and Families Safe Act of 2003, requires States to document in their 5-year child and family services plan that their statewide child abuse and neglect program contains programmatic requirements that include, but are not limited to, policies and procedures that address the needs of infants exposed to drugs, triage procedures for referring children not at imminent risk of harm to community or preventive services, and provisions to refer children younger than 3 who are involved in a substantiated case to early intervention services under the Individuals with Disabilities Education Improvement Act (IDEA) Part C (Administration for Children and Families, 2006a). Currently, 48 States and the District of Columbia receive the grant.

2. Community-Based Child Abuse Prevention Program
(formerly known as the Community-Based Family Resource and Support Program)

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The Community-Based Child Abuse Prevention (CBCAP) program, formerly known as the Community-Based Family Resource and Support program, (1) supports community-based efforts to develop, operate, expand, and enhance child abuse and neglect prevention initiatives; (2) supports networks of coordinated resources and activities to strengthen families and reduce the incidence of child abuse and neglect; and (3) fosters understanding, appreciation, and knowledge of diverse populations to effectively prevent and treat child abuse and neglect (Administration for Children and Families, 2004).

Type of Funding. CBCAP is a formula grant program. Seventy percent of the allotment is based on the number of children younger than 18 in each State; however, no State shall receive less than $200,000. The remaining 30 percent is based on the amount of private, State, or other non-Federal funds leveraged and pooled by the State for community-based child abuse and neglect prevention. States must provide a 20-percent cash (not in-kind) match. Congress appropriates these funds annually; funding for FY 2007 is approximately $42.3 million.

How Funds Are Managed. The Governor of each State designates a lead entity to apply for and administer the funds.[23]

Eligible Populations. Beneficiaries include children and their families and organizations addressing community-based, child abuse prevention-focused programs and activities. There are no income eligibility requirements. According to ACF, families that typically receive services include parents with low-incomes and young parents; caregivers, children, and adults with minimal education; families living in urban and rural areas; families from all ethnic groups; families with adults and children with disabilities; and other vulnerable populations (Administration for Children and Families, 2006b).

Use of Funds. Although funds cannot be used for substance abuse treatment directly, they can be used to provide important support services to families affected by substance use disorders. States have used funds for statewide prevention networks, home visiting,

parent self-help and mutual support, parenting education and training, and other family support services (e.g., respite care, family counseling, referrals to early health and developmental services) that help adults create safe and stable environments for their children.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Treatment providers can best leverage these funds for important support services by establishing partnerships with child welfare agencies. Examples of these partnerships include treatment agencies that have partnered with child welfare administrations to provide parenting or anger management classes to their families. Such partnering not only expands the treatment agency's funding sources, but also reduces the complexity for families to have parenting and other classes at the treatment agency that they are receiving services from.

Important Restrictions. None of note.

Of Special Note. A core feature of the program is the blending of Federal, State, and private funds, which are then made available to community agencies for child abuse and neglect prevention activities and family support programs. The building of this pooled funding requirement into the allotment formula is an example of how the Federal Government can encourage the use of strategic financing strategies. The FRIENDS National Resource Center has developed a guidebook and tool kit to help support State CBCAP lead agencies in their efforts to maximize funding.[24]

3. Title IV-E—Foster Care

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. Title IV-E of the Social Security Act was established in 1980 and is a major Federal funding stream for child welfare services. The Foster Care program helps States provide proper care for eligible children who need temporary out-of-home placement (i.e., in a foster family home or institution). Funds are available to assist with monthly maintenance payments to eligible foster care providers, administrative costs to manage the program, staff and foster parent training, foster parent recruitment, and other related expenses.

Type of Funding. The Foster Care program is an open-ended entitlement funded with a combination of Federal and State/local matching funds. The Foster Care Maintenance Payments Program provides Federal matching funds, ranging from 50 to 83 percent depending on a State's per capita income. The Federal match for training and administration/data collection is 75 and 50 percent, respectively. Funding for FY 2007 is approximately $4.48 billion; for FY 2008, the proposed budget projects an increase of $106 million in IV-E claims.

How Funds Are Managed. Title IV-E funds are usually administered by State child welfare agencies. Funding is contingent on an approved State plan to administer or

supervise the administration of the program. The State must submit yearly estimates of program expenditures, as well as quarterly reports of estimated and actual program expenditures.

Eligible Populations. States must adhere to the eligibility requirements of Title IV-E of the Social Security Act. A child is eligible for IV-E funding if all of the following criteria are met: (1) the child is removed as a result of judicial determinations of "contrary to the welfare" and "reasonable efforts" or via a voluntary placement agreement; (2) responsibility for the child's care and placement resides with the State agency or other public agency with which the State agency has a Title IV-E agreement; (3) the child would have been eligible for AFDC under the State's plan as it was in effect on or before July 16, 1996, if the child was removed before this date; (4) the child is placed in a licensed or approved foster family home or child care institution; and (5) safety requirements for children placed in foster care have been verified.

Documentation for ongoing eligibility also includes a judicial determination regarding reasonable efforts to finalize a permanency plan; a judicial determination within 180 days of a voluntary placement agreement that such placement continues to be in the child's best interest; and continued eligibility for AFDC.

Use of Funds. Allowable maintenance costs include the cost of providing food, shelter, daily supervision, school supplies, and reasonable travel home for visitation. States may wish to explore a number of possibilities related to claiming a portion of their administrative costs. Allowable administrative costs may include referral to services; preparation for and participation in judicial determinations; placement of the child; development of the case plan,[25] case reviews, and case management and supervision; recruitment of foster and adoptive homes; licensing studies of foster homes and facilities; data collection and reporting; and a share of related agency overhead. These options require detailed discussions with ACF regional offices. For example, funds can be used for case management in cases where parents have lost custody of their children because of substance abuse and for the care and protection of a child while a parent is in treatment (Center for Substance Abuse Treatment, 2000). Administrative costs may be claimed only after the State has an ACF-approved cost allocation plan.

Allowable training costs include training personnel employed or preparing for employment by the agency; short-term training of current or prospective foster or adoptive parents; travel, per diem, tuition, books, and registration; salaries, fringe benefits, and travel for agency personnel assigned to training and for experts outside the agency to develop or conduct training; and cost of space, supplies, postage, and training materials. Funds can also be used for costs associated with the Statewide Automated Child Welfare Information Systems, a required computer-based data and information collection system, when the State has an approved Advance Planning Document.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Substance abuse treatment agencies have partnered with child welfare in a variety of ways to provide substance abuse treatment services to parents involved in child welfare. Some treatment agencies provide case management services specific to the treatment and recovery components of the family's case plan. This is often done through a contract similar to how child welfare contracts with foster family agencies for other types of child welfare services. Other substance abuse treatment agencies have become licensed "child care institutions," in particular to provide substance abuse treatment to adolescents who are part of the child welfare system. Child care institutions routinely provide services to families with child abuse or neglect. When a substance abuse treatment agency is also licensed by its State to provide services to the child welfare population, it provides access to a funding stream for children's services but also can reduce fragmentation for families seeking services from multiple agencies.

Important Restrictions. The costs of services related to the prevention of placement are not foster care administrative costs and are therefore not reimbursable. Funds may not be used for costs of social services—provided to a child, the child's family, or the child's foster family—that provide counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions (this includes substance abuse treatment).[26] In addition, IV-E funds used for staff training are limited to training for child welfare agency staff and cannot be used to train private providers of child welfare or substance abuse treatment services.

Of Special Note. In 1994 Congress granted DHHS the authority to approve a limited number of child welfare demonstration projects. These waivers allow States more flexibility in using Title IV-E funds to test innovative strategies for meeting the needs of children and families in the child welfare systems. Waivers enable States to test innovative child welfare service strategies and use funds for other types of services that protect children from abuse and neglect, preserve families, and promote permanency. Since 1996, 17 States have implemented 25 child welfare demonstration projects through IV-E waivers (Lind, 2004). Four States have implemented waivers specifically addressing substance use disorders: Delaware, Maryland, New Hampshire, and Illinois. The first three States focused on early identification of parents with substance use disorders and linking them to treatment and supportive services, whereas Illinois focused on the recovery needs of caregivers and families whose children had already been removed from the home. (For more information on these waiver programs, see Administration for Children and Families, 2005; James Bell Associates, 2006.) All four demonstration projects have ended. Although other States currently operating IV-E waivers may continue to do so, the waiver authority expired on March 31, 2006, and no new waivers are being issued. Over the last several years, other proposals have been considered to increase State and local flexibility regarding use of IV-E funds, but none has been successful.[27]

4. Title IV-E—Adoption Assistance

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The purpose of the Title IV-E Adoption Assistance program is to enable States to provide financial and medical assistance to individuals and families who adopt eligible children with special needs. Similar to IV-E Foster Care funds, these funds also support staff training and administrative costs.

Type of Funding. Adoption Assistance is an open-ended entitlement program. The Federal reimbursement rate for adoption subsidy costs is equal to each State's Medicaid matching rate, which is based primarily on each State's per capita income and ranges currently from 50 up to 77 percent. State adoption subsidy rates made on behalf of individual children are negotiated for each family but may not exceed the amount the child would have received if she or he had been in a foster family home at the time. The Federal match for training and administration is 75 and 50 percent, respectively. Funding for FY 2007 is $2.02 billion; spending is expected to increase to nearly $2.16 billion in FY 2008.

How Funds Are Managed. Title IV-E Adoption Assistance funds are usually administered by State social services departments. Adoptive families receive the subsidy and can spend it in any way they see fit to incorporate the child into the adoptive home.

Eligible Populations. To be eligible for Title IV-E Adoption Assistance funds, a child must be determined by the State to be a child with special needs and meet one of the following four pathways to eligibility:

(1) The child would have been eligible for AFDC (as in effect on July 16, 1996) in the home from which she or he was removed, either pursuant to a voluntary placement agreement under which Title IV-E payments were made or a judicial determination that to remain in the home would be contrary to the child's welfare.
(2) The child is eligible for SSI.
(3) The child is the child of a minor parent in foster care who received an increased payment to cover the cost of the child in the foster home.
(4) The child was eligible for IV-E Adoption Assistance in either a previous adoption that has been dissolved and parental rights have been terminated or an adoption in which the adoptive parents have died. In this case, the State must determine that the child continues to be a child with special needs before the subsequent adoption.

A determination of special needs includes three criteria: (1) the State has determined that the child cannot or should not be returned to the parents' home, (2) a specific factor or condition exists and it has been concluded that the child cannot be placed with adoptive parents without providing Title IV-E Adoption Assistance or Title XIX Medical Assistance, and (3) a reasonable but unsuccessful effort has been made to place the child for adoption (except where it would be against the best interests of the child).

Once all eligibility criteria are met, Federal assistance is available from the time of placement for adoption to age 18 (or 21 if, at State option, the child has a disability that warrants continuation of assistance), as long as the parent continues to be legally responsible for and provide support to the child. All parents adopting children with special needs are eligible for the nonrecurring cost of adoption; there are no income eligibility requirements. A State must determine only that the child meets the definition of a child with special needs. States may receive Federal funds only if their plan has been approved.

Use of Funds. As with some other child welfare funding streams, these funds cannot be accessed directly by substance abuse treatment providers. Adoptive parents can spend the subsidy "in any way they see fit to incorporate the child into their lives. . . . there is no itemized list of approved expenditures for adoption assistance" (Administration for Children and Families, n.d.b). As such, these funds can be used for the costs of adoption and for ongoing financial and medical assistance for adopted children with special needs. This provision may include children who have a special need (e.g., dual disorder, bipolar disorder, autistic spectrum disorder, attention deficit-hyperactivity disorder) that is a result of prenatal substance exposure. Because States have the flexibility to determine the conditions or factors that would make it difficult to place a child without a subsidy, policies may differ from State to State.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Individual agencies or treatment providers cannot access these funds directly. However, they may work with their State adoption specialist to develop a comprehensive postadoption services plan for their State and ensure that individual children and families receive the support services they need (National Adoption Information Clearinghouse, 2005).

Important Restrictions. None of note.

Of Special Note. Nothing at this time.

5. Child Welfare Services—State Grants, Title IV-B, Subpart 1

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The Child Welfare Services program helps States establish, extend, and strengthen coordinated child welfare services provided by community-based agencies to ensure that children are raised in safe, loving families. Child Welfare Services funding is available for programs to prevent the abuse, neglect, and exploitation of children, and the removal of children from their homes; to develop alternative placements if children must be removed; and to reunify children with their families, when possible. In addition, these funds can be used to provide training to ensure a well-qualified child welfare workforce.

Type of Funding. The Child Welfare Services program is a formula grant with a 25-percent State match required to draw down Federal funds. Each State receives a base amount of $70,000 plus an additional allocation based on the State's number of children younger than 21 and its per capita income. Funding for this program is discretionary and capped at $325 million. FY 2007 funding is approximately $287 million.

How Funds Are Managed. Funds are allocated by ACF to the State agency responsible for providing child welfare services and coordinating those services with those provided under Title XX (SSBG) of the Social Security Act. Funds may also be available to federally recognized Tribes with child welfare programs.

Eligible Populations. There are no Federal income eligibility requirements for this program.

Use of Funds. Funds may be used for a wide range of child welfare activities, including prevention, case management, placement of children in out-of-home care, and reunification of families, that meet the following program purposes:

- Protect and promote the welfare of all children
- Prevent the neglect, abuse, or exploitation of children
- Support at-risk families through services that allow children, where appropriate, to remain safely with their families or return to their families in a timely manner
- Promote the safety, permanence, and well-being of children in foster care and adoptive families
- Provide training, professional development, and support to ensure a well-qualified child welfare workforce

States typically use these funds for the cost of personnel to provide protective services to children, licensing and standard-setting for foster and adoptive parents and private child care agencies and institutions, homemaker services, return of runaway children, and prevention and reunification services. States may also use the funds for training to ensure a well-qualified child welfare workforce.

However, States may use funds to provide a parent with substance abuse treatment that is needed to resolve child welfare problems or for related support services, such as case management, child care, transportation, housing assistance, mental health services, screening and assessment, aftercare or recovery community support services, trauma and violence services, parenting and child development education, job training, and education. These funds are flexible so that both parents whose children are in care and parents whose children are still at home can be included (National Center on Substance Abuse and Child Welfare, 2004). States could also use funds to establish two-generation intervention models to provide parent–child mental health and behavioral interventions for families with young children (Johnson & Knitzer, 2005).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Substance abuse treatment agencies can access these funds through contracts with the child welfare administrations. Substance abuse treatment can provide a full range of intake, assessment, treatment, and aftercare services to clients who need these services to prevent a child from being placed in protective custody or to safely return a child to his/her parents' custody.

Important Restrictions. None of note.

Of Special Note. This program provides an important, albeit limited, amount of funds to the States for social services to these families. States recognize that Title IV-B, Subpart I, funds—as a stand-alone funding source—may not cover all of identified needs of families in their State. These funds may need to be combined with other State, local, and private funds to ensure adequate provision of services.

6. Promoting Safe and Stable Families, Title IV-B, Subpart 2

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The Promoting Safe and Stable Families (PSSF) program provides funds to States to stabilize families, strengthen family functioning, prevent out-of-home placement of children, enhance child development, increase competence in parenting abilities, facilitate timely reunification of the children, and promote and support appropriate adoptions that are in the best interests of the children. It is one of the few Federal sources for prevention and intervention services to address the problems that cause families to become involved with the child welfare system and is a critical component for meeting the goals of the Adoption and Safe Families Act (Child Welfare League of America, 2006).

Type of Funding. PSSF is a capped State entitlement program with a 25-percent State match requirement. Allotments are based on the number of children receiving food stamps in each State. Federal funding is capped at $305 million for mandatory funds, which are provided automatically without an annual appropriation, and up to $200 million for discretionary funds, which Congress must approve each year. The Child and Family Services Improvement Act of 2006, signed into law on September 28, 2006, reauthorized the PSSF program from 2007 to 2011. The new legislation included an additional $40 million annually in mandatory funds, some of which are designated for a competitive grant program to increase the well-being of and improve permanency outcomes for children affected by methamphetamine or other substance abuse, and some of which are provided as a formula grant to State child welfare agencies to support monthly caseworker visits. Although the core PSSF program can receive up to $505 million annually, funding for FY 2007 is $305 million for mandatory funds[28] and $89.1 million for discretionary funds.

How Funds Are Managed. Funds are allocated by ACF to the State agency responsible for providing child welfare services and coordinating such services with those provided under Title XX (SSBG) of the Social Security Act. Funds may also be available to federally recognized Tribes that have child welfare programs.

Eligible Populations. There are no Federal income eligibility requirements for this program.

Use of Funds. At least 20 percent of PSSF funds must be spent on each of the following four service categories: family preservation, family support services, time-limited family reunification services, and adoption promotion and support services. States may spend less than 20 percent on each of the four categories if they have a strong rationale to justify the exception. Funds are used for services to the family as a whole but must meet both individual and family needs. Services range from preventive to crisis services under these categories and may include the following (PSSF program regulations [Sec. 430]; Bazelon Center for Mental Health, 2005; Child Welfare League of America, 2006; National Center on Substance Abuse and Child Welfare, 2004).

- Substance abuse assessment and treatment[29]
- Mental health services
- Domestic violence services
- Preplacement preventive services programs, such as intensive family preservation programs for children at risk of foster care placement
- Followup care to families after a child has returned from foster care
- Respite care, as well as temporary child care and therapeutic services for families, including crisis nurseries
- Parenting skills and child development training and education
- Infant safe-haven programs
- Family support services (broadly defined to include a wide range of community-based activities that promote the safety and well-being of children and families)
- Structured parent–child interaction and parent–child bonding
- Intensive in-home services
- Parent and mutual support services (e.g., drop-in centers to give families opportunities for informal interaction with other families and with program staff)
- Individual, group, and family counseling
- Medication management
- Case management/care coordination to stabilize families in crisis (e.g., assistance with transportation, housing and utility payments, access to adequate health care)
- Life skills training and education (e.g., budgeting, nutrition, stress reduction, coping skills)
- Information and referrals to other community services (e.g., child care, health care, adult education literacy programs, legal services, mentoring services)
- Early developmental screening and assessment of children and assistance in obtaining needed developmental services
- Tutoring

- Health education for youth
- Services to help children and families prepare for adoption and address their postadoptive needs

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Substance abuse treatment providers can access these funds through contracting with their child welfare administrations. A full range of substance abuse services can be provided through this funding source to parents who have retained custody of their children, although their children may be at risk of being placed in protective custody. In Sacramento County, for example, the Bridges substance abuse treatment program provides case monitoring and recovery management services to families that have been investigated for child abuse or neglect but the children have not been determined to be in imminent risk; the child welfare agency provides child welfare services to the families while the child remains in the home.

Important Restrictions. State grantees must limit their administrative expenditures to 10 percent of the total allotment.

Of Special Note. The Bazelon Center for Mental Health Law (2005) notes, "Given the great need for services to prevent out-of-home placements, there is particularly strong competition for these resources." States may need to explore different strategies for maximizing these funds. For example, the North Carolina Division of Social Services has combined PSSF and Child Abuse Prevention and Treatment Act (CAPTA) CBCAP funds with its State appropriation for family resource centers into a single funding pool that supports various local community programs (North Carolina Institute of Medicine, 2005).

7. Child Care and Development Fund and the Child Care and Developmental Block Grant

Responsible Federal Agency. ACF, DHHS.

General Description. The Child Care and Development Fund (CCDF) is the primary Federal child care subsidy program, funding both direct services and quality enhancements. It helps parents with low incomes, parents receiving TANF, and parents transitioning from TANF obtain child care so they can work or attend training or education. The 1996 welfare reform law consolidated three Federal child care funding streams into a single, integrated child care system known as CCDF. However, Congress treats CCDF and CCDBG as separate programs, under the jurisdiction of separate authorizing committees. The CCDF mandatory and matching programs are appropriated as part of welfare policy, whereas CCDBG is appropriated annually (Ransdell & Boloorian, 2005).

Type of Funding. CCDF includes mandatory and matching funds and the CCDBG discretionary funds, as described below. States must spend at least 70 percent of their CCDF mandatory and matching funds on families receiving, transitioning from, or at risk of becoming dependent on TANF. States also must spend at least 4 percent of their

overall CCDF funds on activities to improve the quality and availability of child care. No more than 5 percent of funding can be spent on administration.

- *Mandatory funds* are the previous AFDC-related child care funds. They are 100-percent Federal funds and do not require a State match. States receive these funds as an entitlement and are guaranteed an annual fixed amount. A State's share of mandatory funds is based on the Federal share of the State's funding for the previous AFDC-linked child care programs. DRA reauthorized mandatory funds through 2010; the FY 2007 formula allocation is approximately $1.18 billion.

- *Matching funds* are remainder funds (the difference between the amount appropriated by Congress for a given year and the amount of mandatory funds distributed to States). Matching funds are allocated on the basis of the number of children younger than 13 in a State. States must provide matching funds at the current Medicaid match rate and meet a State MOE requirement equal to the State's spending for AFDC-related child care programs in FY 1994 or 1995 (whichever was higher). Federal CCDF matching funds were also reauthorized in DRA and total approximately $1.67 billion in FY 2006. The State MOE totals approximately $888 million.

- *Discretionary funding (CCDBG)* is authorized by Congress at $1 billion per year. There is no required State match. Funds are allocated using a proportional formula based on three factors: a State's number of children younger than 5, a State's number of free or reduced-price school lunch recipients, and a State's per capita income. Discretionary funds include three quality set-asides: afterschool resource and referral services, infant and toddler care fund, and additional quality expansion. Total discretionary funding for FY 2007 is approximately $2.06 billion. States may supplement their CCDBG discretionary funds with "optional" funds or transfers from other categorical programs, such as TANF.

How Funds Are Managed. The Governor appoints a designated State lead agency (typically the human services or welfare agency) to administer the program. States must develop and submit their CCDF plan every 2 years.[30]

Eligible Populations. States may serve families whose parents are working or in school or training and families whose children are receiving protective services. States set the income eligibility for their subsidy program, but Federal funds cannot be used for families with incomes above 85 percent of the State median income for a family of the same size. Children are eligible for CCDF-funded subsidies if they are younger than 13 (or younger than 19 if the child is under court supervision or cannot care for himself or herself because of a mental or physical disability). States must give priority to children with special needs and to children from families with very low incomes; States have discretion in defining these terms. States can also choose to give priority to other categories of children (e.g., teen parents, children in foster care, parents in homeless or domestic violence shelters).

Use of Funds. States have considerable flexibility in using CCDF funds to develop and implement child care programs and policies that best meet the needs of their children and families. CCDF can fund both direct services and quality enhancements. Funds can be used, for example, in support of child care for parents enrolled in substance abuse treatment programs, as well as for nontraditional hour programs in family day care homes and other child care centers.

States have the most flexibility with how they spend the 4-percent quality set-aside funds (under the discretionary dollars). These set-asides give States the opportunity to extend services beyond subsidy-eligible families as well as create targeted training programs for providers, which could include training to child care workers on the special needs of children of parents with substance use disorders. States have also used the quality set-aside to finance early childhood mental health consultation in child care settings (Johnson & Knitzer, 2006).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

In some States, eligible families receive child care subsidies in the form of vouchers or certificates that can be used with center-based care, group-home care, family child care, in-home care, and other providers that meet the State's health and safety requirements. Many States also issue contracts or grants to eligible providers to secure a certain number of child care slots for subsidy-eligible children. In this case, parents can choose to use a contracted provider rather than receive a voucher (The Finance Project, 2001). Substance abuse treatment providers should contact their designated State agency to find out their State's process and the requirements for becoming a certified or licensed child care provider that can receive these funds.

Important Restrictions. States may not use CCDF funds for the purchase or improvement of land or for the purchase, construction, or permanent improvement of any building or facility. (Minor renovations and upgrading to meet State and local child care standards are permitted). No funds provided directly to child care providers may be expended for any sectarian purpose or activity; however, parents receiving vouchers or certificates must have the opportunity to choose faith-based or community child care providers. In addition, no funds may be used to provide services (1) to students in grades 1 through 12 during the regular school day, (2) for which students receive academic credit toward graduation, or (3) that supplant or duplicate the academic program of any public or private school.

Of Special Note. States may transfer up to 30 percent of their TANF grant to CCDF to support parents transitioning into work or participating in training programs.

8. Early and Periodic Screening, Diagnostic, and Treatment Program and Medicaid

Responsible Federal Agency. CMS, DHHS.

General Description/Overview. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals younger than 21. EPSDT enables providers to screen, assess, diagnosis, and treat a child's physical, emotional, and developmental needs early on, before a child's health problems become more complex and require more costly treatment. EPSDT has two mutually supportive, operational components: (1) ensuring the availability and accessibility of required health care resources and (2) helping Medicaid recipients and their parents or guardians effectively use these resources (McCarty, Edmundson, Green, & McFarland, 2003). (For more information on Medicaid, see description in preceding section on funding sources for parents' substance abuse treatment.)

Type of Funding. EPSDT is part of Medicaid, which is an open-ended entitlement through States financed by a combination of State and Federal funds (see earlier discussion of Medicaid for more information).

How Funds Are Managed. Federal funds go to a designated State Medicaid Agency, which varies from State to State. In most States, Medicaid funds do not follow to the SSA for substance abuse.

Eligible Populations. EPSDT is for Medicaid-eligible children younger than 21 (see earlier discussion of Medicaid for more information). However, if States choose to restructure coverage through the new "benchmark" option made available by DRA, full EPSDT benefit coverage may be narrowed to children younger than 19. The DRA citizenship documentation requirements for new applicants and current recipients also apply to children, with the exception of those receiving child welfare services through Titles IV-B or IV-E (Rubin et al., 2006). The passage of the Family Opportunity Act included in DRA gives States the option of creating a new Medicaid eligibility group for children with disabilities who are younger than 19 in families with incomes up to 300 percent of the Federal poverty level. This optional coverage will be phased in beginning in January 2007 for children from birth to age 6 (see Bazelon Center for Mental Health Law, 2006; Johnson, 2006a).

Use of Funds. Children are the single largest group of Medicaid beneficiaries. Johnson and Knitzer (2006) note, "Medicaid is the most important potential source of funding for prevention, early intervention, and treatment of social and emotional challenges facing young children." Under EPSDT, children have a broader entitlement to Medicaid services than adults. There are opportunities for more preventive and early intervention services, including services for children at high risk for emotional problems, such as children who have a parent with a documented substance use disorder (Johnson, Knitzer, & Kaufmann, 2002). This increased access is an important point: A recent study of 50 States found that without EPSDT, all States would restrict or omit coverage for certain services needed by

children with serious physical and developmental conditions. The study also found that State coverage of optional Medicaid services that provide important specialized therapeutic services for children with chronic or disabling conditions varies considerably. Furthermore, even when benefits are provided, States often impose condition or treatment exclusions that adversely affect children in particular (Fox & McManus, 2005).

EPSDT benefits must include comprehensive health and developmental screening (including for developmental delays, mental health conditions, and substance use disorders); physical examination; immunizations; health education; laboratory tests; dental, vision, and hearing services; and other necessary health care to treat problems found in screening services. Mandatory mental health coverage includes inpatient and outpatient care and prescription drugs. States may also choose to provide optional services, such as residential care, case management, and clinic services (National Governors Association, 2005). EPSDT may be used to cover substance abuse treatment and prevention services for adolescents. As discussed earlier in the Medicaid overview, DRA gives States the option of creating a "benchmark" alternative benefit plan. In these cases, States are still required to continue EPSDT as a "wraparound" benefit. As of September 2006, Kentucky and West Virginia were pursuing this option.

EPSDT requires States to provide any medically necessary service to children and adolescents. A service is therefore covered if it is determined—by a provider, managed care organization, or the State—to be medically necessary. However, how a service is defined and who determines medical necessity vary among States (National Center for Children in Poverty, 2006).[31] Data indicate that many children do not receive the EPSDT services for which they are eligible (U.S. General Accounting Office, 2001).

Medicaid has increasingly become an important source of funding for child welfare services because it provides routine health care for most children in the foster care system. Its broad coverage standards for children encompass preventive, clinical, and medical case management services, as well as assistance with scheduling and transportation. In addition, Medicaid can fund comprehensive needs assessments, development of individualized treatment plans, child abuse prevention services, family therapy, individual and family management to help families remain intact, collateral intervention with schools and other child service systems, substance abuse and mental health services, and domestic violence services (Rubin, Halfon, Raghavan, & Rosenbaum, 2005; also Lind, 2004). States have used the therapeutic, rehabilitative, and TCM options, which allow home- and community-based service delivery, to provide a wide range of services such as life skills, intensive in-home therapeutic services and other supports, employment services, housing assistance, peer counseling and peer supports, medication self-management, symptom self-management, accessing community supports and services, and crisis response (National Center on Substance Abuse and Child Welfare, 2004). At least 38 States use the TCM option for children in foster care to ensure they receive comprehensive and coordinated care (Child Welfare League of America, 2008). However, DRA now specifies that Medicaid will not pay for certain services that have traditionally been provided by child welfare system case managers. Examples of foster care services that may not be billed to Medicaid TCM include, but are

not limited to, research gathering and completion of required foster care program documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, home investigations, transportation, and placement arrangements (Bazelon Center for Mental Health Law, 2006). However, as noted in the discussion of Medicaid for adults, bills have been introduced in both the House and Senate that would place a 1-year moratorium on several DRA-imposed changes to Medicaid regulations, including those affecting Medicaid case management and TCM, to determine whether the rules are in line with the congressional intent of DRA.

Medicaid can be used to provide child development services, although Medicaid's medically oriented design and structure can make this a challenge. For instance, Medicaid was intended to finance health care, whereas education and social services agencies (e.g., Head Start, child care, home visiting programs) are thought to be the customary providers of child development services. Unfortunately, these agencies generally do not qualify as Medicaid providers on their own and cannot be reimbursed for early childhood health and mental health services provided in nonmedical settings (Johnson & Knitzer, 2006). In addition, because current Federal Medicaid guidance does not specifically define child development services, States are forced to figure out how to cover such services under existing, and often cumbersome, benefit categories.

However, in 2003, CMS approved one Current Procedural Terminology (CPT) reimbursement code for developmental screening and another for developmental testing (Smith, P.K., 2005).[32] Some States are making progress by streamlining the early childhood developmental screening and assessment process for Medicaid providers and families. For instance, Illinois, Iowa, and Minnesota have clarified that primary care clinicians and other providers who use a standardized developmental screening tool can bill that service using CPT code 96110 (Kaye, May, & Abrams, 2006). Connecticut, Florida, and Minnesota have adopted or are considering new billing codes for a defined set of services related to children's social and emotional development.[33] Other State child welfare systems have used Medicaid to fund onsite mental health professionals to increase children's access to mental health services (Rubin et al., 2005).

In addition, some States have used Medicaid 1915(c) home and community-based service (HCBS) waivers to expand services to children with serious emotional disturbances. HCBS waivers allow States to expand the amount, duration, and scope of Medicaid services and provide access to intensive mental health services for youth who might not otherwise be financially eligible for Medicaid. Intensive home and community services provided through HCBS waivers include case management, wraparound facilitation, individualized care coordination, parent and family education support and training, daily and independent living skills, community and social supports and crisis interventions, specialized transportation, therapeutic foster care, counseling and therapeutic services, and intensive in-home services (Ireys, Pires, & Lee, 2006).

In most States, child welfare and State Medicaid agencies are linked financially through the intergovernmental transfers system. This system allows public child welfare agencies to certify covered health expenditures that are made on behalf of Medicaid-enrolled

children and youth as State medical and administrative expenditures that qualify for allowable Federal financial support (Rubin et al., 2005).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

A substance abuse treatment agency must be a certified provider to receive reimbursement for EPSDT services provided to children. Providers should contact the SSA responsible for the administration of Medicaid/EPSDT in their State to find out the process and requirements. Providers can ensure that the children of parents who are in treatment have access to EPSDT services including health care and developmental screenings when appropriate.

Important Restrictions. Required activities for State Medicaid agencies include informing all Medicaid-eligible persons younger than 21 that EPSDT services are available; setting specific periodicity schedules for screening, dental, vision, and hearing services; and annually reporting EPSDT performance information (e.g., number of children who received health screenings, number referred for treatment, number who received dental services) to CMS.

Of Special Note. Many States have not taken full advantage of EPSDT as an established funding source for children and adolescent health and mental disorders. Increased provider training, public awareness, and education are needed on how EPSDT works and the flexibility it offers in covering various services, particularly mental health care. Data show that of 22.9 million eligible children, only 37 percent receive a medical screen, including an assessment of their mental health. In addition, 23 States and the District of Columbia do not use specialized behavioral health screen tools or include behavioral health questions in their comprehensive screens (National Governors Association, 2005).

As noted above, programs serving infants, children, and adolescents may be affected by DRA, which gives States options for how EPSDT services will be delivered and how to shape child health benefits under Medicaid. The core provisions of DRA that could affect young children's health and development are related to changes in eligibility, premiums, cost-sharing, the benefit package, and TCM services. Although States may have new authority to charge for care, some protections for children and families are in place, such as ensuring that certain services and children who fall within mandatory eligibility categories are not subject to cost-sharing. If CMS implements its final rule as planned, it is unclear how States will respond to DRA and what the short- and long-term implications will be for children and families, particularly those involved in the child welfare system. (For a more extensive discussion, see Demske, 2006; Guyer, Mann, & Alker, 2006; Johnson, 2006a; Rosenbaum & Markus, 2006; and Rubin et al., 2006.)

9. State Children's Health Insurance Program

Responsible Federal Agency. CMS, DHHS.

General Description/Overview. SCHIP is a Federal–State partnership designed to provide health insurance coverage for children younger than 19 from low-income families who are not eligible for Medicaid. It was created as part of the Balanced Budget Act of 1997 and enacted as Title XXI of the Social Security Act. In designing their SCHIP programs, States could expand Medicaid (Medicaid expansion plan), create an entirely new program (a State-designed or private plan), or both expand Medicaid and create a separate private plan for different populations (combination plan).

Type of Funding. SCHIP is a formula grant program with a required State match. The Federal Government matches State funds at an enhanced Medicaid rate, up to a maximum of 85 percent. Funds are allocated to States that have approved SCHIP plans based on the number of children potentially eligible for SCHIP and the State cost factor. There is a maximum allocation for each State. Congress allocated more than $40 billion for SCHIP through 2007; funding for FY 2007 was $5.43 billion. On December 29, 2007, the SCHIP Extension Act of 2007 (P.L. 110-173) was signed into law, extending SCHIP through March 31, 2009, with sufficient funding to maintain current enrollment.

How Funds Are Managed. To receive funds, States must submit plans to CMS for approval. The actual flow of funds varies by State and depends on what type of SCHIP plan (Medicaid expansion, separate State plan, or combination) is in place.

Eligible Populations. SCHIP eligibility is limited to uninsured children younger than 19 (unless a State has obtained a waiver) whose family income is above the State's Medicaid income eligibility threshold, typically up to 200 percent of the Federal poverty level. Children who are eligible for Medicaid or State employee health coverage through a parent cannot apply for SCHIP. In addition, a child cannot be a resident of a State institution. States can apply for a Section 1115 waiver to expand coverage to new groups, provide new services, or redesign their programs in ways not allowed normally under the SCHIP statute. (However, DRA no longer allows States to use SCHIP funds for parents or other adults.) As of February 2004, 13 States have received approval for waivers. States also may amend their plans to cover pregnant women ineligible for Medicaid, whose unborn child will be eligible for SCHIP. As of April 2004, seven States received approval for such amendments (National Conference of State Legislatures, 2005).

Use of Funds. Like Medicaid, SCHIP is not a diagnosis-based program and primarily covers services based on where (e.g., inpatient hospital) or by whom (e.g., physician) they are delivered. For Medicaid expansion programs, benefits must equal the State's Medicaid program. For State-designed plans, benefits may be more limited, as States may choose from four different coverage options. All States, however, cover inpatient and outpatient care, emergency room care, many types of specialist care, well-child visits, and immunizations. In addition, most States cover mental health and substance abuse services, although there may be limits to these services, such as maximum number of

visits or total costs incurred per year.[34] States with separate SCHIP plans can broadly define medical necessity to cover key child developmental services (Johnson & Knitzer, 2006).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

A substance abuse treatment agency typically must be a certified provider and part of a State's SCHIP provider network to receive reimbursement. Treatment providers need to know what substance abuse benefits are covered in their State's plan, who is eligible to provide such services, and what it takes to be a participating provider.

Important Restrictions. States may spend up to 10 percent of their total matched SCHIP expenditures (Federal and State) on administrative costs, including direct contracting expenses, outreach, and enrollment. A State may choose to spend more than 10 percent on outreach, but those additional funds must be State-only funds and are not subject to the Federal match.

Of Special Note. States are allowed 3 years to spend their original allotments. After that, any remaining funds may be reallocated to States that have already used their allotments. However, in September 2004, Congress chose not to redistribute nearly $1.1 billion in unspent SCHIP funds; this money was returned to the U.S. Treasury (National Conference of State Legislatures, 2005).

10. State Court Improvement Program

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The Court Improvement Program (CIP) helps State courts improve their handling of proceedings relating to foster care and adoption. The program was enacted in 1993 as a response to increases in child abuse and neglect cases and the expanded role of the courts in achieving stable, permanent homes for children in foster care (National Child Welfare Resource Center on Legal and Judicial Issues, n.d.). The DRA added new data collection and analysis and training grants under the CIP to strengthen the performance of courts on behalf of children in the child welfare system. The CIP enables State court systems to conduct detailed self-assessment of their foster care and adoption laws and judicial processes and develop and implement needed reforms.

Type of Funding. CIP is a formula grant program requiring a 25-percent match in non-Federal funds. The law authorizes a mandatory funding level of $10 million for each of the three grant programs under CIP, and an additional 3.3 percent of any PSSF discretionary funds appropriated to be added to the basic CIP grant. For each of the three grants, each State court with an approved application is allotted an annual base amount of $85,000. The remainder of the total appropriated amount for that grant is then divided proportionately among all participating States according to the number of children younger than 21 in each State.

How Funds Are Managed. Court Improvement Programs are administered by the highest State courts. Virtually all States are participating in the CIP. Although the highest State court is ultimately responsible for CIP, it may choose to formally collaborate with another entity (e.g., university, nonprofit organization) to carry out CIP requirements (Administration for Children and Families, 2003).

Eligible Populations. All States participating in the Title IV-E program are eligible to apply for CIP funds.

Use of Funds. CIP was established as a flexible source of funding to undertake broad-based, comprehensive systemic reform of the court's child welfare functions. However, States are expected to give priority to strengthening areas of weakness identified in the State's CFSR and Title IV-E foster care eligibility review (Administration for Children and Families, 2003). Funds may be used for activities that include, but are not limited to, the following:

- Developing and implementing mediation programs
- Improving judicial competence, skills, and leadership for dependency issues
- Implementing changes (e.g., limiting workloads, reducing the number of mandated case reviews) that enable the courts to more effectively manage caseloads
- Developing management information systems to improve docketing, case tracking, data collection (including linking court-agency data), performance measurement, and decisionmaking
- Institutionalizing stronger links with child welfare agencies, tribal courts, and community programs (including faith-based programs) to improve care coordination for children
- Encouraging communication between and conducting cross-systems training of court and agency personnel
- Improving the amount and quality of legal representation for children, parents, and agencies

State courts are expected to work on improvements in collaboration with others—representatives of the State child welfare, health, mental health, and substance abuse agencies, as well as other professionals in the legal system (e.g., court-appointed special advocates, guardians *ad litem*, child welfare agency and defense attorneys)—who share responsibility for the care, representation, and protection of children removed from their homes.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Although CIP funds do not support direct substance abuse treatment, they are an important source for substance abuse treatment providers who are seeking to strengthen their connections with the courts and deliver substance abuse training to court staff. Several States have used CIP funds to support ongoing collaborative efforts among child welfare, substance abuse, and court staff. In addition, Court Improvement Programs have included training judicial officers and attorneys on substance abuse-related issues. Providers could become involved with their State's CIP planning effort to ensure that training on substance use disorders, treatment, and recovery are part of the overall CIP plan.

Important Restrictions. None of note.

Of Special Note. Nothing at this time.

11. Individuals with Disabilities Education Improvement Act

Responsible Federal Agency. Office of Special Education and Rehabilitative Services, U.S. Department of Education.

General Description/Overview. IDEA, formerly the Individuals with Disabilities Education Act, is the Nation's special education law. It provides billions of dollars in Federal funding to assist States and local communities in providing educational supports and services to approximately 6.8 million children with disabilities. Under IDEA, States are required to provide free appropriate public education in the least restrictive environment. The law was originally enacted in 1975 and most recently reauthorized (and renamed) in 2004.

Type of Funding. Special education services are funded through a combination of Federal, State, and local funding. IDEA has three Federal formula grant programs:

- *Special Education Grants to States—IDEA Part B.* Part B funds are allotted based on the number of children with disabilities (aged 3 to 21) receiving special education and related services each year. Part B includes a State MOE requirement.[35] FY 2007 Federal funding is estimated at $10.49 billion.

- *Special Education Preschool Grants—IDEA Part B, Section 619.* Section 619 funds are targeted to preschoolers with disabilities and awarded to States based on a statutory formula. A State receives a base amount equivalent to its FY 1997 allotment. If, in any subsequent year, the Section 619 appropriation exceeds the preceding year's amount, the excess is divided among States based on their relative population of all children between ages three and five and the number living in poverty. FY 2007 funding is approximately $381 million.

- *Special Education Grants for Infants and Families with Disabilities—IDEA Part C.* Part C provides early intervention for infants and toddlers with disabilities and

their families. State allocations are based on the population of children, from birth to 3 years, in each State. No State receives less than 0.5 percent of the funds available for all States. Most, but not all, States augment Part C funds with State-appropriated dollars; State dollars compose more than one-third of most Part C programs (Johnson & Knitzer, 2006). Funding for FY 2007 is approximately $423 million.

How Funds Are Managed. IDEA funds are administered by the State department of education. To receive Part B funds, local educational agencies (LEAs) apply to their State educational agency.

Eligible Populations. The three funding streams serve different age groups of children with disabilities; eligibility for Part B services is more limited.[36] Part B serves all children between ages three and 21, whereas Part B, Section 619, funds are for children between ages three and five (and, if the State chooses, two-year-old children who will turn three during the school year). Part C funds are for infants and toddlers (aged zero to three) with disabilities and their families. Under Part C, States may also choose to include in their eligibility criteria infants and toddlers *at risk* for disabilities or delays.[37] States have the option to merge Part C and Part B preschool programs, so a child may stay in the Part C program to age five (Johnson & Knitzer, 2006).

Use of Funds. Children who were exposed to alcohol or drugs during pregnancy may suffer from a range of disabilities that may be present at birth or during infancy or may manifest later during the early childhood years. IDEA funds support children receiving needed services; the act provides strong legal authorization for services.

- *Part B—Special Education Grants.* Part B funding, considered the cornerstone of the IDEA program, is used to provide the special education and related services needed to make free appropriate public education available to all children with disabilities. Funds can be used for the following:

  – Direct services, including supplemental educational services
  – Assistance to LEAs in providing behavioral and mental health services and interventions
  – Transitional services and care coordination for children who are transitioning to postsecondary activities
  – Capacity-building activities and service delivery improvements
  – Alternative programming for children with disabilities who have been expelled from school, are in correctional facilities, are enrolled in State-operated or State-supported schools, or are in charter schools
  – Technical assistance, personnel preparation, professional development and training, and other support to LEAs and schools

- *Part B, Section 619—Special Education Preschool Grants.* These funds are used broadly to provide a free appropriate public education to preschool children with disabilities. They can be used for:

  - Direct services
  - Support services (including establishing and implementing the mediation process)
  - Activities to meet the State's performance goals
  - Early intervention services that promote school readiness (in accordance with Part C)
  - Continued service coordination or case management for families who receive services under Part C
  - Supplementing other funds used to develop and implement a statewide coordinated service system (limited to 1 percent of these funds)

- *Part C—Infants and Their Families.* In general, Part C funds are used to develop, implement, and maintain a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families. In addition to providing direct early intervention services (not otherwise funded through other sources) and expanding and improving existing early intervention services, Part C funds can be used to initiate, expand, or improve collaborative efforts. This includes establishing linkages with appropriate public or private community-based organizations to identify and evaluate infants and toddlers at risk, make necessary referrals, and conduct periodic followups. Indeed, CAPTA amendments of 2003 require States to have "provisions and procedures for referral of a child under age three . . . in substantiated cases of abuse and neglect to early intervention services funded under Part C."[38] Early intervention services, as defined by the legislation, are those designed to meet a child's physical, cognitive, communication, social/emotional, or adaptive development and may include services such as:

  - Family training, counseling, and home visits
  - Speech and language services
  - Occupational or physical therapy or both
  - Psychological services
  - Service coordination
  - Medical diagnostic or evaluation services
  - Early identification, screening, and assessment
  - Certain health services
  - Social work services
  - Transportation and related costs

IDEA also allows LEAs to use up to 15 percent of their total funding to provide early intervening services to students before they are identified as having a disability. This activity is optional at the local level. LEAs can use early intervening funds for prevention and earlier intervention, professional development activities, educational supports and services, positive behavioral supports and evaluations, or other activities to help children succeed in school (U.S. House of Representatives Committee on Education and the Workforce, 2005).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

State substance abuse agencies may want to work with their State education agency to broaden IDEA eligibility definitions to include children exposed to substance abuse (as well as domestic violence, maternal depression, or related problems), rather than exclude them or categorize them as at risk (Johnson & Knitzer, 2006). In addition, individual treatment providers need to make sure that the children of parents in treatment are getting access to IDEA services. The Massachusetts Early Childhood Linkage Initiative, in response to the CAPTA 2003 amendments, established three pilot sites to refer all children younger than three involved with a newly substantiated case of child abuse or neglect to IDEA early intervention services—with the understanding that a substantial number of these cases involved children affected by parental substance use disorders (Thomas & Lippitt, 2007).

Important Restrictions. All IDEA funds are subject to nonsupplanting requirements and must use a restricted indirect cost rate (referenced under 34 CFR 76.564-76.569).

Of Special Note. IDEA allows local districts a great deal of flexibility in determining whether a child has a specific learning disability but encourages States and LEAs to use research-based practices to identify children with disabilities (U.S. House of Representatives Committee on Education and the Workforce, 2005). However, although the Part C legislation mentions social and emotional development as one of five domains to be assessed, the required child screening and other eligibility evaluations typically are not adequate in identifying and measuring social and emotional delays (Johnson & Knitzer, 2005). Furthermore, most State Part C eligibility definitions do not mention social–emotional, psychosocial, or behavioral conditions in their list of qualifying developmental delays (Johnson & Knitzer, 2006). Promising reforms do exist. Illinois, for instance, clarified that children whose parents suffer from perinatal depression or some other severe mental disorders are eligible to receive Part C early intervention services. North Carolina now includes attachment disorder (which is often seen in infants and children prenatally or postnatally exposed to parental substance abuse) as an established risk category (Kaye et al., 2006).

12. Developmental Disabilities Basic Support and Advocacy Grants
(also referred to as State Councils on Developmental Disabilities and Protection and Advocacy Systems)

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. This program enables individuals with developmental disabilities to become independent, productive, integrated, and included in all facets of community life. The program helps States develop a comprehensive and coordinated system of services and other activities to enhance the lives of individuals with developmental disabilities and their families and supports a system that protects their legal and human rights.

Type of Funding. This formula grant program provides funding for basic support and for protection and advocacy. States are required to submit a State plan not less than every 5 years. Allotments are based on the State's population, extent of need for services for individuals with developmental disabilities, and financial need. Basic support requires a 25-percent State match, except in certain cases; no State match is required for the protection and advocacy allotments. The State can only receive funding for its basic developmental disabilities program if it is participating in the protection and advocacy program. Total funding for FY 2007 is an estimated $111 million.

How Funds Are Managed. The designated State agency in each State receives and disburses funds. The State Developmental Disabilities Council (which is appointed by the Governor) develops, administers, and carries out the activities in the State plan. Per Federal law, at least 60 percent of the State council must consist of individuals with developmental disabilities, their parents, guardians, or family members. The remainder of the council typically includes representatives from local service providers and State agencies that serve individuals with disabilities.

Eligible Populations. The term "developmental disability" is defined as a severe, chronic disability of an individual that is attributable to mental or physical impairments or both; is manifested before age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of major life activities (i.e., self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency); and reflects an individual's lifelong need for services. Infants and children from birth through age nine are included if they have a developmental delay or specific congenital or acquired condition that is highly likely to result in a developmental disability if services are not provided.

Use of Funds. Allotments for basic support may be used for priority areas (e.g., education and early intervention, employment, child care, health, housing, community supports) and other activities, including administrative costs, capacity-building, refocusing of existing services, and advocacy to better meet the needs of individuals with developmental disabilities. Activities may include comprehensive health and mental health for both children and adults; child welfare services such as permanency planning; family support; child care; transportation; vocational training and other work assistance; and independent living, rehabilitation, and assistive technology services. In Massachusetts, for example, Children's Hospital, Boston, received council funding to implement a validated developmental screening tool to identify children at high risk for developmental needs and ensure that children referred for further evaluation receive needed community developmental services (Massachusetts Developmental Disabilities Council, n.d.). States also may use protection and advocacy funds to support a system that has the authority to pursue legal and other remedies to protect the rights of individuals with developmental disabilities within the State. This might include technical assistance and training to service providers and agencies, as well as other activities.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

State councils typically disperse funds through a competitive grant process (i.e., request for applications) based on the priorities outlined in the State's plan. Treatment providers should contact their State's council for more information.

Important Restrictions. Federal funds may be expended for up to half the cost of the functions of the designated State agency but may not exceed 5 percent of a State's allotment or $50,000 (whichever is less).

Of Special Note. Nothing at this time.

MAJOR FEDERAL FUNDING SOURCES THAT BROADLY ADDRESS PARENTS/ADULTS, CHILDREN, AND FAMILIES

- Community Mental Health Services Block Grant
- Community Services Block Grant
- Maternal and Child Health Services Block Grant—Title V
- Social Services Block Grant

1. Community Mental Health Services Block Grant

Responsible Federal Agency. SAMHSA, DHHS.

General Description. The Community Mental Health Services (CMHS) Block Grant was established in 1981 and is the primary Federal funding source for improving mental health service systems nationwide. This block grant provides assistance to States to establish or expand an organized community-based system of care that provides mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Type of Funding. This formula grant program includes a State MOE requirement, but no State match. Allotments to States are based on State population data by age group, total taxable resources, and a cost of services index factor. No State receives less than 20.6 percent of its FY 1992 allotment under the Alcohol, Drug Abuse and Mental Health Block Grant. Funding for FY 2007 is approximately $428 million.

How Funds Are Managed. The State's mental health agency manages the funds. Each State is required to have a mental health planning council review the State's mental health plan. Resources are passed to appropriate, qualified community programs that meet prescribed criteria (e.g., community mental health centers, child mental health programs, psychosocial rehabilitation programs, peer support programs).

Eligible Populations. This program serves all adults with SMI, including those with co-occurring substance use and mental disorders, and children with SED. The program has no income or age eligibility requirements. Individuals must have a current or past year diagnosable mental, behavioral, or emotional disorder that meets diagnostic criteria

specified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or that results in functional impairment. The impairment substantially interferes with or limits one or more of an adult's major life activities or a child's role or functioning in family, community, or school activities. For both children and adults, diagnoses may not be based on DSM "V" codes,[39] substance use disorders, or developmental disorders unless these problems co-occur with another DSM diagnosis. States may use mental disorders listed in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (and subsequent revisions) (Bazelon Center for Mental Health Law, 2005).

Use of Funds. States have a fair degree of flexibility in how they use the funds to meet the program objectives and may provide a full range of community-based mental health and support services. Services for adults may include:

- Substance abuse treatment (for integrated treatment for individuals with co-occurring disorders)
- Health, mental health, and rehabilitation services
- Employment and educational services
- Housing services
- Medical and dental services
- Case management (the program specifies that this be provided to individuals with the most serious mental disorders)
- Family support and family reunification services
- Child abuse and neglect prevention
- Domestic violence services
- Other supportive services (e.g., child care, transportation, food)
- Services provided by local school systems under IDEA
- Other activities leading to reduction of hospitalization

There is a required set-aside—no less than a State's calculated set-aside amount for FY 1994—to provide integrated services for children with SED. Integrated services for children may include:

- Social services
- Educational services, including services provided under IDEA
- Juvenile justice services
- Substance abuse services
- Health and mental health services

The program encourages partnerships among the various service systems—health, mental health, vocational, housing, education—as well as among Federal, State, and local government agencies. Up to 5 percent of grant funds may be used for administration.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Many substance abuse treatment agencies also provide mental health services to adults and children. States' certifying and licensing categories for accessing these funds vary; substance abuse treatment providers should contact their local or State mental health authorities for information on how to become licensed or certified to provide these services.

Important Restrictions. Funds may *not* be used for the following:

- Provide inpatient and residential services
- Make cash payments to intended recipients of health services
- Purchase or improve land or purchase, construct, or permanently improve (other than minor remodeling) any building or other facility
- Purchase major medical equipment
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds
- Provide financial assistance to any entity other than a public or nonprofit private entity

Of Special Note. Beginning in FY 2005, the program began its shift toward Performance Partnerships through a stronger and slightly different emphasis on performance indicators. The grant application now emphasizes the use of SAMHSA's NOMs.

2. Community Services Block Grant

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The Community Services Block Grant (CSBG) is designed to reduce poverty, revitalize low-income communities, and empower families and individuals with low incomes to become fully self-sufficient. It provides assistance to States to operate a network of local agencies to create, coordinate, and deliver programs and services.

Type of Funding. Grants are determined by a statutory formula based on each State's poverty population. No State match is required to receive funding. The program is funded at $630 million for FY 2007.

How Funds Are Managed. The Governor of each State designates a lead agency to prepare and submit the State's plan. Funds are distributed to States, which in turn subcontract with qualified community action agencies and neighborhood-based organizations. State CSBG administrators must pass through 90 percent of the monies to local agencies.

Eligible Populations. Individuals who meet the official Federal poverty line are eligible for CSBG-funded services.

Use of Funds. CSBG gives States the flexibility of tailoring their programs to meet the particular services needs in their communities. Funds can be used to provide a range of services and activities in the following areas: employment, education, health care, income management, substance abuse, family support, housing, other supportive services (e.g., transportation, child care), emergency assistance for immediate individual and family needs (e.g., nutritious food), and service coordination.

At least 90 percent of funds must be distributed to local agencies and organizations eligible to provide services. No more than 5 percent can be used for administration at the State level. The remaining funds are considered discretionary and can be used to demonstrate new initiatives, provide technical assistance and training, strengthen coordination and communication, or support other statewide activities that help build the capacity of the local service network.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Typically, States distribute funding by making subgrants to or contracting with locally based Community Action Agencies (CAAs) and other eligible entities. Treatment providers should contact their State's CSBG agency for more information on how funds are used in their community. In Oklahoma, for example, the CAA created Turning Point, the CAA substance abuse division. With funding from multiple sources, including CSBG funds for administrative support, Turning Point implemented a street outreach program to engage individuals in substance abuse treatment and provide onsite counseling, education, referral, and prevention services about substance abuse and sexually transmitted diseases (including HIV) in a culturally sensitive manner (Community Action Agency of Oklahoma City and Oklahoma/Canadian Counties, Inc., 1995).

Important Restrictions. None of note.

Of Special Note. The President's FY 2008 budget once again proposes terminating CSBG. However, in past budget discussions, Congress has rejected this recommendation and continued to fund the program.

3. Maternal and Child Health Services Block Grant—Title V [40]

Responsible Federal Agency. Health Resources and Services Administration (HRSA), DHHS.

General Description/Overview. The Title V Maternal and Child Health (MCH) Services Block Grant of the Social Security Act has operated as a Federal–State partnership for more than 65 years. The MCH Services Block Grant enables States to plan, promote, coordinate, and evaluate health care for pregnant women, mothers, infants, children, and adolescents. Title V also includes an emphasis on children with special health care needs.

Type of Funding. Title V funds are allocated to States based on the amount awarded to the States in 1981 for the preblock grant programs that were later consolidated into the MCH Services Block Grant and the proportion of children living in poverty in a State

relative to the total number of such children nationally. States must provide a $3 match for every $4 of Federal funds allotted. In-kind matching is permitted, but Federal funds from other sources may not be used to match the MCH Services Block Grant allocation. The State MOE must be at least equal to the level of funds provided in FY 1989. Federal FY 2007 funding is $693 million.

How Funds Are Managed. Each State's health agency is responsible for the administration and supervision of the program.[41] States must conduct a statewide needs assessment every 5 years.

Eligible Populations. In general, mothers, infants and children, and children with special health care needs, in particular those from low-income families or with limited availability of health services, are eligible. Although there is Federal guidance regarding the definition of a child with special health care needs, State determines who qualifies as a child with special health care needs, who will receive services, and what services will be financed. As a result, specific eligibility criteria vary greatly by State. Typically these categories include children with chronic illnesses, genetic conditions, and physical disabilities but not children with social and emotional disabilities (Johnson & Knitzer, 2006). The law permits States to serve youth up to age 25, but most serve youth only up to age 21 (Bazelon Center for Mental Health Law, 2005). Children eligible for SSI qualify automatically.

Use of Funds. States can use Title V funds to design and implement a wide range of maternal and child health programs that meet both national and State needs. This includes prenatal substance use prevention and treatment programs. However, States must use at least 30 percent of their Federal allotment for preventive and primary care services for children and at least 30 percent for services for children with special health care needs. No more than 10 percent of each State's allotment may be used for administration. Within these parameters, States generally fund services such as:

- Assessments and followup diagnostic and treatment services (including newborn screening for genetic disorders)
- Comprehensive prenatal and postpartum care for women with low incomes
- Preventive and primary care services for children from low-income families
- Comprehensive care, including long-term care services, for children with special health care needs, and rehabilitation services for children younger than 16 who are blind and disabled and who are eligible for SSI
- Comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children with special health care needs

The conceptual framework for Title V services encompasses four levels of services:

- *Direct Health Care/Medical Services*. These services are typically the most intensive and are provided to individual clients. Examples include specialized medical visits for children with special health care needs (which may have been the result of prenatal substance exposure) and home visiting, which can be

targeted to families affected by substance use disorders that may need ongoing monitoring and recovery support. Although MCH Services Block Grant funds can pay for mental health services, most Title V agencies exclude coverage of such inpatient and outpatient care, noting that another State agency typically covers these services and that Title V's traditional emphasis is on physical health services (Markus, Rosenbaum & Cyprien, 2004).

- *Enabling Services.* Families in substance abuse treatment may need these wraparound and supportive services; they include transportation, outreach, case management and care coordination, health education, nutrition counseling, respite care, and other family support services.

- *Population-Based Services.* These services include newborn screening, immunizations, and injury prevention. They are geared toward the larger maternal and child health population at a State or local level.

- *Infrastructure Building.* These services are not client based, but rather involve activities such as needs assessments, evaluation, planning, policy development, systems coordination, and applied research. Funds can be used, for instance, to support substance abuse training to physicians and other health care and social service providers who work with women with substance use disorders and their children or to conduct research and standards development regarding State prenatal substance abuse screening policies and practices.

In FY 2006, Federal–State Title V expenditures for the 50 States and the District of Columbia totaled more than $4.9 billion. More than $2.7 billion (51 percent) of these expenditures were spent on direct health care services. Another $1.2 billion (22 percent) was spent on enabling services, while nearly $728 million (14 percent) went toward population-based services and $673 million (13 percent) was spent on infrastructure. Children with special health care needs accounted for 52 percent of all expenditures, while infants younger than a year old made up 11 percent and children and youth ages 1 to 22 represented 22 percent of all expenditures. Approximately 7 percent of all funds were spent on pregnant women, while all other individuals accounted for another 5 percent and 2 percent went for administration (Health Resources and Services Administration, Maternal and Child Health Bureau, n.d.).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Improved pregnancy and birth outcomes and strengthening the health and well-being of children with special needs are all desired goals of the MCH Services Block Grant program. Many States identify substance abuse treatment and prevention as a priority issue or include the percentage of women who use alcohol and drugs during pregnancy as one of their State's performance measures. As such, substance abuse treatment providers are poised to work with—and should contact—their State and local MCH agencies to target these issues.

Important Restrictions. Funds may not be used for inpatient services other than those provided to children with special health care needs or high-risk pregnant women and infants or if such services are approved by DHHS. States are also prohibited from using funds for cash payments to recipients for health services, purchase and improvement of land, construction or permanent improvement of buildings, purchase of major medical equipment, matching other Federal grants, or providing funds for research or training to entities other than public or private nonprofit agencies.

Of Special Note. Nothing at this time.

4. Social Services Block Grant

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. SSBG funds States, Territories, and insular areas for the provision of social services directed toward achieving economic self-support or self-sufficiency; preventing or remedying neglect, abuse, or the exploitation of children and adults; preventing or reducing inappropriate institutionalization; and securing referral for institutional care, where appropriate.

Type of Funding. SSBG is a capped State entitlement program; no matching funds are required. Grants are determined by a statutory formula based on each State's population.[42] Since 2000, SSBG has been maintained at $1.7 billion; the proposed FY 2008 budget reduces SSBG funding to $1.2 billion for FY 2008 and beyond.

How Funds Are Managed. A designated State agency (typically health and human services, social services, children, and families) administers the funds.[43]

Eligible Populations. Within the legal specifications, each State determines what services are provided, which categories and populations of adults and children are eligible, which geographic areas of the State services will be provided, and whether the services will be provided by State or local agencies (i.e., county, city, and regional offices) or through grants and contracts with private qualified organizations.

Use of Funds. States have substantial discretion and flexibility in how funds are distributed to provide services that meet one of the following five program goals outlined in the law: (1) to prevent, reduce, or eliminate dependency; (2) to achieve or maintain self-sufficiency; (3) to prevent neglect, abuse, or exploitation of children and adults; (4) to prevent or reduce inappropriate institutional care; and (5) to secure admission or referral for institutional care when other forms of care are not appropriate. ACF uses the Uniform Definitions of Services,[44] as established in Title XX, to determine allowable expenditures under the SSBG. These definitions provide guidelines for reporting purposes; they are not meant to constrain a State's use of SSBG funds. State and local agencies and service providers often use SSBG funds to supplement other funding and leverage additional resources, rather than rely on SSBG funding to fully support a given service or program.

The ACF 2005 SSBG annual report lists 28 social service categories on which funds were expended. These include substance abuse services, adoption services, case management, counseling services, child care, education/training, employment services, family planning services, foster care services, health-related services, home-based services, housing services, information and referral, pregnancy and parenting, prevention/intervention, child protective services, special services for individuals who are disabled and at-risk youth, and transportation (Administration for Children and Families, 2007).

Within these 28 categories, States can use SSBG funds for needs assessments, family reunification and permanency services, child abuse prevention services, family support services (e.g., food, employment services, transportation), detoxification and other substance abuse treatment services, parent education or social services for clients with substance use problems, mental health services (both early childhood and adult), domestic violence services, and a limited set of medical services (see Important Restrictions below). States can also use funds to support staff training, licensing activities, planning and evaluation, and other administrative functions (Center for Substance Abuse Treatment, 2000; Hutson, 2004; Johnson et al., 2002; and Lind, 2004).

Although most States use SSBG funds to provide child welfare services, only about one-fourth use these funds for substance abuse prevention and treatment services. In 2005, for example, 38 States spent $359 million in SSBG expenditures on child foster care services (the largest expenditure category of 2005), and 41 States spent $257 million on child protective services. Yet only 12 States[45] spent $6.45 million of SSBG funds on substance abuse services. These funds provide substance abuse services to 182,662 individuals (97 percent of whom were adults). Connecticut accounted for 25 percent of that $6.45 million. Of the 12 States, substance abuse services accounted for no more than 4 percent of any State's total SSBG expenditures (Administration for Children and Families, 2007).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Each State undertakes a planning process to determine how to allocate funds. Planning occurs in State agencies and in local community or regional organizations and is typically conducted as part of the State budgeting process. Disbursement can occur at both State and local levels; allocation formulas may be based on historical funding patterns, current needs, and the availability of other funding sources. In New Jersey, for example, Human Services Advisory Councils within each county develop county-level comprehensive social services plans that are used to prioritize services and develop SSBG expenditure recommendations. In Delaware, the annual allocation is shared almost equally between the Department of Children, Youth and Families and the Department of Health and Social Services—an arrangement that has been in place for about 20 years. Discussions within the Department of Health and Social Services and the Department of Children, Youth and Families play the most important role in SSBG planning. Spending in Illinois, however, is based primarily on input from the TANF Workgroup (a group of 20 individuals involved with fiscal and budgeting issues) and the Self-Sufficiency Advisory Council. The Self-Sufficiency Advisory Council plays an integral role in the planning process because it conducts open meetings regularly and accepts input from the community, studies services, compiles best practices, and reports findings to the Illinois Department of Human Services.[46]

These examples reiterate the need for treatment providers to develop a deep understanding of how their State and local budgeting processes work and to get involved wherever possible. For instance, providers should ensure that they and former clients are represented and have a "voice" on advisory groups that play a role in setting priorities and allocating funds. Influencing the process will take time and perseverance and use needs assessment and treatment outcomes data to make a case for funding.

Important Restrictions. Except for the first two items below, for which a waiver may be requested, Federal funds cannot be used for the following:

(1) Purchase or improvement of land or the purchase, construction, or permanent improvement of any building or other facility
(2) Medical care (other than family planning services, rehabilitation services, or initial alcohol or drug detoxification) unless it is an integral but subordinate part of a an allowable social service
(3) Cash payments as a service for daily living expenses (other than during rehabilitation) or room and board (unless it is short term and an integral but subordinate part of a larger social service or a temporary protective shelter)
(4) Wages to any individual as a social service (other than payment of wages to welfare recipients employed as child care providers)
(5) Social services (except substance abuse treatment) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison to any individual living in such institution
(6) Educational services that are otherwise generally available to a State's residents without cost and without regard to their income
(7) Child day care services that do not meet applicable State and local standards

(8) Payment for any item or service provided by an individual or entity excluded from participation in the program, pursuant to Section 1128 or Section 1128(A) of the Social Security Act

Of Special Note. A State may transfer up to 10 percent of its SSBG allotment to programs for preventive health services, alcohol and drug abuse services, mental health services, and maternal and child health services. States may also transfer up to 10 percent of their TANF funds to SSBG. These transferred funds are not subject to certain TANF restrictions regarding substance abuse treatment; however, they must be used only for programs and services to children or their families whose income is less than 200 percent of the Federal poverty line. During FY 2005, 45 States transferred funds from TANF to the SSBG program. Two of these States used TANF transfer funds for substance abuse services; TANF transfer expenditures accounted for approximately 10 percent ($624,905) of SSBG expenditures for substance abuse services (Administration for Children and Families, 2007).

MAJOR FEDERAL FUNDING SOURCES TARGETING SPECIFIC POPULATIONS OF PARENTS/ADULTS, CHILDREN, AND FAMILIES

- Chafee Foster Care Independence Program
- Juvenile Accountability Block Grants
- Title V—Community Prevention Incentive Grants
- Family Violence Prevention and Services—Grants for Battered Women's Shelters; Grants to State Domestic Violence Coalitions
- Family Violence Prevention and Services—Grants to States and Indian Tribes
- Housing Opportunities for Persons with AIDS
- HIV Care Formula Grants
- Project for Assistance in Transition from Homelessness
- Residential Substance Abuse Treatment for State Prisoners

1. Chafee Foster Care Independence Program

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. The John H. Chafee Foster Care Independence Program assists current and former foster care youth in achieving self-sufficiency and successfully transitioning to adulthood. The program is for foster youth who are likely to remain in foster care until age 18 and those between ages 18 and 21 who have aged out of the foster care system.

Type of Funding. This is a capped entitlement ($140 million annually) formula grant program that requires a 20-percent State cash or in-kind match; the match can come from third-party, in-kind contributions. A State's allocation is based on its relative number of children in foster care. Data submitted by States into the Adoption and Foster Care Analysis and Reporting System's national database are used to calculate State allotments.

Allotments may vary yearly as caseloads change. Each State receives $500,000 or at least the amount it received in FY 1998, whichever is greater. Congress appropriates these funds annually. An additional $60 million in discretionary funds is authorized for payments to States for education and training vouchers for youth who age out of foster care to assist them in developing skills necessary to lead independent and productive lives (this is known as the Chafee Educational and Training Voucher Program).

How Funds Are Managed. States must submit a 5-year plan that specifies which State agency or agencies will administer, supervise, or oversee the programs carried out under the plan. Each State must submit a new plan every 5 years as part of its larger Child and Family Services Plan.

Eligible Populations. Services are provided to children and youth who are likely to remain in foster care and former foster care recipients up to age 21. The Foster Care Independence Act of 1999 does not define "likely to remain in foster care until age 18," and most States have implemented broad eligibility criteria. Chafee is a voluntary program that serves only those youth who actively and willingly desire to participate. The program is generally available to youth between ages 16 and 21 who have been in out-of-home placement (licensed foster care, group home, or relative placement) for at least 3 months; youth who have been assessed with the ability to emancipate and who can benefit from the program; youth in shelter situations who have a goal of emancipation; and youth who are developmentally disabled (if they can benefit from services). States have the flexibility of setting their age guidelines for services, and many States have started providing independent living services to teens beginning at age 13 or 14.

Services cannot be provided to youth who return to their own homes. However, services may be available if a youth returns home and is then placed in foster care again before turning 21. Runaway foster youth or those who have lost contact with the agency are eligible for services if they return for assistance before reaching age 21. Funds cannot be used for youth who are incarcerated, but former foster youth exiting corrections are eligible once their incarceration is complete.

Use of Funds. States have a great deal of flexibility in how they use Chafee funds but must use a portion of their funds for assistance and services to older youth who have left foster care but have not yet reached age 21. Funds may be used to provide activities and programs that include substance abuse prevention; education, vocational training, and related services; help in preparing for and obtaining employment; independent life skills training; financial management and budgeting training; housing and related general community support services; personal and emotional support through mentors and the promotion of connections to caring, dedicated adults; counseling and related support services; and preventive health services (e.g., tobacco prevention, nutrition education, pregnancy prevention). Unlike most other Federal programs, this program has no specific cap on the amount of funds that can be used for administration (Bazelon Center for Mental Health Law, 2005; Nixon, Chang, Jorgensen, Duran, Shapiro, Torrico, et al., 2005). States can use up to 30 percent of their Independent Living Program funds for room and board for youth between ages 18 and 21 who have left foster care.

States can use Chafee funds to provide general support services and extensive case management to former foster care youth with SED who are between ages 18 and 20. Such SED transitional services include assessment of functional abilities, skills, and knowledge for self-sufficiency; care coordination and linkages with needed community supports and resources; and provision of transportation, housing support, education and employment services, and other related support.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

All States must develop multiyear plans that describe how they will design and deliver programs. However, how each State chooses to disperse the funds varies. For instance, some States may provide the services directly using State employees; others may contract out to private providers; and still others may distribute to counties who then distribute using a formula allocation. Treatment providers should contact their State coordinating agency for more information.[47]

Important Restrictions. The cost of training foster care parents, group home workers, and case managers on understanding and addressing the issues facing adolescents who are transitioning from foster care must be charged to the Title IV-E training program rather than Chafee.

Of Special Note. For transition-age (18–20 years) youth who have been in foster care, States have the option of extending their Medicaid eligibility up to age 21, thereby providing these youth with access to important treatment and rehabilitation services that can help them with independent living. As of fall 2006, 17 States used the extended Medicaid option and another five planned to extend their coverage in the next State legislative session (Patel & Roherty, 2007).

2. Juvenile Accountability Block Grants

Responsible Federal Agency. Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs (OJP), U.S. Department of Justice.

General Description/Overview. The Juvenile Accountability Block Grant (JABG) program helps States and local governments reduce juvenile offending by developing accountability-based initiatives focused on both the offender and the juvenile justice system. The program began in 1998 as the Juvenile Accountability Incentive Block Grants program but was later modified and renamed JABG in FY 2003 (Office of Juvenile Justice and Delinquency Prevention, 2003).

Type of Funding. JABG includes both formula and project grants; this discussion focuses on the formula grants. Each State receives 0.5 percent of the appropriated amount after set-asides, and the remaining funds are allocated based on each State's juvenile (younger than 18) population. States must provide a 10 percent cash match (or 50 percent when funds are for the construction of corrections facilities). The FY 2007 appropriation was approximately $49.5 million.

How Funds Are Managed. Funds are provided to the designated State agency,[48] which must distribute at least 75 percent of the funds to local jurisdictions. The minimum grant for localities is $10,000, and allocations are based on localities' juvenile justice expenditures. Both States and local units of government receiving grants must establish advisory boards and submit coordinated enforcement plans for planned JABG activities.

Eligible Populations. This program is designed to benefit all young people involved in the juvenile justice system. There is no income or other eligibility restriction.

Use of Funds. Formula grant funds may be used for any one of 17 identified program purpose areas. These areas include the following:

- Risk and needs assessments of juvenile offenders to facilitate early intervention and the provision of comprehensive services, including mental health screening and treatment and substance abuse testing and treatment
- Juvenile drug court programs
- Interagency information-sharing programs that enable the juvenile and criminal justice systems, schools, and social services agencies to make more informed decisions about the early identification, control, supervision, and treatment of juveniles who repeatedly commit serious delinquent or criminal acts
- Accountability-based programs that enhance school safety
- Prerelease and postrelease systems and programs to facilitate the successful reentry of juvenile offenders from State or local custody in the community

Within the rubric of these broad program purpose areas, States have a great deal of flexibility in determining what specific treatment and support services are provided to youth and their families. A State may use up to 5 percent of its total grant fund award for administrative costs. Local government units may also use up to 5 percent of their JABG funds for administrative costs. All funds used for administrative costs are subject to the matching requirement.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

To maximize resources, the Federal Government requires participants to form coalitions that will develop recommendations for expenditure of funds. The State and each unit of local government that receives funds must establish an advisory board that includes, at minimum, representatives from law enforcement, juvenile justice and the courts, schools, businesses, and social services organizations involved in crime prevention. Substance abuse treatment providers should ensure they are represented on both the State and local advisory boards because the advisory boards are responsible for developing a coordinated enforcement plan, which helps guide funding decisions.

Important Restrictions. Although nonprofit organizations may not apply for grants, the law encourages States and units of local government to contract with private, nonprofit entities and community-based organizations to develop and administer JABG-funded programs.

Of Special Note. The President's FY 2008 budget proposes to eliminate JABG, Title V Community Prevention Incentive Grants (see below), and other related juvenile justice programs and consolidate the funds into a new, single, flexible competitive grant program, the Child Safety and Juvenile Justice Grant Program, that can address multiple child safety and juvenile justice needs, as well as school safety.

3. Title V—Community Prevention Incentive Grants[49]

Responsible Federal Agency. OJJDP, OJP, U.S. Department of Justice.

General Description/Overview. The Title V Community Prevention Incentive Grants program was established in the 1992 reauthorization of the Juvenile Justice and Delinquency Prevention Act of 1974 to help States and local governments establish collaborative, multiyear, community-based delinquency prevention efforts. Working from a research-based framework, the program helps communities focus on identifying and reducing risks and enhancing protective factors to prevent youth from entering the juvenile justice system. Six fundamental principles drive the program's overall approach to juvenile delinquency prevention: comprehensive and multidisciplinary approaches, research foundation for planning, community control and decisionmaking, leveraging of resources and systems, evaluation to monitor program progress and effectiveness, and a long-term perspective.

Type of Funding. The Title V Community Prevention Incentive Grants program is a formula grant program that requires a 50-percent State and/or local government cash or in-kind match. Allocations were initially based on a State's population of youth under the maximum age of original juvenile court delinquency jurisdiction. In FY 2003, however, Congress designated the majority of Title V funds for earmarked programs, necessitating the suspension of formula-based allocations for that year (see Of Special Note below) (Office of Juvenile Justice and Delinquency Prevention, 2005). OJJDP distributed a total of $14.6 and $14.7 million to States on a formula basis in FYs 2004 and 2005, respectively. However, in FY 2006, once again too little remained after earmarks to use formula-based allocations. OJJDP, therefore, distributed a set amount of $56,250 to each State.[50]

How Funds Are Managed. The designated State agency oversees the grant funds. The funds are distributed through the State advisory group to local government units through a competitive process. States must ensure their neediest areas receive funding.

Eligible Populations. Youth at risk of juvenile justice involvement and their families are eligible to receive services under this program. The program guidelines emphasize the need to address risk factors at the earliest stage in each child's development. Individual communities have the flexibility of identifying the best risk and protective factor strategy that suits their needs; as a result, some communities focus their efforts on preschool- or young school-aged children, whereas others target adolescents.

Use of Funds. The program guidelines identify five categories of risk factors for juvenile delinquency: (1) individual characteristics such as alienation, rebelliousness, and lack of bonding to society; (2) family influences such as parental conflict, child abuse, poor family management practices, and family history of problem behavior (substance abuse, criminality, teen pregnancy, and school dropout); (3) school experiences such as early academic failure and lack of commitment to school; (4) peer group influences such as friends who engage in problem behavior (minor criminality, drugs, gangs, and violence); and (5) neighborhood and community factors such as economic deprivation, high rates of substance abuse and crime, and neighborhood disorganization. Funds may be used to provide services that focus on one or more of these life domains. More specifically, communities may fund a broad range of programs for children and youth including:

- Screening, assessment, and early intervention
- Early childhood programs (nurse home visitation, preschool, and parent training)
- Substance abuse prevention and treatment
- Mental health services (e.g., psychological and psychiatric evaluations and treatment, counseling, and family support services)
- Child abuse and neglect programs
- Gender-specific services (to address the needs of girls at risk and first-time, nonserious female offenders)
- Services for children of incarcerated parents
- Mentoring, tutoring, and remedial education
- Afterschool programs and recreation services
- Truancy and dropout reduction
- Gang prevention outreach and intervention
- Leadership development activities

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Funds are distributed through the State advisory group to local government units through a competitive process. The local government units can contract with public or private agencies to provide administration or program services. Treatment providers should contact their State's Title V Coordinator and applicable local government unit to find out more about how funds are allocated and criteria for becoming a contracted provider.[51]

Important Restrictions. Like most funds for Federal programs, these funds cannot be used for construction and land acquisition or to supplant Federal, State, or local funds supporting existing programs or activities.

Of Special Note. As noted in OJJDP's *2003 Report to Congress*, the Community Prevention Grants Program was essentially cut short in FY 2003 when Congress decided to allocate the majority of the Title V appropriation to earmarked programs, leaving too little to continue the formula distribution to the States. The report states that although many communities have benefited from Title V Federal support, "many thousands more communities have requested, but not yet received, funding and technical assistance to develop their own prevention programs. . . continued support and patience at the federal

level are critical at this time" (Office of Juvenile Justice and Delinquency Prevention, 2005).

Funding challenges notwithstanding, OJJDP continues to provide training and technical assistance to help communities choose evidence-based juvenile delinquency prevention strategies. A key tool developed by OJJDP is the Title V Model Programs Guide and Database, which is an interactive Web page available to both current and potential Title V subgrantees, juvenile justice practitioners, and researchers. The database describes state-of the-art research on 16 programs organized within the 5 life domains (individual, peer, family, school, and community). The Web page includes a searchable database and program descriptions of more than 100 model programs.[52]

4. Family Violence Prevention and Services—Grants for Battered Women's Shelters; Grants to State Domestic Violence Coalitions

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. This grant program strengthens domestic violence intervention and prevention through coordination, training, and collaboration with systems that affect women who are victims of domestic violence and provides services, community education, and technical assistance to establish and maintain shelter and related services for these women and their dependents.

Type of Funding. Under this formula grant program, no less than 10 percent of funds are made available to the State Domestic Violence Coalitions, which are membership organizations representing the majority of domestic violence shelters in each State. FY 2006 funding is approximately $12.6 million. Each State Domestic Violence Coalition received approximately $237,000 in FYs 2005 and 2006 and will receive approximately the same amount in FY 2007 based on small changes in the allotment.

How Funds Are Managed. Funds are awarded directly to statewide nonprofit State Domestic Violence Coalitions.

Eligible Populations. Services funded under this program benefit victims of domestic violence, their children and other dependents, their families, and other persons affected by such violence, including friends, relatives, and the general public. There is no income or other eligibility restriction.

Use of Funds. The State coalitions provide information, technical assistance, and training to local domestic violence programs and support the implementation of collaborative activities with public agencies and other direct service providers (including substance abuse treatment providers) within their States. Funds may be used for a range of activities such as:

- Working with judicial and law enforcement agencies to encourage appropriate responses to domestic violence cases and to examine legal issues

- Working with family law judges, criminal court judges, child protective services, and children's advocates to develop appropriate responses to child custody and visitation issues in domestic violence cases as well as cases where both domestic violence and child abuse are present
- Conducting domestic violence public education campaigns
- Providing trauma-informed and trauma-specific services

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Because many women with substance use disorders also experience domestic violence, substance abuse treatment providers often include domestic violence services as part of their comprehensive set of services. To increase the likelihood of tapping into these family violence and prevention services, treatment providers should increase their networking by seeking representation on or developing close connections with the State Domestic Violence Coalition and identifying opportunities to collaborate directly with domestic violence shelters to provide co-located substance abuse and domestic violence services for clients.

Important Restrictions. None of note.

Of Special Note. Nothing at this time.

5. Family Violence Prevention and Services—Grants to States and Indian Tribes

Responsible Federal Agency. ACF, DHHS.

General Description/Overview. This grant program helps States and Indian Tribes prevent incidents of family violence and provide immediate shelter and related assistance to victims of family violence and their dependents.

Type of Funding. The reauthorization of this formula grant program in 2000 established a base amount of $600,000 for each State. Any remaining funds are allotted based on each State's population. At least 10 percent of funds are allocated to Indian Tribes, tribal organizations, and nonprofit private organizations approved by an Indian Tribe. Existing programs are required to provide a minimum 20-percent cash or in-kind local match; for new programs, the match is 35 percent. Funding for FY 2007 is approximately $100 million.

How Funds Are Managed. States and Tribes distribute these funds to local public agencies and nonprofit organizations that provide domestic violence prevention and intervention services.

Eligible Populations. This program is for victims of family violence and their dependents. States and Tribes are prohibited from imposing an income eligibility standard on individuals receiving services supported by funds.

Use of Funds. States must allocate at least 70 percent of funding to entities to provide immediate shelter for victims of family violence and related assistance and at least 25 percent for other family violence and prevention-related services. States have substantial discretion in how they use the latter; services may include, but are not limited to:

- Community prevention and outreach
- Preventive health services within domestic violence programs (including nutrition, disease prevention, exercise, and substance abuse prevention)
- Referrals to appropriate health care services, including substance abuse treatment, and other community services
- Employment training and educational services
- Parenting training and education
- Individual, family, or group counseling
- Children's counseling, support services, and specialized programs
- Crisis intervention
- Transportation and technical assistance in obtaining other Federal and State assistance
- Legal advocacy and assistance
- Child care services
- Linkage to child protection services
- Trauma-informed and trauma-specific services

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Because of the overlapping needs of clients in the substance abuse, domestic violence, and child welfare systems, treatment providers need to collaborate to provide integrated services to these women and their children. Providers need to learn their State's process for determining service and funding priorities and partner with others as needed.

Important Restrictions. Funds cannot be used for direct financial payments to victims or reimbursements for health care services but can be used to link individuals to other programs that provide needed financial assistance and health care.

Of Special Note. States must give special emphasis to nonprofit, community-based projects with demonstrated effectiveness.

6. Housing Opportunities for Persons with AIDS

Responsible Federal Agency. Community Planning and Development, U.S. Department of Housing and Urban Development (HUD).

General Description/Overview. The Housing Opportunities for Persons with AIDS (HOPWA) program helps States and localities develop long-term comprehensive strategies to address the housing needs of persons with low incomes and HIV/AIDS and their families. This assistance enables individuals living with HIV/AIDS and their

families to establish or maintain stable housing, reduce their risks of homelessness, and improve their access to health care and other related support.

Type of Funding. The HOPWA grant program includes both formula (90 percent of appropriated funds) and competitive project grants (10 percent). The formula grants are allocated to States and cities qualifying as eligible metropolitan statistical areas (population of more than 500,000 and at least 1,500 cumulative AIDS cases). The metropolitan areas allocation is based on its proportionate share of the incidence of AIDS cases. The FY 2007 HOPWA appropriation is approximately $286 million; the President's proposed FY 2008 budget request increases this to $300.1 million.

How Funds Are Managed. With the metropolitan areas, which receive the majority of the formula grants, the largest city serves as the formula grant administrator.

Eligible Populations. Eligible beneficiaries are persons with low income who have been diagnosed with HIV or AIDS and their families. Grantees report that about 91 percent of HOPWA beneficiaries have a family income of less than $1,000 per month and all families are low income (less than 80 percent of area median income). Regardless of income, persons with AIDS may receive housing information and persons living near community residences may receive educational information.

Use of Funds. HOPWA funds have helped many communities establish strategic AIDS housing plans, better coordinate local and private efforts, engage in program planning and development activities, fill gaps in local systems of care, and create new housing resources. Funds may be used for a variety of permanent housing information and placement services:

- Counseling, information and referral, and resource identification
- Purchase, lease, construction, rehabilitation, and conversion of housing
- Rental or mortgage payment assistance
- Operating costs for housing (e.g., utilities, insurance, furnishings, security)
- Technical assistance, training, and oversight in establishing and operating a community residence

Appropriate support services must be provided as part of any HOPWA-assisted housing and are seen as an essential component of overall client assistance. Approximately 25 to 30 percent of HOPWA expenditures are for support services; in 2001, nearly $3.5 million (four percent of all support service formula grant expenditures) was spent on substance abuse services (U.S. Department of Housing and Urban Development, 2003, 2006). Funds may be used for a range of support services including, but not limited to:

- Drug and alcohol abuse treatment and counseling
- Health services (see Important Restrictions below)
- Mental health services
- Outreach
- Needs assessments

- Case management/care coordination
- Child care
- Personal assistance
- Education
- Employment assistance and training
- Legal services
- Life skills management
- Nutritional services
- Intensive care when required
- Assistance in obtaining local, State, and Federal government benefits and services
- Transportation

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Local jurisdictions decide how best to use the funds to meet the locally determined housing needs of people living with HIV/AIDS. At the local level, a range of public agencies (e.g., housing and community development, health and human services, welfare) administers HOPWA formula grants in their communities, typically through a competitive process. In their plans, States must indicate their method of selecting sponsors (including providing access to grassroots faith-based and other community organizations).

Important Restrictions. Health services may only be provided to individuals with HIV/AIDS, not their family members. Payments for AIDS drug assistance and other health care costs are limited to items and services that are not covered under insurance, compensation programs, or other health benefits programs. The program has established general standards for housing and rental activities.

Of Special Note. In 2006, after 2 years of collaborative work among national housing and community development associations, HUD, and the Office of Management and Budget, HUD's Office of Community Planning and Development implemented a new outcome performance measurement system for HOPWA and several other HUD formula funding programs. Grantees must incorporate these performance measures in FY 2007.[53]

7. HIV Care Formula Grants (Title II of the Ryan White CARE Act)

Responsible Federal Agency. HRSA, DHHS.

General Description/Overview. This grant program helps States improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease.

Type of Funding. All Title II HIV Care grants are determined by formula. Each State's allocation is based on its estimated number of living AIDS cases.[54] However, a minimum grant provision ensures no State shall receive less than $200,000 if it has less than 90 estimated living AIDS cases or $500,000 if it has more than 90 estimated living AIDS cases. Matching funds (cash or in-kind, based on a formula) are required from States with

more than 1 percent of the total AIDS cases reported to the Centers for Disease Control and Prevention nationally (Johnson & Morgan, 2005). Requested funding for FY 2007 care grants was approximately $401 million, $70 million more than the FY 2006 appropriation of $331 million. (Title II also includes approximately $789.5 million in earmarked funds for the AIDS Drug Assistance Program, which provides HIV-related medications and is the largest single CARE Act program.) On December 19, 2006, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 was signed into law, extending services under the Ryan White CARE Act program.

How Funds Are Managed. The State's public health agency is responsible for administering the grant. Most States provide some services directly, whereas others work through subcontracts with their Title II HIV Care Consortia (an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers HIV treatment and support services).

Eligible Populations. Individuals and families with HIV disease may receive Title II-funded services. Services must be accessible to individuals with low incomes.

Use of Funds. Under the new 2006 law, grantees must spend at least 75 percent of funds to provide core medical services, which include:

- Outpatient and ambulatory health services
- Pharmaceutical assistance
- Substance abuse outpatient care
- Mental health services
- Oral health
- Medical nutritional therapy
- Health insurance premium assistance
- Home health care
- Hospice services
- Home- and community-based health services
- HIV/AIDS early intervention services
- Medical case management, including treatment adherence services

Remaining funds may be spent on support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes, such as:

- Outreach
- Medical transportation
- Legal services
- Housing services
- Linguistic services (e.g., interpretation and translation)
- Case management (non-medical)
- Child care and respite care
- Health education/risk reduction

- Child welfare and family services (including foster care and adoption services)
- Psychosocial support services
- Referrals for health care and other support services

States must use a percentage of the grant to provide health and support services to infants, children, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV. The reauthorization also provides for supplemental grants to States for the universal testing of newborns for HIV/AIDS. It also supports the provision of family-centered care for women and children with HIV/AIDS, including the provision of support services such as referrals for inpatient hospital services, treatment for substance abuse, mental health services, and other social services.

A recent national survey of Title II State agencies found that of the 47 responding States, 18 (38 percent) fund some form of substance abuse services (e.g., outpatient counseling, methadone maintenance, residential treatment, acute detoxification, inpatient treatment, other support services). Of these 18 States with substance abuse treatment programs, seven said they target women and four indicated they target women and their children (Tobias, Wood, & Drainoni, 2006). In addition, data on Title II services provided in 2003 indicate that nearly 1,900 clients received permanency planning support services and nearly 1,200 received child welfare services (Health Resources and Services Administration, HIV/AIDS Bureau, 2005).

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

This is an important funding source for many substance abuse treatment providers. Because State practices vary (e.g., some provide services directly, whereas others work through subcontracts with their Title II HIV Care Consortia), treatment providers should contact their State's public health agency for more information on their State's structure, operations, and application process.

Important Restrictions. A State may not use more than 15 percent of funds for the combined activities of planning, evaluation, and administration; individually, States cannot spend more than 10 percent on each respective activity. Funds may not be used to purchase or improve land; to purchase, construct, or make permanent improvement to any building except for minor remodeling; or to make payments to individuals receiving services.

Of Special Note. To receive Title II funding, States must ensure that they will make a good faith effort to notify a spouse of an HIV-infected patient and advise that spouse to seek testing.

8. Project for Assistance in Transition from Homelessness

Responsible Federal Agency. SAMHSA, DHHS.

General Description/Overview. The Project for Assistance in Transition from Homelessness (PATH) helps States provide community-based support to individuals with SMI or a co-occurring SMI and substance use disorder and who are homeless or at imminent risk of becoming homeless.

Type of Funding. This formula grant program provides allotments based on a State's urban population compared with the total U.S. urban population. States with larger populations receive more funding; however, each State receives a minimum allotment of $300,000. There is a required one-third cash or in-kind State match (i.e., State or local agencies must put up $1 for every $3 of Federal funds they receive). The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 authorized PATH at $75 million; FY 2007 funding is $54 million.

How Funds Are Managed. Funds are provided to States, which disperse them to qualified local service providers that serve individuals who are homeless and have a mental illness.

Eligible Populations. Individuals who are homeless and have an SMI are eligible. There are no age limits, but individuals must qualify according to specific State guidelines.

Use of Funds. Funds may be used for a variety of services and activities including:

- Substance abuse treatment (for those with co-occurring disorders)[55]
- Outreach
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community mental health services
- Case management services
- Assistance in obtaining income support and other services
- Referrals for primary health services, job training, and educational services
- A limited set of housing services
- Staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are homeless require services
- Supportive and supervisory services in residential settings

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Substance abuse treatment agencies should contact their designated State agency for more information on how PATH is administered in their State.[56] In California, for example, only county mental health departments can apply directly to the California Department of Mental Health for PATH funding. County mental health departments can use the funding to directly provide PATH-approved services or contract with private providers.

Important Restrictions. Not more than 20 percent of funds may be used on housing services. Funds may not be used to support emergency shelters or construction of housing facilities; to pay inpatient psychiatric treatment or inpatient substance abuse treatment costs; or to make cash payments to intended recipients of mental health or substance abuse services.

Of Special Note. Funds may not be provided to any entity that has a policy of excluding individuals from mental health services because of the existence or suspicion of substance abuse or vice versa.

9. Residential Substance Abuse Treatment for State Prisoners

Responsible Federal Agency. Bureau of Justice Assistance, OJP, U.S. Department of Justice.

General Description/Overview. The Residential Substance Abuse Treatment (RSAT) for State Prisoners program provides assistance in developing and implementing residential substance abuse programs for incarcerated inmates in State and local correctional facilities; assists offenders and communities with the reentry and reintegration process; and creates and maintains community-based treatment and other aftercare services for offenders.

Type of Funding. Under this formula grant program, each participating State is allocated a base award of 0.4 percent of the total available RSAT funds. The remaining funds are allocated to States based on their prison population relative to the total prison population nationwide. The program requires a 25-percent cash State match. The allocation for FY 2006 was $9.6 million.

How Funds Are Managed. The State Administering Agency (SAA), which is the State office designated to administer the Byrne Justice Assistance Grant Program, awards subgrants to State agencies (typically department of corrections) or units of local government that will implement treatment programs for incarcerated offenders. States must give preference to subgrant applicants who provide aftercare services to program participants.

Eligible Population. Offenders in State and local correctional and detention facilities are eligible to participate in RSAT. Participation should be limited to inmates with 6 to 12 months remaining in their confinement, so they can be released from prison or jail instead of returning to the general inmate population after completing the program.

Use of Funds. Funds may be used to implement three types of treatment programs: residential, jail based, and aftercare. At least 10 percent of a State's allocation must go to local correctional and detention facilities (provided such facilities exist) for either residential or jail-based substance abuse treatment programs.

Residential and jail-based treatment programs must be set apart from the general correctional population; focus on the substance use problems of the inmate; and develop the inmate's cognitive, behavioral, social, vocational, and other skills to solve his or her substance abuse and related problems. Residential programs must last between 6 and 12 months, whereas jail-based programs must be a minimum of 3 months and based on effective, scientific practices.

Aftercare services must involve coordination between the correctional treatment program and other social service and rehabilitation programs, such as education and job training, probation and parole, halfway houses, self-help, and peer group programs. To use funds for aftercare, States must certify that they provide an adequate level of residential treatment services. To qualify as an aftercare program, the head of the substance abuse treatment program must work with State and local authorities and other substance abuse treatment organizations to place program participants into community substance abuse treatment facilities on their release.

How Substance Abuse Treatment Providers/State Agencies Can Leverage These Funds

Treatment providers should contact their SAA for information on their State's priorities, which State or local agency will be distributing funds, and how to become a contracted treatment provider.[57]

Important Restrictions. A State may use RSAT funds to provide treatment to offenders for a maximum of 1 year after their release. No more than 10 percent of the total award may be used for treatment of those released from a State facility. Funds may not be used for land acquisition or construction projects.

Of Special Note. Applicant States must agree to implement or continue to require urinalysis or other proven reliable forms of drug and alcohol testing of individuals assigned to residential substance abuse treatment programs in correctional facilities.

A Word About Federal Discretionary Project Grant Opportunities

In addition to the nearly 30 formula and block grant programs identified above are a multitude of Federal discretionary project grant programs that fund substance abuse treatment and related support services for women and their children and families. (See Appendix B for some examples of these discretionary grant programs.) As with almost any funding source, there are drawbacks and benefits. On the one hand, discretionary grants are often short term, targeted, and highly competitive. On the other hand, they allow grantees to test and implement new and innovative approaches, identify best practices, fund specific program components or activities (e.g., collaboration) that formula or block grants might not allow, and fill short-term funding gaps. The size and length of the award can vary greatly by program. As a result, some require and support a strong evaluation component, whereas smaller grants do not include enough funding to perform adequate evaluation.

Treatment providers can take steps to increase access to and maximize discretionary grant opportunities. For instance, many grant programs require a community-based prevention and treatment collaboration. By creating partnerships with a range of other community organizations, individual treatment providers (particularly small ones) can expand their funding options. Working as part of a collaborative or consortium to identify and pursue shared funding needs minimizes the labor and other costs associated with the grant application process (Relave & Mendes, 2005).

A key challenge with discretionary programs is their dynamic nature. Various opportunities change with budget cycles and shifts in priorities, so routine monitoring of funding prospects is needed. Several Web-based resources (e.g., http://www.grants.gov, http://www.cfda.gov) provide information about new funding opportunities and identify and track discretionary programs that support clinical treatment and community support services for women and their children and families. Most sponsoring agencies, such as SAMHSA, ACF, and HRSA, provide extensive information on their Web sites and send out funding announcements to interested individuals. The Federal Government also offers technical assistance resources, such as Webcasts, conferences, trainings, and manuals on grant-writing and application processes.[58] It is important to be aware of these resources because, since FY 2006, Federal agencies have not announced new grant opportunities in the Federal Register. In a related matter, the Federal Funding Accountability and Transparency Act of 2006 (S. 2590) was signed into law on September 26, 2006. Pursuant to this legislation, a single, searchable, publicly available Web site was developed (http://www.usaspending.gov) that provides comprehensive data on all Federal grants, subgrants, contracts, and loans awarded during the past 10 fiscal years.

IV. STATE FUNDING ISSUES AND SOURCES

While Federal formula grants and entitlement programs are important sources of substance abuse treatment funding, State resources are an equally important and essential piece of the funding puzzle. Indeed, among public payers, State and local government funding (excluding the State portion of Medicaid) accounted for more than half (52 percent) of all public substance abuse treatment spending in 2003, up from 45 percent in 1993. When the State and local share of Medicaid is added, the percentage of State funding in 2003 increases to approximately 62 percent. From 1993 to 2003, the annual growth rate for State and local government substance abuse treatment spending was 6.1 percent, compared with 4.4 percent for Medicaid and 1.7 percent for other Federal expenditures (Mark et al., 2007).

Program Sustainability—Lessons From CSAT's Residential Women and Children and Pregnant and Postpartum Women Projects

(Caliber Associates, 2003)

Between 1993 and 1995, CSAT awarded 50 grants under the RWC/PPW Demonstration Program. As part of the cross-site evaluation of the program, a sustainability study was conducted with 36 projects. The study found that all but three had obtained funding to sustain themselves, and one-third (12) maintained, or even expanded, treatment services following their CSAT grant period.

The study documented that securing funding from the State was key to sustainability. Projects obtained State support and funding by engaging in early and careful sustainability planning, developing effective relationships with SSA officials and State legislators, and using evaluation data, among other factors. Projects also obtained additional financial support from private foundations and from Federal and local governments.

State support is often vital to a program's sustainability. As demonstration or short-term Federal or private foundation project funding comes to an end, a program—provided it has proven outcomes—may lobby the State for long-term, sustained support. For instance, many original grantees under CSAT's Residential Women and Children and Pregnant and Postpartum Women (RWC/PPW) Demonstration Program found that obtaining State funding was key to program sustainability (see box).

This section provides a general overview on State spending for substance abuse treatment, discusses several major State funding sources, and describes examples of initiatives that States may draw on to advance their ability to track substance abuse treatment funding and use such information for program planning, sustainability, and policymaking.

A. State Agency Spending

Obtaining an accurate picture of State spending on substance abuse treatment and supportive services is a complex endeavor. The National Association of State Budget Officers (NASBO) is the only entity that regularly collects and publishes (in its *State Expenditure Report*) State budget expenditure data for the 50 States (Flores, Douglas, & Ellwood, 1998). NASBO provides important data on State spending across seven major expenditure categories, yet the data are aggregated in such a way that spending

specifically on substance abuse treatment is impossible to identify.[59] A more detailed companion document to the *State Expenditure Report* is the *2002–2003 State Health Expenditure Report*, which identifies and summarizes the amount of State-funded health expenditures in the following broad categories: Medicaid, SCHIP, State employees' health benefits, corrections, higher education, insurance and access expansion, direct public health care, State facility-based services, community-based services, and population health (Milbank Memorial Fund, National Association of State Budget Officers, and the Reforming States Group, 2005). Information in each category includes expenditures to cover treatment of physical health conditions and mental health and substance abuse services. Again, spending on substance abuse treatment cannot be easily teased out because it falls under multiple categories including corrections, State facility-based services, direct personal health expenditures, and population health expenditures.

Most State funding for substance abuse treatment tends to come from State General Funds and cuts across various State agencies, including health, education, and criminal justice. Currently, no centralized source of information identifies across the States the total amounts allocated from State General Funds for substance abuse treatment to the various State agencies that provide substance abuse services. Rather, available data tend to report aggregate State-level expenditures, broken out more generally by State agency or major funding source.

The States' SAPTBG applications present funding information from the perspective of the SSAs, which have the primary responsibility for managing the provision of substance abuse treatment services that are supported by multiple funding streams (e.g., the SAPTBG, other Federal funds, State funds, Medicaid funds, private foundations). The *State Substance Abuse Prevention and Treatment Block Grant Inventory*, published by the Office of National Drug Control Policy, provides a detailed accounting of all SSA expenditures on substance abuse prevention, treatment, and other activities. In FY 2003, SSA expenditures from all State agencies (excluding Medicaid) totaled nearly $1.68 billion and accounted for 42 percent of total expenditures on substance abuse treatment. State funds as a percentage of total SSA substance abuse expenditures varied among the States, ranging from 12 to 69 percent, with an average of 39 percent. State funds composed 50 percent or more of all substance abuse treatment spending in 13 States and 25 percent or less of all funds in 12 States. SAPTBG dollars as a percentage of total expenditures ranged from 13 to 87 percent, with an average of 44 percent. SAPTBG funds made up 50 percent or more of all spending in 19 States and 25 percent or less in 9 States (Office of National Drug Control Policy, 2006).

In addition to General Funds and SAPTBG dollars, many States also provide funding sources that may be used to support substance abuse treatment and related services. Several are described below. Because State funding sources are so numerous and diverse—so much so that listing them all is not possible—providers need to be knowledgeable about how their State government is organized and which divisions are responsible for which funds (Center for Substance Abuse Treatment, 2000).

B. Tobacco Master Settlement Agreement Funds

Aside from State General Funds and various State agency contributions, tobacco settlement funds represent another potential funding source for many States. Under the 1998 Master Settlement Agreement (MSA), tobacco companies will give $206 billion to 46 States over 25 years.[60] In FY 2005, these 46 States received approximately $5.8 billion in MSA funds (down from $9.7 billion in FY 2004). MSA allows States to use their tobacco settlement payments for any purpose. To help decide how to spend the funds, some States established planning commissions and working groups to develop recommendations and strategic plans. In six States voters approved initiatives restricting the use of funds for certain purposes, whereas in 30 States, the legislatures enacted laws restricting their use (U.S. Government Accountability Office, 2007).

From FY 2000 through FY 2005, States used the largest portions to fund health care programs (including substance abuse treatment) and address budget shortfalls (30 and 23 percent, respectively). Funds were also used for general purposes, infrastructure, education, tobacco control, and social services (including drug courts, child welfare, and foster care services), among other things. However, States' allocations to these various categories have fluctuated over the years. For example, allocations for health care programs ranged from 20 to 38 percent, whereas funds for budget shortfalls ranged from 4 to 44 percent of the total payments. In FY 2005, Illinois, Maryland, Michigan, and Pennsylvania, allocated larger amounts to health care than other States; Maryland used some of its funds for substance abuse services (U.S. Government Accountability Office, 2007).

Most States that fund health-related programs broadly allocate their monies for health care services. Although several States have approved—at one time or another—line items for substance abuse prevention and treatment programs, few States have consistently identified alcohol and drug abuse treatment as a priority expenditure for tobacco settlement funds.[61] In 2001, for example, ten States allocated money for substance abuse or mental health programs (National Governors Association for Best Practices, 2001). Below are examples of some States' efforts over the last several years; this is not an exhaustive list (Campaign for Tobacco-Free Kids, 2002; McKinley, Dixon, & Devore, 2003):

- *Colorado* enacted legislation in 2000 regarding the distribution of the State's tobacco settlement revenue, which included up to $8 million for substance abuse treatment. However, lawmakers have not always followed this initial framework.
- *Indiana* has allocated funds since 2003 to support the Indiana State Department of Health Prenatal Substance Use Prevention Program and the legislatively mandated Test for Drug Afflicted Babies (Indiana Tobacco Prevention and Cessation, 2005).
- *Kentucky*'s spending plan includes 25 percent to early childhood development and 25 percent to health care improvement. The early childhood initiative, which began in 2001, includes a public awareness campaign about the harmful effects of substance use during pregnancy as well as a substance abuse and pregnancy

initiative that provides screening, prevention education, and treatment services to all pregnant women in the State. In FY 2004, $2.2 million was allocated to substance abuse programs under the auspices of health care improvement.

- In *Maine*, for both FY 2003 and FY 2004, $5.6 million was allocated for adult and youth substance abuse treatment and prevention, with an additional $900,000 to support drug court efforts.
- *Maryland*'s General Assembly appropriated $18.5 million for substance abuse treatment in FY 2002 and $17.1 million for substance abuse treatment for FY 2004.
- In *Mississippi*, the Department of Health received $6.5 million in 2003 funding for crisis centers and substance abuse programs.
- *Wyoming* enacted legislation in 2002 that allocated $25 million of the State's tobacco settlement funds to provide a State comprehensive substance abuse program.
- *Vermont*'s FY 2001 appropriation included $1.1 million for the Office of Alcohol and Drug Abuse and an additional $450,000 for youth drug abuse prevention.
- *Utah*, in 2004, used tobacco settlement money to support nine Adult Felony Drug Courts, four Family/Dependency Courts, three Juvenile Drug Courts, and one Dual-Model Drug Court; funds provided case management, treatment, and drug testing (Division of Substance Abuse and Mental Health, 2005).
- The *Solano County (California)* MSA Project Implementation Plan includes reduced rates of alcohol, tobacco, and drug use as one of its two key goals. Funds have been allocated for various prevention planning and treatment activities, with an emphasis on reduced use by youth (Solano County Health and Social Services, 2005).
- *Iowa* is one State that has consistently identified substance abuse treatment among its priority uses for the tobacco settlement funds. In FYs 2003–2005, Iowa's Department of Public Health received $11.8 million in tobacco funds for substance abuse treatment. Also in FY 2005, as mandated by the Healthy Iowans Tobacco Trust bill (HF 862), the department received an additional $800,000 for a grant program to provide substance abuse prevention programs for children and $400,000 for a high school mentor substance abuse prevention grant program. The bill also appropriated funds to the Department of Corrections for drug court programs.[62]

C. Alcohol and Cigarette Excise Taxes

Two other sources of State funds that can be tapped for substance abuse treatment are alcohol and tobacco excise taxes. All 50 States and the District of Columbia currently have both State alcohol and tobacco excise taxes in place. Tax revenues typically flow into States' general funds, where they may be allocated for any number of programs (e.g., education, transportation, pension relief). However, a number of States have chosen to use some portion of these revenues for substance abuse prevention and treatment efforts. For example, ten States currently earmark *alcohol* excise tax revenues to fund substance abuse treatment programs; [63] several other States, including Massachusetts, Missouri, and Oklahoma, have recently debated similar proposals (Turner, 2005).

It is not known how many States currently allocate *cigarette/tobacco* excise tax revenues to substance abuse programs. No comprehensive source regularly tracks how States allocate these revenues. Funding varies among States and can vary from one legislative session to the next. *The Fiscal Survey of States*, which is published twice a year by the National Governors Association and the National Association of State Budget Officers, indicates, for instance, that in FY 2006, Governors in 10 States enacted changes to their States' alcohol and/or cigarette and tobacco taxes that were expected to result in more than $1.2 billion in additional revenue, whereas in FY 2007, 5 States enacted legislation to generate an anticipated $493.3 million in additional revenue. FY 2008 shows a continued trend in increased taxes, with eight States increasing cigarette/tobacco excise taxes to produce nearly $762 million in revenues, making such taxes the largest source of revenue increases in enacted FY 2008 budgets.[64]

An inventory of all dedicated State tax revenues for FY 1997 indicated that 10 States allocated some portion of their alcohol and/or tobacco sales, use, and excise taxes for substance abuse prevention, treatment, or related programs. The amount of funding varied among States, as indicated below (Fiscal Planning Services, Inc., 2000):

- *Arizona*. $4.4 million of liquor taxes dedicated to drug treatment, prevention, and education programs
- *Idaho.* $6.8 million from alcohol and tobacco taxes to alcohol treatment and substance abuse programs in public schools
- *Michigan.* $8.0 million of liquor taxes for local governments, including for substance abuse treatment
- *Missouri.* $32.3 million of cigarette taxes for health initiatives, including substance abuse treatment and rehabilitation
- *Montana.* $1.6 million of alcohol taxes for treatment of, rehabilitation from, and prevention of alcoholism
- *Nevada.* $600,000 of liquor taxes for alcohol and drug abuse treatment programs
- *New Jersey.* $76.1 million from alcohol taxes to support alcohol education, rehabilitation, and enforcement
- *Oregon.* $5.8 million of alcohol excise taxes for substance abuse prevention, intervention, and treatment
- *Tennessee.* $100,000 of beer excise taxes for alcohol and drug treatment programs
- *Washington.* $48 million from alcohol and tobacco taxes to alcohol and drug programs (plus $7.9 million for drug enforcement and education)

Recently, as State budgets have become increasingly tight, many States have been trying—with varying degrees of success—to levy increases in their alcohol or tobacco excise taxes to support substance abuse treatment programs. In March 2007, for example, Iowa passed legislation (SF 128) increasing the cigarette tax from $0.36 to $1.36 a pack. Revenues from the increased tax are to be deposited into a health care trust fund that will be used to provide funding for health care; substance abuse treatment and prevention; and tobacco use prevention, cessation, and control (Iowa Legislature General Assembly, n.d.). Wyoming and South Dakota, however, were not as successful in their efforts. In early

2008, both States tried, but failed, to pass tax increases. Wyoming's proposed beer tax increase, which would have generated $14.5 million annually to be directed into a new substance abuse treatment account to pay for prevention and treatment services, failed upon introduction to the House. South Dakota's dime-a-drink alcohol tax increase that would have raised $35 million to help pay for programs to address problems related to alcohol abuse suffered a similar fate.

Despite strong public support for increased taxes (Harwood, Wagenaar, & Bernat, 2002), research supporting that higher alcohol taxes result in less drinking and fewer drinking-related problems (National Institute on Alcohol Abuse and Alcoholism, 2000), and the Institute of Medicine's recent recommendation that Congress and legislatures increase alcohol taxes to curb underage drinking (Bonnie & O'Connell, 2004), these types of proposals can encounter fervent opposition from some politicians and industry lobbyists. For example, in 2003, only 14 of the 36 States that proposed tobacco excise tax increases passed them (use of additional funds may have been earmarked for various activities, not necessarily to support substance abuse treatment) (National Conference of State Legislatures, 2003). Six States passed legislation or ballot initiatives to increase their cigarette taxes in 2006, whereas eight States increased their cigarette taxes in 2005 (American Lung Association, 2007). In determining their readiness for such legislation, States will need to comprehensively assess their social, political, cultural, and economic environments (Tremper & Mosher, 2005).

D. Treatment as an Alternative to Incarceration and Other Ballot Initiatives

Although legislators have a large role in funding decisions on substance abuse treatment, the general public can help shape State-level policy. One way is through the initiative process. Twenty-four States have a direct or indirect initiative process, which enables residents to place a proposed law on the statewide ballot, bypassing the State legislature (Initiative and Referendum Institute, n.d.). Even though 24 States have the statewide initiative process, more than 60 percent of all initiative activity has taken place in just six States: Arizona, California, Colorado, North Dakota, Oregon, and Washington (Ballot Initiative Strategy Center, n.d.).

The ballot initiative process has been a driving force behind the "treatment as an alternative to incarceration" movement that has succeeded in a number of States and is picking up momentum in several others. States are increasingly being forced to deal with budget shortfalls and find innovative ways to address mounting fiscal pressures. In response to the high costs of incarceration, a growing prison population of drug offenders, and research showing the cost effectiveness of substance abuse treatment versus prison (McVay, Schiraldi, & Ziedenberg, 2004), several States have opted to enact legislation that provides treatment instead of incarceration to certain nonviolent drug offenders (Rinaldo & Kelly-Thomas, 2005).

Arizona was the first State to pass a treatment instead of incarceration proposition, and California later followed suit. These two States have served as models for Kansas, Kentucky, Hawaii, Maryland, and Washington, which have passed similar legislation. (The District of Columbia passed a similar initiative in 2002, but it was overturned by

court order in January 2005.) In addition, Alabama passed the Mandatory Treatment Act of 1990, which established, among other things, a court referral pretrial diversion program allowing any person arrested or charged with a controlled substance offense to request substance abuse treatment in lieu of undergoing prosecution; the district attorney has discretion to approve or deny the request (Colker, 2004). Brief descriptions of Arizona's and California's efforts are provided below.

Arizona—Drug Medicalization, Prevention and Control Act

In November 1996, voters passed the Drug Medicalization, Prevention and Control Act, which required courts to sentence first- and second-time nonviolent drug offenders to probation and substance abuse treatment. The act, which was reauthorized in 2000, established the Drug Treatment and Education Fund (DTEF) to provide the required education and treatment services and mandated the Administrative Office of the Courts to prepare a report detailing the cost savings realized from this diversion program.

The DTEF receives a percentage of revenues from Arizona's luxury taxes on liquor. Half of the funds are allocated to the 15 Superior Court adult probation departments throughout the State to pay for the probationers' substance abuse education and treatment programs. The other half is transferred to the Arizona Parents Commission on Drug Education and Prevention for programs that increase and enhance parental involvement and increase education about the risks and public health problems caused by substance abuse.

In FY 2005 more than $3.1 million was expended by adult probation departments throughout the State to provide treatment services to 8,575 probationers either mandatorily sentenced to probation pursuant to the drug act or to probationers in need of subsidized substance abuse treatment services. Of the 7,158 who ended treatment at the end of FY 2005, 56 percent complied with treatment requirements. The average cost of substance abuse treatment per probationer who entered treatment was approximately $363; cost avoidance for that year was estimated at more than $11.7 million (Arizona Supreme Court, 2006).

California—Substance Abuse and Crime Prevention Act (Proposition 36)[65]

In November 2000, California voters approved the Substance Abuse and Crime Prevention Act (SACPA), also known as Proposition 36. This initiative allows first- and second-time nonviolent, simple drug possession offenders to receive substance abuse treatment instead of incarceration. SACPA, which went into effect on July 1, 2001, allocated $60 million to the Substance Abuse Treatment Fund from the General Fund for the final 6 months of FY 2000–2001. An additional $120 million has been allocated annually through FY 2007–2008; funding for FY 2008–2009 is $108 million.

Funds are distributed to California's 58 counties based on per capita arrests for drug possession, treatment bed availability, and individual offender needs. These funds must serve as additional resources for substance abuse treatment and cannot supplant any

existing treatment funds. In the 2001–2002 budget year, Proposition 36 funding accounted for 19 percent of California's $682 million in State and Federal funding for substance abuse treatment.

SACPA defines substance abuse treatment to include a wide array of treatment services, including prevention, education, vocational training, family counseling, housing, and supportive services. It requires local agencies to coordinate their efforts to ensure clients receive needed services. Each of California's 58 counties was required to create and implement a localized plan. At the State level, agencies created an interagency committee to review implementation efforts and advise State leaders on policy or funding changes necessary for success.

In the first 4 years of SACPA, a total of 193,884 offenders were referred to treatment; of these, 139,804 (72 percent) entered treatment. About half of SACPA treatment clients in each year were entering treatment for the first time. The percentage breakdown by gender has remained virtually the same across the 4 years, with slightly more than one-fourth (27 percent) being female. The majority of clients were placed in outpatient treatment programs.[66]

Even with treatment defined to include a full spectrum of necessary treatment and supportive services, the California model provides annual savings of up to $20,000 per client (Little Hoover Commission, 2003). It is expected that this initiative will save California taxpayers $1.5 billion over 5 years.

The University of California, Los Angeles, Integrated Substance Abuse Program (UCLA-ISAP) conducted a 5-year independent statewide evaluation of SACPA. The evaluation covered four domains: implementation, offender outcomes, cost-offsets, and lessons learned. The final evaluation report released by UCLA-ISAP outlined several cost savings to State and local governments. Overall, SACPA saved nearly $2.50 for every $1 invested; for offenders who completed their required drug treatment, nearly $4 was saved for each $1 expended. Furthermore, cost savings per offender were constant across 2 years ($140.5 million for first-year offenders and $158.8 million for second-year offenders), suggesting stability in cost-benefit outcomes (University of California, Los Angeles, Integrated Substance Abuse Program, 2007). In addition, a 2006 report from the Justice Policy Institute found that since the implementation of SACPA, the drug possession incarceration rate has declined 34 percent and, of the 10 largest State prison systems, California has experienced the largest drop in the number of drug prisoners (Ehlers & Ziedenberg, 2006). A second round of evaluation of SACPA began in 2007.

Supporters of SACPA are currently gathering the needed signatures to get a new measure, the Nonviolent Offender Rehabilitation Act of 2008, on the November 2008 ballot in California. The measure would require increased treatment funding for offenders and give judges latitude to incarcerate offenders who do not comply with court-ordered treatment, among other things.

Other California Ballot Initiatives—Mental Health Services Act (Proposition 63) and California Children and Families Act (Proposition 10)

In addition to SACPA in 2000, California leveraged the ballot initiative process in 2004, when 54.4 percent of voters passed the Mental Health Services Act (MHSA), or Proposition 63. MHSA establishes a 1-percent tax on California residents with incomes over $1 million and prohibits the State from decreasing funding levels for mental health services below current levels. The revenues will be used to develop a comprehensive community-based mental health service and support system that includes prevention, early intervention, intensive services, education, training, and other infrastructure-building programs.

MHSA defines service delivery requirements for children, youth, adults, and older adults. The act has the potential to advance services for individuals with co-occurring mental and substance use disorders. Program requirements state, for instance, that individuals with dual diagnosis should receive integrated substance abuse and mental health services "simultaneously, not sequentially, from one team with one service plan for one person." MHSA funds may be tapped to provide services to children with serious emotional or behavioral problems; this could include children whose problems result from exposure to parental substance use (either prenatally or environmentally).

Specific recommended strategies for children and youth include services and supports for children, youth, and their families with co-occurring mental and substance use disorders within the context of a single child/family services and supports plan and permanent supportive housing for homeless families and families reunifying after a child or parent has been in an institution (e.g., jail, juvenile hall, hospital) or other out-of-home placement. Specific strategies identified for adults are integrated assessment teams that provide comprehensive mental health, social, physical health, and substance abuse and trauma assessments (including intergenerational assessments), which are strength-based, gender and culturally appropriate, and trauma-informed and trauma-specific services, particularly for women with co-occurring disorders (California Department of Mental Health, 2005).

During FYs 2005 to 2007, eight State departments, including the Department of Alcohol and Drug Programs (ADP), were allocated MHSA funding. ADP is using its MHSA funding to provide coordination and technical assistance in implementing collaborative programs that link mental health and substance use prevention and treatment services at the local level. The Managed Risk Medical Insurance Board is using some of its funding to evaluate the mental health and substance abuse treatment service delivery system for children with serious emotional disturbances who are enrolled in the Healthy Families Program, California's SCHIP (Mayberg, 2007). At the local level, several counties (e.g., Kern, San Mateo, Santa Clara, Sonoma) are using MHSA funding to expand co-occurring mental health and substance abuse treatment services.[67]

In 1998, California voters also approved Proposition 10, the California Children and Families Act, which added a 50-cent-per-pack tax on cigarettes to provide all children up

to age 5 with a comprehensive, integrated system of early childhood development services to promote school readiness. The initiative is expected to generate approximately $700 million annually. Twenty percent of the funds are appropriated to the First 5 California Commission (State level) to support mass media communications, statewide public education, quality child care, research and development, and other activities. The remaining 80 percent is allocated to the 58 county commissions, which fund programs and services in the following areas: family functioning (e.g., parenting education, resources and referrals, parent support services), child development (e.g., early education programs, comprehensive screening and assessment, special needs intervention), child health (e.g., home visitations for newborns, prenatal care, primary and specialty medical services, safety education), and systems of care (e.g., provider capacity building, service outreach, community strengthening efforts). Behavioral, substance abuse, and other mental health services are one category of services funded to improve family functioning. In FY 2006−2007, approximately 32,335 parents, guardians, and primary caregivers received behavioral services. Behavioral services represented 15 percent of all family functioning services expenditures, which totaled nearly $72.8 million (California Children and Families Commission, 2007).[68]

In November 2006, Arizona voters passed a similar measure, Proposition 203, the Arizona Early Childhood Development and Health Initiative, which adds an 80-cent-per-pack tax to cigarettes to raise approximately $150 million annually for early childhood development programs and services (e.g., parent and family education and support, child care, preschool health screenings, access to preventive health programs) for children up to age 5 and their families. At least 40 percent of the funds must be provided to families with incomes below 100 percent of the Federal poverty level.

E. Implications of Other State Legislation and Policies

Funding and budgeting are inherently political and complex processes. As previously stated, budgets for issues affecting women with substance use disorders and their children are often buried in other system categories, such as maternal and child health, mental health, employment, family support, child care, and child developmental services. Although the initiative process is one way in which the general public can convey its voice and values, the fact remains that policymakers and government officials still hold much of the decisionmaking power when it comes to funding.

As discussed in Section II, treatment providers need to understand their local and State budget-making processes (both formal and informal) and they need to establish effective partnerships and close connections with their State and local policymakers and government officials. Such knowledge and relationships are indispensable if providers are to successfully advocate and argue for increases in substance abuse treatment funding.

In any given year, State legislatures may pass myriad laws that impact substance abuse treatment budgets and appropriations. For instance, Iowa passed legislation in 2005 (HF 875) that established the Transitional Housing Revolving Loan Program Fund to expand

affordable housing for parents who are reuniting with their children while completing or participating in substance abuse treatment. The funds are to be used to finance the construction of affordable transition housing that is geographically close to licensed substance abuse treatment programs. Preference is given to projects that reunite mothers with their children.[69] Also in 2005, New Hampshire enacted HB 206 to prevent the diversion of dedicated substance abuse prevention and treatment funds to other purposes. The legislation declares that monies deposited into the Alcohol Abuse Prevention and Treatment Fund (established in 2001) will not be used for any other purpose. The original language stated that "at least half" of funds disbursed will be used primarily for alcohol education and abuse prevention.[70] In Washington, the legislature appropriated an additional $51 million for 2005–2007 to expand access to treatment for certain Medicaid-eligible individuals, TANF recipients, and financially eligible teenagers (Washington State Department of Social and Health Services, 2005). In 2006, Colorado passed a bill that used revenues from fines imposed for certain underage drinking crimes to create the Adolescent Substance Abuse Prevention and Treatment Fund. In 2007, Illinois enacted legislation requiring that any person required to submit to a drug test within the State pay a $2 fee and the funds be deposited into a special fund to make grants to drug courts for certain specified purposes. Also in 2007, Tennessee passed a bill requiring any person convicted of a drug offense to pay a $100 fee (in addition to any other costs and punishments required by law), the proceeds of which are to be deposited into the State's Alcohol and Drug Treatment Fund.[71]

F. State Funding Inventories—A Key Planning and Accountability Tool

Section II of this paper stresses the importance of treatment providers mapping out all existing substance abuse funding to develop an effective funding strategy for comprehensive services for women and their children. This need to detail alcohol and drug-related spending across all State agencies was a top recommendation of the Blueprint for the States National Policy Panel (Rosenbloom, Leis, Shah, & Ambrogi, 2006). Backed by a legislative mandate, Arizona has been compiling such a State-level inventory for approximately 15 years. California embarked on a preliminary one-time funding inventory effort but has not implemented a systematic tracking system. Although it is unclear the extent to which other States have implemented an annual substance abuse funding inventory (no comprehensive review has been done to date), many States have successfully developed a related effort—a family and children's budget. Whereas family and children's budgets track spending more generally, they may serve as a useful template and provide initial starting points for States seeking to map their substance abuse funding. At the Federal level, at least two SAMHSA-supported activities may serve as models for the development of State funding inventories. All initiatives are discussed briefly below.

Arizona Drug and Gang Prevention and Treatment Program Inventory

In 1990, Arizona Revised Statute 41-617 was enacted, creating the Arizona Drug and Gang Prevention Resource Center (ADGPRC) and the Drug and Gang Policy Council and mandating an annual Arizona Drug and Gang Prevention and Treatment Program

Inventory. The program inventory is a statewide accounting of publicly supported Arizona substance abuse prevention and treatment programs and gang prevention programs. It catalogs all prevention and treatment funds that flow from State agencies to communities, thereby helping programs address funding accountability within agencies, communities, and local service providers. Per the legislation, ADGPRC conducts the annual program inventory and reports the results to the Drug and Gang Policy Council to inform planning and policymaking at both agency and statewide levels. The program inventory has been a national model for tracking prevention and treatment program finances and services.

The program inventory captures how and where substance abuse prevention and treatment funds are being spent, on what types of programs and services, and which participants are being served. It includes information such as:

- Total funds by Federal, State, and local funding sources
- Program descriptions, including program objectives, services, and effectiveness
- Target populations served and client demographics by age, gender, and race/ethnicity

The inventory provides an aggregated summary of findings both for the State and by State agency, as well as detailed information by program. Expenditures on *prevention* programs and services are broken down into categories that include curriculum-based substance abuse/violence prevention; public information, media campaigns, and social marketing; life and social skills development; family and/or parent support, training, and education; community education, presentations, and workshops; and character, civics, and law-related education. Information on *treatment* expenditures is allocated to six service categories: counseling and treatment services; short-term crisis intervention; laboratory or medical services; aftercare and ancillary services; program design and evaluation; and administration. In 2002, the data collection process was redesigned to streamline the forms, modify certain questions to reflect the State's movement toward a risk-and-protective-factor framework, and implement a Web-based data entry system.

Data in the program inventory are used to answer questions about the distribution and use of substance abuse resources and services in Arizona. These data help answer questions concerning needs, current treatment capacity, and service gaps. They allow the State to identify, track, and examine trends in funding, services, and populations being served. These trends can be compared across time and across agencies.

In FY 2007, 12 State agencies were involved in the delivery of substance abuse prevention and treatment services. The State spent an estimated $172 million on substance abuse services. This amount included approximately $58.4 million in State General Funds, $84.9 million in Federal funding, $20.9 million in non-appropriated funds, and $7.9 million in appropriated funds. Approximately $135.4 million (or 79 percent) of total spending was on treatment, while $36.6 million (21 percent) was spent on prevention services (Governor's Office of Strategic Planning and Budgeting and Joint Legislative Budget Committee, 2007).

In 2005, the Drug and Gang Policy Council and its statutory authority requiring the annual program inventory expired. However, this work (renamed a "resource assessment") has become the responsibility of the Arizona Substance Abuse Partnership, which was formed as a requirement of Arizona's Strategic Prevention Framework State Incentive Grant (SPF SIG). The data are now presented as part of the State's annual *Substance Abuse Epidemiology Profile*.

California Substance Abuse Funding Matrix

Unlike Arizona, California has no single State entity responsible for annual tracking of funding across various agencies. In 2003, California's Little Hoover Commission[72] estimated the amount of total public funding allocated to substance abuse treatment in California (Little Hoover Commission, 2003), but it did not establish, as Arizona has, any methods for updating this information. Using the commission's effort as a building block, Children and Family Futures, in conjunction with the County Alcohol and Drug Program Administrators Association of California, UCLA-ISAP, and the Alcohol and Drug Policy Institute, developed a substance abuse treatment funding inventory for FY 2002 (Children and Family Futures, 2003). This inventory was one component of a larger set of tools designed for counties to assess and manage need, demand, and capacity of substance abuse treatment services. This one-time funding matrix was to provide counties with an example for developing their own local funding inventory. Currently, the State Department of Alcohol and Drug Programs provides an online statewide budget allocation by county for informational and planning purposes; the summary includes select substance abuse treatment expenditures from sources that include State General Funds, the SAPTBG, and Parolee Services Network Funds.[73] Building on its earlier work, Children and Family Futures has developed a draft all-funds inventory for FY 2008−2009 that attempts to identify a total of $1.06 billion in statewide prevention and treatment spending, in comparison with the $663 million listed in the lead State agency's budget.

State Family and Children's Budgets

Much like funding for women with substance use disorders and their children, spending for families and children is spread across many different agencies in the public and private sectors at the Federal, State, and local levels. It involves myriad funding sources that support hundreds of different programs. Similar to a substance abuse treatment funding inventory, a family and children's budget provides a picture of how much money is being spent, by whom, and for what types of services. Although these types of budgets cast a wide net that encompasses more than just women, children, and families affected by substance use disorders, they provide a useful way of identifying sources of support that might be included in a detailed substance abuse funding inventory.

In general, there are three approaches to creating such budgets: gather basic budget data, analyze spending across system components (e.g., by department, types of services), or create a children's budget to use as an analytical, policy, and advocacy tool to focus

services strategies and improve results (Johnson, 2006b). In the last two decades, more than 30 States and localities have created different forms of family and children's budgets (Friedman & Danegger, 1998). Examples include the following:

- *Colorado.* The Colorado Children's Budget provides a 6-year funding history for more than 50 programs that are funded with Federal, State, and local dollars. These programs span the broad areas of providing income support, health care, public health and nutrition, prevention, education, early care and education, and youth corrections (Colorado Children's Campaign, 2005).
- *Pennsylvania.* The Philadelphia Children's Budget—together with The Report Card companion document—helps the city monitor and formulate an effective funding plan for children and youth services and improve coordination and efficiency among various departments and programs serving children. The Children's Budget presents spending data by funding source, purpose of the spending (e.g., prevention and development, education and training, general support services, intervention and crisis services, corrective services), and type of services provided.[74]
- *Oklahoma.* Since 1991, the Oklahoma Commission on Children and Youth has had the statutory responsibility of developing the State Plan for Services to Children and Youth and annually reporting State and Federal funding for Oklahoma children and youth programs. Its Oklahoma's Investment in Tomorrow report provides a 5-year plan of spending on programs for children, youth, and families by 11 agencies (Oklahoma Commission on Children and Youth, 2003).
- *Kansas.* The Kansas Children's Budget was established as a requirement in 1993[75] and is published each year as part of the Governor's formal budget submission to the legislature. The Children's Budget presents 3 years of expenditures and analyzes spending in eight functional categories: prevention services, maintenance services, institutional and treatment services, medical and health services, education and training programs, social services, correctional activities, and child care services (Friedman & Danegger, 1998).

SAMHSA Efforts That May Facilitate State Funding Inventories

Another good starting point for States seeking to create a substance abuse funding inventory is to access State-level information on SAMHSA formula and discretionary grant allotments (http://www.samhsa.gov/StateSummaries). Although this resource is clearly limited in scope to Federal funds, it provides essential information for compiling a more comprehensive inventory.

Another SAMHSA initiative—SPF SIGs—may also serve to promote State efforts in establishing a substance abuse funding inventory. The multiyear grant program emphasizes the importance of a data-driven strategic approach, adopted across service systems at the Federal, State, community, and service delivery levels. A required State-level activity is a statewide needs assessment, which includes creating a profile of population needs and community assets and resources to address the problems. Several of

the SPF SIG FY 2004−2006 grantees specifically emphasize planned improvements that will enhance identification, tracking, coordination, and allocation of funding and resources.[76]

G. Summary

States will likely continue to play an increasingly important role in funding substance abuse treatment and supportive services for women and their children. State funding for treatment of substance use disorders is substantial and cannot be ignored in making policy decisions. It is imperative for local providers to understand their local funding context and possibilities as they seek to sustain comprehensive programming. As such, it is essential to develop an extensive understanding of how State funds flow to the treatment community and how States and providers can tap multiple sources of funding to support comprehensive services for women and their children. The challenge, however, is that State funding is highly fragmented, with few compilations routinely and consistently collected across all relevant State agencies.

The next section provides information on the importance and role of the private sector in funding comprehensive substance abuse treatment and provides overarching recommendations and guidance regarding private funding sources.

V. PRIVATE-SECTOR FUNDING SOURCES

A. Introduction

The previous sections have discussed potential Federal and State funding sources that can support comprehensive substance abuse treatment services for women and their children and families. But developing an effective funding strategy cannot stop there. Treatment providers must broaden their reach beyond the public sector to include the private sector. Providers must diversify their funding to survive and thrive. Indeed, treatment providers who can access multiple funding sources are more likely to be involved with larger community coalitions and broader networks of service providers and more likely to provide the appropriate continuum of care and broad array of services that clients and their families need.

The private sector includes a vast number and range of potential financial supporters, such as individual donors, local and regional business associations, corporate leaders, community groups, local activist and advocacy organizations, local provider and professional trade organizations, public foundations (e.g., United Way), private foundations, and private insurance providers. In addition to project grants, funding from such supporters may take the form of charitable donations, corporate gifts, in-kind contributions (e.g., volunteer hours, materials, space), endowment grants, fellowships and scholarships, capital grants, low-interest loans, and fundraisers. Such assistance may be used for the overall organization or a selected service or program component (Substance Abuse and Mental Health Services Administration, 2005a).

Obtaining the involvement and support of the private sector is essential to a provider's overall funding strategy, requires a substantial commitment of time and resources (both financial and human), and includes many challenges. For instance, public- and private-sector systems often have different interests or priorities, speak different "languages" (e.g., acronyms and jargon), have little experience working together on issues such as substance abuse, and have a limited understanding (and sometimes misunderstanding) of both the opportunities and the constraints inherent in each sector.

Despite these challenges, public–private sector partnerships can produce important benefits and outcomes for individuals with substance use disorders and their families and communities. Through such collaboration, for example, both sectors can develop a more comprehensive understanding of existing barriers and gaps in service delivery and together create and implement far-reaching system improvements. Not only can the private sector share new resources and new ideas, but its increased flexibility typically enables it to act more immediately on a given issue than the often constrained public sector. Some private funders are more inclined to fund robust evaluations that public funding cannot support. Such partnerships can promote more indepth discussion about substance abuse-related problems at all community levels.[77]

The ability of treatment providers to forge multiple and broad alliances that enhance service delivery and improve treatment effectiveness depends on finding the right fit

between a funder's agenda and a grantee's needs. This effort entails learning about a potential partner's needs, assets, culture, and capacity, as well as a thorough assessment of one's own mission, goals, assets, needs, and desired partnership characteristics and results (Substance Abuse and Mental Health Services Administration, 2005a). (See Section II.)

All private-sector sources are important[78] and should be explored by treatment providers. This section, however, focuses only on the role of independent foundations and private insurance providers, which are considered two of the more central private-sector sources that treatment providers can tap. For instance, the underlying mission of independent foundations is to address critical community problems (and they typically focus more on programmatic issues than on corporate foundations). Private insurance providers are crucial because substance abuse is a behavioral and physical health care issue that significantly affects them. Private donors, though important, are typically time-consuming to cultivate. SAMHSA's recent publication, *Maximizing Program Services Through Private Sector Partnerships and Relationships: A Guide for Faith- and Community-Based Service Providers,* provides an extensive discussion on other possible partners (Substance Abuse and Mental Health Services Administration, 2005a). Although this paper discusses private foundations as a funding source and suggests ways to approach them, it does not identify every foundation that might support substance abuse treatment and comprehensive services for women and their children and families.

B. Foundation Funding

Before seeking out foundation funding, it is useful to keep in mind several overarching points. In general, foundation funding (similar to Federal discretionary project grants) is best used to develop, implement, and evaluate new treatment strategies or pilot projects; provide certain services or engage in specific program activities that Federal formula grants do not allow; and bridge temporary funding gaps. Foundations are less likely to pay for core administrative costs such as staff training and strategic planning (De Vita & Fleming, 2001). Indeed, program support accounted for 50 percent of all grant dollars from the largest foundations in 2006, whereas general/operating support composed 19 percent (The Foundation Center, 2008b). Foundations typically operate on very lengthy timelines. If a program needs immediate funding, a foundation grant may not be the best option.

Advice From SHIELDS

SHIELDS uses private foundation funding to test pilot projects. Also, to facilitate obtaining and managing research grants, SHIELDS developed its own Institutional Review Board—rather than work with a nearby university's—which allows it to operate on its own timetable.

The Foundation World Is Diverse

There are several different types of foundations that substance abuse treatment providers might consider approaching, including independent national foundations, family

foundations,[79] community foundations, and corporate foundations. The success of working together depends on how closely each party's agendas, needs, and priorities are aligned. For instance, community-based treatment providers may find it fruitful to approach a local community foundation that targets their specific geographic area or a small family foundation that has been established by an individual or has donors in recovery or whose family members have been affected by substance use disorders. In contrast, a large independent foundation may be interested in innovative programs of national significance that can serve as model programs and be widely replicated.

In addition, different types of foundations take different overall approaches to grant giving. Small family foundations tend to be personal and the least likely to publicize their existence or issue RFPs, providing them with the flexibility to fund innovative programs on their own timetable. Some foundations may proactively marketing their existence and strategic visions (but still accept unsolicited proposals), and others may have specific priority areas for which they request proposals on a regular funding cycle and are unlikely to consider unsolicited submissions. Still others focus narrowly on their strategic missions and programs and have a long-term funding strategy from which they are unlikely to veer (Grantsandfunding.com, 2001).

Determining the best funding prospects and how much to apply for requires time and research (e.g., analyzing foundation annual reports and other materials, reviewing various funding publications, clarifying program priorities and guidelines with program officers). Although 230 foundations indicate they make grants in the area of substance abuse,[80] only a few (e.g., Robert Wood Johnson,[81] Schwab, Metlife) identify substance abuse as a priority and have significant programs in this area. The more that is known about the foundations and their grantmaking trends, the greater the probability for establishing a successful partnership. The opportunities are clearly there, as evidenced below.

A Brief Look at Foundation Giving

In 2006, the Nation's more than 71,000 grantmaking foundations gave a total of $40.7 billion, an increase of approximately $4.3 billion (or 11.7 percent) from 2005. Independent foundations (which include family foundations and most foundations formed as a result of health care conversions) make up the majority (89 percent) of these foundations and accounted for more than two-thirds (68 percent) of all giving in 2006. Although community foundations represented only 1 percent of all grantmaking foundations in 2006, they accounted for approximately 9 percent of all giving; community foundations showed the strongest increases in 2006 giving, surpassing both independent and corporate foundations (Lawrence, Austin, & Mukai, 2007).

A report highlighting 2006 giving trends from approximately 1,265 large private and community foundations states that the areas of health and education benefited from the largest share of grant dollars. Health, which encompasses grants for general and rehabilitative health, specific diseases, medical research, and mental health/substance abuse,[82] represented 23 percent (or approximately $4.39 billion) of all grant-giving dollars in 2006 and 13 percent of the total number of grants. Human services (e.g., crime

and justice, housing and shelter, employment, youth development, multipurpose human services) represented 14 percent (or approximately $2.6 billion) of all grant dollars, but 26 percent of total number of grants. Whereas health was one of the largest allocation areas for independent foundations, community foundations gave proportionately more to human services than other types of funders (The Foundation Center, 2008b).

> ***Advice From SHIELDS***
>
> *Be creative and think outside the box. Think about how to frame your issue or need—don't ever rule out a funding source.*

With regard to giving to targeted special population groups, children and youth accounted for the second largest share of grant dollars in 2006 ($3.23 billion or 17 percent); grants for economically disadvantaged individuals represented the largest share. Individuals with substance use disorders accounted for less than 1 percent of all grant dollars (or $84.5 million), a slight decrease from the $130.9 million in such grants in 2005. Other special population groups that substance abuse treatment providers might serve included women and girls (6 percent or nearly $1.1 billion), victims of crime or abuse (0.8 percent or $155.2 million), people with AIDS (5.2 percent or $1.0 billion), and single parents (0.1 percent or $36.5 million) (The Foundation Center, 2008a).

Because substance abuse treatment agencies provide many individual and community support services that broadly fall under the auspices of "human services" and serve other special population groups (e.g., children of parents with substance use disorders, victims of trauma, single parents), the challenge becomes how to effectively craft and communicate proposals to prospective foundations. For example, nearly 600 foundations provide grants in the area of child welfare, whereas more than 770 provide grants in the area of family services.[83] In some cases, it may be effective to tailor a funding request to explicitly convey that improved child welfare and increased family stability are the primary program outcomes, as opposed to submitting a more general request for substance abuse treatment support.

General Strategies for Accessing and Working With Foundations—The Importance of Relationships and Persistence[84]

Establishing strong, personal relationships with foundation funders is a key to gaining their initial and sustained support. Treatment providers must approach this activity as a long-term courtship—a process that entails not only establishing and managing the relationship but also regularly communicating and evaluating. Outreach (e.g., marketing, public education and advocacy, networking, collaboration) is critical and the means through which treatment providers build and maintain a strong base of support.

However, treatment providers also need to target their relationship-building efforts. They should cultivate a key contact (e.g., the relevant program officer who oversees grantmaking in a given funding category) in the foundation who can answer questions about program objectives, goals, priorities, and budgets. Treatment agencies should draw on their board members and other collaborating service providers to establish relationships and achieve credibility with foundation funders. Before submitting a

proposal, providers should try to set up a phone or in-person interview with the contact. To facilitate communication and develop rapport, providers should begin by telling a story. Most people have been affected by substance abuse—either directly through their own addiction and recovery or indirectly through experiences with a family member or friend. These stories provide a common background from which to build a productive relationship.

Treatment agencies should not be deterred by an initial turndown. In some cases, a foundation may have allocated all of its funding for a given grant cycle; in others, it could just be a matter of modifying the proposal. It is important to get specific reasons for the rejection, ideas for how to improve the proposal, and feedback on whether it makes sense to resubmit a modified proposal. Such conversations not only help strengthen the proposal but also serve to build the relationship and improve the likelihood of being funded in the future. Foundations reward both persistence and the willingness to incorporate their suggested changes to ensure a closer match between their mission and the provider's program.

Advice From SHIELDS

Rather than bringing in an outside grant writer, SHIELDS has found it more effective to use in-house staff members because they "know you and your organization." SHIELDS' Executive Director and Assistant Director are actively involved with all grant writing.

Foundations are a growing source of funding for large substance abuse treatment providers and local provider coalitions that address prevention and treatment for substance use disorders. Although a substantial outlay of time and resources is needed to establish productive foundation relationships and secure foundation funding, the return on such an investment is great: increased flexibility in use of funds, broadened acknowledgment and support of the agency's mission, and enhanced credibility that can foster relationships with other funders.

C. Private Health Insurance Coverage for Substance Abuse Treatment

The lack of adequate private health insurance among individuals with substance use disorders, together with tight utilization management by insurance companies, is often cited as a barrier to treatment entry, retention, and completion. According to the 2006 National Survey on Drug Use and Health, of those respondents who needed but did not receive treatment or felt a need for treatment and made an effort to get treatment, 44 percent cited cost and insurance barriers as a reason for not receiving treatment. Approximately one-third of those who did not attempt to get treatment also cited cost and insurance as a barrier (Office of Applied Studies, 2007b).

Private health insurance benefits, more so than public coverage, tend to vary based on whether substance abuse treatment services are facility based and the level or setting of care. The situation is further complicated because coverage and reimbursement depend on whether a service is considered either a medical service or a substance abuse treatment service. In addition, utilization management procedures also play a central role in an

individual's ability to access needed services (Center for Substance Abuse Treatment, 2006). In general, substance abuse benefits are characterized by higher cost sharing and annual and lifetime limits on inpatient and outpatient care than other health benefits. These limits generally do not exist for other medical conditions and have increased since 1990 (Gabel et al., 2007).

The Persistence of Alcohol and Drug Exclusion Laws

There have been some gains in insurance coverage for substance use disorder treatment, but several States still have exclusion laws that allow insurance companies to decline coverage of injuries sustained under the influence of alcohol or drugs. The original intent of such laws—which date back to 1947 when treatment opportunities were few and trauma centers were not yet developed—was to decrease insurance costs (Gentilello, 2003). In 2001, the National Association of Insurance Commissioners voted to recommend repealing the exclusion laws (Haigh, 2006). Since then, several States have repealed or amended their exclusion laws. As of January 1, 2007, 33 States still had exclusion laws on the books.[85]

It was not until the early 1970s that States began to pass legislation requiring that group health insurance plans include coverage for treatment of alcoholism, limited to 30 days of inpatient care and $500 for outpatient services. (However, health insurance providers still have certain exclusions; see box.) The advent of managed care in the 1980s brought further limits on the use of inpatient treatment and a shift to outpatient care (Join Together, 2006). This shift continued throughout the 1990s. In 1993, 41 percent of substance abuse treatment expenditures went for inpatient care, but by 2003 this figure dropped to 21 percent. In contrast, outpatient care increased significantly from 34 to 49 percent (Mark et al., 2007).

In their study of substance abuse benefits in employer-sponsored insurance in 2006, Gabel and colleagues (2007) found that use of limits on coverage of substance abuse services has become more widespread. For example, in 1989, 56 percent of employees with substance abuse benefits had limits that were different from medical-surgical benefits, compared with 81 percent in 2006. Furthermore, the magnitude of cost sharing was higher for substance abuse than for medical-surgical services, primarily because of the nature of cost-sharing mechanisms associated with substance abuse treatment (e.g., coinsurance, higher copayments, no out-of-pocket spending maximums). The authors state that the insurance benefit structure discourages treatment initiation, as well as followup treatment and monitoring. Greater patient out-of-pocket expenses may hinder access to treatment, while caps and other limits may encourage short stays, which may lead to inadequate treatment. The authors conclude, "There is a clear need to modernize private insurance benefit design to incorporate recent developments in the understanding of [substance abuse] disorders and of effective evidence-based treatment for this chronic condition" (Gabel et al., 2007).

As mentioned in Section III, there have been other important shifts in substance abuse treatment funding from 1993 to 2003. Chief among these was the decline in private payer expenditures for substance abuse treatment. Overall, the percentage of total private payer expenditures dropped from 32 percent in 1993 to only 23 percent in 2003. Private health

insurance payments, which make up the majority of all private payer expenditures, accounted for only 10 percent of all substance abuse treatment spending in 2003, down from 14 percent in 1993. Out-of-pocket payments decreased over the decade, dropping from 13 percent of all expenditures in 1993 to 8 percent in 2003 (Mark et al., 2007). These trends could be due to the growing use of managed care (see box on managed care), as well as the increasing numbers of people who lacked private health insurance during the study period (Curley & Edwards, 2005).

Managed Care as a Source of Funding for Substance Abuse Treatment

In 2006, just under half (47 percent) of substance abuse treatment facilities said they had agreements or contract with managed care companies for the provision of treatment services; this is down from 51 percent in 2002 (Office of Applied Studies, 2007a; 2002). Managed care contracts present both opportunities and challenges for substance abuse treatment providers. Advantages include sustained and more flexible funding; the potential to reinvest any savings in other program services; and, according to some, increased access to treatment. Disadvantages for substance abuse treatment providers include managed care's emphasis on cost-containment (which many translate to benefit and utilization limitations on treatment), a competitive contract-bidding process, and the tendency of managed care companies to contract with a single service provider to achieve economies of scale. To better leverage managed care opportunities, smaller treatment providers may find it advantageous to collaborate and form a coalition with other providers (Center for Substance Abuse Treatment, 2000).

To be most effective, substance abuse treatment agency administrators and staff must thoroughly understand the managed care and community political and fiscal environments. Both Oregon and Iowa have had positive experiences with managed care. In 1994, through a Section 1115 Medicaid waiver, Oregon implemented the Oregon Health Plan, which changed the administrative system for outpatient substance abuse treatment from a fee-for-service to a managed care model. Although Oregon experienced some problems (e.g., ineffective communication among stakeholders, problems with reimbursement), it reduced costs of providing treatment and increased a sense of professionalism among public treatment providers (D'Ambrosio, Mondeaux, Gabriel, & Laws, 2003). In Iowa, a behavioral health care organization was used to manage substance abuse treatment expenditures. An evaluation of the Iowa Managed Substance Abuse Care Plan 3 years after implementation found that for Medicaid recipients the rate of substance abuse treatment doubled, residential and outpatient services increased, use of inpatient hospital services and direct care costs decreased, and total expenditures remained stable (McCarty & Argeriou, 2003).

Despite the downward trend, private insurance still provides significant dollars for substance abuse treatment—nearly $2.1 billion in 2003. When individual out-of-pocket expenses and other private payers are added, total private payments near $4.7 billion (Mark et al., 2007). Beginning in 2008, physicians can use two new CPT codes for screening and brief intervention for privately insured patients; CPT codes are used to bill insurance companies (Knopf, 2007). This may help certain individuals access treatment. Perhaps of greater importance, however, is that an individual's health insurance status can affect treatment outcomes. Research has shown that uninsured clients are less likely than others to complete treatment and that lack of insurance predicts not entering

substance use treatment (Brady & Ashley, 2005; Mammo & Weinbaum, 1993; Oggins, 2003). Among adult female clients specifically, those whose primary source of payment was private health insurance left treatment earlier than those with other payment sources (Brady & Ashley, 2005; Ashley, Sverdlov, & Brady, 2004).

Thus, while the role of private coverage for substance abuse treatment services is limited, individual providers and coalitions of providers must seek to tap and maximize all available private coverage sources wherever possible. Public funding alone is not sufficient to enable treatment agencies to provide the necessary clinical treatment and individual, family, and community support services. The blending of various public–private funding sources is essential if treatment providers are to provide as wide a spectrum of care as possible to adequately meet the needs of parents and their children and families.

In fact, in 2006, nearly two-thirds (64 percent) of treatment facilities said they accepted private health insurance, whereas more than half (52 percent) said they accepted Medicaid and 32 percent accepted State-financed health insurance (Office of Applied Studies, 2007a). This is important, considering that the majority (53 percent) of individuals who received substance abuse treatment in 2004 said they used two or more sources of payment for their services. Forty-four percent said they used their savings or earnings to pay for some or all of their treatment, and 26 percent mentioned that private health insurance was the source of payment. (Women were more likely than men to pay a portion of their treatment costs with private insurance, 31 vs. 24 percent.) Various types of public funding when combined (e.g., Medicaid, Medicare, other public assistance programs, military health care, courts) were used by 57 percent (Office of Applied Studies, 2006).

D. Insurance Parity—An Unresolved Tension

A difficult, ongoing issue within the private insurance sector is the subject of parity for substance abuse treatment. Parity requires that private health insurance cover the same level of benefits for mental health and substance use disorders as for other physical disorders and diseases. These elements include visit limits, deductibles, copayments, and lifetime and annual limits. Those who oppose parity argue that costs of health care and insurance premiums will increase (leading to a higher uninsured rate); effective treatment for substance abuse treatment does not exist; and many professional definitions of mental illness are too broad (i.e., they include all mental illnesses, not just those that are biologically based or SMIs). A plethora of studies have documented the cost benefits of providing parity and that parity can be implemented with minimal cost increases.[86] In addition, although the costs of implementing substance abuse treatment parity are relatively small, the savings of effective treatment in health care, criminal justice, child welfare, and other systems costs can be substantial.[87] Advocates argue that parity will reduce the stigma associated with mental and substance use disorders.

Recently, momentum for parity has grown at both Federal and State levels. Still, there is no Federal law on parity, and only a handful of States have enacted full parity laws. In

1996, President Clinton signed into law the Mental Health Parity Act, which went into effect in 1998. The act was limited in a number of ways, including that it did not cover substance abuse. Congress has extended the original sunset provision repeatedly; the current extension runs through 2008. In January 2001, based on an earlier Presidential Directive, the Federal Employees Health Benefits (FEHB) program, the largest employer-sponsored health insurance program in the Nation, instituted a full-parity policy for mental health and substance abuse services. An evaluation of the FEHB parity requirement concluded: "Overall, the parity policy was implemented as intended with little or no significant adverse impact on access, spending, or quality, while providing users of [mental health and substance abuse] care improved financial protection in most instances" (Northrup Grumman Information Technology, Inc., 2004).

Leveraging Private Insurance for Families With Co-Occurring Disorders

For children and parents affected by co-occurring mental and substance use disorders, mental health benefits for some children may be covered as a result of their parents' substance use disorders. Children who are diagnosed with developmental disabilities and special education needs that are related to parental substance exposure (either prenatally or environmentally) may be eligible for mental health services as part of a comprehensive set of family treatment services. Although it may require difficult negotiations among the separate systems, private coverage may be combined with public eligibility for some children whose parents have coverage.

Since 2001, several bills have been introduced into Congress—but none signed into law—to provide mental health and substance abuse parity. The Mental Health Equitable Treatment Act, which initially mirrored the FEHB parity provisions, has received much focus.[88] It was first introduced in 2001, modified and reintroduced in 2003 as the Senator Paul Wellstone Mental Health Equitable Treatment Act, and reintroduced, with modifications as H.R. 1402 in 2005. This bill was unsuccessful. However, in September 2006, the Betty Ford Center and Caron Treatment Center joined congressional sponsors to promote the bill and have created a Web site to raise public awareness and support for equal parity (Treatment centers join with Congressmen to demand parity, 2006). The bill was reintroduced in March 2007 as the Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424). At about the same time, a compromise Senate bill, the Mental Health Parity Act of 2007 (S. 558) was reintroduced in the Senate. The Senate bill passed on September 18, 2007, and was referred to the House Subcommittee on Health, Employment, Labor, and Pensions. Meanwhile, H.R. 1424 passed the House on March 5, 2008, and was placed on the Senate Legislative Calendar for debate. Both bills would expand on the 1996 Mental Health Parity Act by requiring parity for financial requirements (e.g., deductibles, copayments, annual and lifetime limits) and treatment coverage, though neither mandates group plans to provide substance abuse or mental health coverage (National Alliance on Mental Illness, 2007). The House bill is considered the more comprehensive of the two, in part because it requires group health plans that offer substance abuse or mental health coverage to cover every DSM diagnosis and condition (rather than allows insurance companies to determine which illnesses they cover) and it requires equity in out-of-network coverage if it exists on the medical-surgical side.

At the State level, every State except Wyoming has enacted a law mandating or regulating mental health benefits (Nagy, 2006); however, not all extend coverage to substance abuse. Because there is no universally accepted definition of mental health and substance abuse parity, the National Conference of State Legislatures divides coverage into three categories: full parity (equal coverage), minimum mandated benefit laws (specifies base levels of coverage), and mandated offering laws (requires insurers to offer the option of coverage, but often with higher premiums) (Wood, 2005). Laws in 46 States include coverage for substance abuse, but equal benefits are provided to varying degrees, and some apply only to alcohol abuse or dependence. Only 13 of these States offer full parity for substance abuse; even then, North Carolina's and South Carolina's parity applies only to State employee health plans, and other States allow exceptions for small employers.[89] Vermont's parity law, enacted in 1998, is considered one of the most comprehensive for mental health and substance abuse treatment and has served as a model for other States (National Alliance on Mental Illness, 2006). To assist States in drafting legislation, the National Conference of Insurance Legislators (NCOIL) created a Mental Health Parity Model Act; NCOIL first adopted the model law in 2001, and it was readopted in 2004 and 2006 (National Conference of Insurance Legislators, 2006).

However, even if full parity for substance abuse treatment were implemented, a question remains about whether it would be enough to increase access and ensure adequate quality of care for individuals with substance use disorders. Several challenges still need to be considered including, but not limited to, the following (see, for example, Greenfield, 2005; Oggins, 2003; and Wood, 2005):

- Managed care organizations can act as gatekeepers and control access to benefits.
- Federal legislation prohibits States from placing insurance mandates on self-funded health plans.
- Exemptions in parity legislation for small employers prevent many people from taking advantage of parity.
- Individuals with substance use disorders may be less likely to work (full or part time) than the general population and therefore are less likely to benefit from increases in employer-paid health insurance coverage.[90]
- Available level of treatment may be limited or inadequate (e.g., inappropriate for parents with substance use disorders and their children and families) or require significant copayments.
- Social stigma remains a barrier to care for many people in need of treatment.

Clearly, much more work needs to be done to expand and strengthen public–private sector partnerships. Yet all parties must recognize both the potential and the necessity of such collaborations to achieve the desired outcomes for individuals and families affected by substance use disorders, as well as their communities and the nation as a whole.

VI. CONCLUSION—GUIDING PRINCIPLES AND ACTION STEPS

This paper has discussed the various funding sources and strategies that can result in the development of comprehensive substance abuse treatment and support services for women and their children and families. The length and complexity of this paper are indicative of the challenging task of securing and integrating multiple funding streams to support the necessary range of services and appropriate continuum of care.

The process of developing a comprehensive funding strategy is akin to constructing a large-scale building: a well-researched overall plan maps out each step and phase of the construction—from obtaining the necessary permits to building the foundation to installing the plumbing and electrical components to framing the structure to finishing the exterior and interior. A multidisciplinary construction team, guided by the influential leadership of the architect, contractor, and project engineer, is needed to ensure the plan is carried out. Creating a funding "building" is much the same. It requires initial research and groundwork to identify parameters and craft an informed plan. A thorough understanding of the community and clients then provides the basis for a solid foundation, while financial management and client data tracking systems provide the necessary wiring and plumbing. Qualified staff and collaborations, together with leadership and guidance from program administrators and State and local policymakers, frame, finish, and secure the structure.

Embedded in this report is a set of seven principles that can guide the implementation of the overall "blueprint." These guiding principles are outlined below,[91] together with suggested action steps for treatment providers and State substance abuse agencies to design a process of seeking and securing funding that increases comprehensiveness and effectiveness.

Guiding Principle 1: Ensure Clients' Needs Drive the Funding Search

No matter what specific funding tactic or strategy a State agency or individual provider may choose to adopt, the clients' needs (rather than the agency's needs or availability of restricted funds) must be the driving force behind all decisions for two reasons. First, most funders are astute at distinguishing a proposal that is written to improve client outcomes from one that is written to meet an organization's immediate funding needs. Second, clients' needs, rather than a funder's objectives, are the best measure for determining which services need to be added to complete the comprehensive services array. The bottom line: The odds of obtaining new resources increase as an agency or organization gains skills in gathering and applying information about what clients need to succeed in treatment and recovery.

Steps for Treatment Providers: Know what is happening in the communities and to clients. This entails conducting a needs assessment, focus group, or related activities (as suggested in Section II) to identify and prioritize clients' clinical treatment and supportive service needs and to match those needs with available funding sources that would improve comprehensiveness. Communicate and share information about clients' needs with other service providers and State substance abuse agencies.

Steps for State Agencies: Adopt a family-centered approach to recovery that focuses on ensuring that the various treatment and support needs of clients with substance use disorders and their families are met across a spectrum of fragmented and often isolated agencies (Center for Substance Abuse Treatment, 2000). State substance abuse agencies must work with other State agencies to assemble cross-systems data on clients who overlap systems and programs, such as women with co-occurring physical and mental disorders and parents with substance use disorders who are involved in the welfare or child welfare systems. A critical first step is for those State agencies most likely to be dealing with individuals with substance use disorders to compile prevalence data on substance use issues among their client populations involved in TANF, child welfare, mental health, juvenile and criminal justice, and other systems. This State-level data can be compared with national prevalence data to assess what data State agencies may need to better understand their caseloads. If State agencies' current technology does not capture basic prevalence and related data, then a suggested interim step would be a more limited case review to quantify how often families need substance abuse treatment and particular support services. State agencies should communicate and work closely with various service providers, who may be compiling relevant information (either formally or informally) that can inform State-level decisionmaking. For large States, these steps may also be taken at the county level.

Guiding Principle 2: Map and Track Funding Streams

As discussed in Section II, both treatment providers and State agencies need to acquire baseline knowledge—what treatment resources exist, at what levels, controlled by whom, and for what populations—of a community's or State's institutional funding base. Such knowledge is essential to leverage existing dollars more effectively and determine what new funding sources have the most potential and should be targeted.

Steps for Treatment Providers: Use contacts such as SSAs or State or county provider associations to find out which agencies have the most responsibility, authority, and influence regarding substance abuse treatment policy and funding decisions. To obtain a better sense of State funding priorities, the SSA can provide a copy of the State agency's annual plan for the allocation of SAPTBG and other key Federal funds, if available, that support substance abuse treatment and related support services (Center for Substance Abuse Treatment, 2000).

Steps for State Agencies: Invest resources in building and sustaining a substance abuse treatment funding inventory, which will prove to be a useful planning tool. Take incremental steps if necessary. If the State provides its localities with a breakout of substance abuse funding by geographic area, complete the picture by adding the full array of funding streams to this inventory. Explore the possibility of geocoding the data so that allocations to specific communities can be mapped. If one does not already exist, develop an interagency workgroup to focus on continually improving the depth, breadth, and accuracy of the data so that the inventory becomes precise and all-encompassing.

Guiding Principle 3: Develop Collaborative Relationships at All Levels

Comprehensive funding requires comprehensive networking and collaboration. This collaboration needs to be multidirectional. Both vertical and horizontal relationships are important including, but not limited to, links among the following:

- Various local substance abuse treatment providers (e.g., to develop networks across the continuum of care and modalities to increase the network's competitive edge)
- Local substance abuse treatment providers and other local service providers (e.g., mental and primary health care providers)
- Substance abuse treatment providers and State substance abuse agencies
- State substance abuse agencies and other State service systems (e.g., child welfare, criminal justice, welfare, education)
- State substance abuse and collaborating systems and their Federal agency counterparts
- State substance abuse agencies and State insurance and legislative offices
- Private- (e.g., foundations, health insurance companies) and public-sector funding sources

Collaboration across these multiple fronts seeks to achieve several interrelated goals:

- Leverage all available resources and expertise to research, identify, track, pursue, obtain, and manage different funding streams
- Provide a more comprehensive range of services to clients
- Provide services more efficiently and effectively
- Enhance outcomes for women and their children, families, and communities

Negotiating for funding from a prospective revenue source is a critical collaborative skill, yet the capacity to collaborate is developmental in that agencies acquire it through practice and by applying lessons learned (their own or others). As providers and State agencies become more adept at true collaboration, their ability to access and secure new and multiple sources of funding will improve. Over time, treatment providers and agencies will learn how to negotiate for additional resources in a way that produces results and value for both funders and grantees.

Steps for Treatment Providers: Identify what community collaborations currently exist and whether their mission, values, and target populations are a good match. Determine what to bring to the table and how establishing a partnership will provide tangible benefits to all involved entities and maximize client outcomes. Work with provider associations, State agencies, and other information sources to identify possible funding options. Explore other service providers' willingness and ability to collaborate to fill in gaps in comprehensiveness. Learn the service language and goals of other systems.

> *Ohio found that cross-agency collaboration was facilitated by the passage of a statute specifying that the Department of Alcohol and Drug Addiction Services coordinate the substance abuse treatment services of various State departments, the criminal justice and law enforcement systems, the legislature, local programs, and substance abuse professionals (Rosenbloom, Leis, Shah, & Ambrogi, 2006).*

Steps for State Agencies: Support joint associations or networks of providers and other collaborative efforts to expand funding. Convene and collaborate with other State agencies (e.g., child welfare services, Medicaid, employment, criminal justice) that are interested in substance abuse treatment and whose programs and resources are essential to support effective recovery for individuals with substance use disorders and provide prevention and intervention services for their children and families. Extend collaborative ventures to include public and private partnerships that can provide consistent and sustained support and State-level attention to these issues, even in the face of changes in State leadership or the emergence of new and competing priorities (Join Together, 2006). To establish common goals, expand collaboration, maximize funding, create incentives for quality improvement across State agencies that manage various funding streams, and strive to develop memorandums of understanding and joint contracting models or protocols (Marton, Daigle, & de la Gueronniere, 2005; Join Together, 2006). Multiple State agencies that purchase substance abuse services should seek to establish consistent purchasing practices and uniform requirements for the same benefits and work together to bridge gaps in benefits that affect treatment access and outcomes (Smith & Mulkern, 2006).

Guiding Principle 4: Ensure Funding Is Diversified

With Federal funding from the SAPTBG representing only 8 percent of all public dollars spent on substance abuse treatment nationally and, on average, less than half of an SSA's substance abuse treatment expenditures (Mark et al., 2005), the need to create a diverse funding portfolio is clear. The ideal portfolio should move beyond this core source to include a broader range of institutional funding sources, such as Medicaid and Title IV-E Child Welfare Services; available discretionary funding from Federal, State, and private foundation sources; and private health insurance reimbursement and managed care contracts. However, States and localities vary widely in their skills and experience in identifying and integrating different funding sources and in implementing unified funding strategies (e.g., pooling or redirecting funds).

Steps for Providers: Assess not only the organization's capacity and capability to identify and integrate different funding sources but also that of current and potential collaborating partners and State and local substance abuse agencies. Knowing the organization's and others' current funding sophistication levels is important to adequately gauge the amount of time and energy that will be required to adopt a comprehensive funding strategy and to plan accordingly.

Steps for State Agencies: Invest the time and resources to stay current on external funding streams. Take advantage of available technical assistance and related resources from SAMHSA/CSAT and other Federal agencies, as well as foundations that fund major substance abuse treatment initiatives, such as the Resources for Recovery program (see box), which emphasize broad dissemination of lessons learned. State agencies must also make it a priority to engage the private sector and encourage private health insurance companies and businesses that purchase health insurance benefits for their employees to offer adequate coverage for substance abuse treatment.

Resources for Recovery Initiative—Lessons Learned and Available Tools

The Resources for Recovery program was established in 2002 with funding from The Robert Wood Johnson Foundation to help States enhance their capacity to treat individuals with substance use disorders. Each of the 15 selected States was required to identify and implement strategies to expand substance abuse treatment access and resources and enhance treatment outcomes. States were encouraged to work within existing funding resources, increase collaboration between their Medicaid and substance abuse treatment systems, and create innovations in current State financing of care.

Key components of the program included grant funds to support planning and analysis; onsite specialized technical assistance; peer-based technical assistance; cohort technical assistance opportunities; and information dissemination. Grantees implemented various strategies, including the creation of formal partnerships, needs assessments and gap analyses, indepth exploration of funding opportunities for services, evaluation and assessment protocols to better identify individual service needs, consolidated purchasing or contracting arrangements, creation of administrative efficiencies, and program and service redesign (Smith & Mulkern, 2006).

Initial results show that during the first year of the program, funding for substance abuse services increased by $5.6 million, and second year funding is expected to increase by another 25 percent—gains that should translate into increased access and new and renewed formal collaborations among State purchasers that extend well past grant timeframes. New service development focused on case management, medication management, community supports and aftercare, community and ambulatory detoxification, and multisystemic therapy (Smith & Mulkern, 2006).

The program's overall evaluation will focus on five domains: access to treatment and numbers served, service utilization, financing and cost savings, infrastructure improvements that support substance abuse services, and a taxonomy of the service names and procedure codes used in each State.

There are a number of available Resources for Recovery materials that treatment providers and State agencies may find useful, including examples of and tools for developing State Action Plans, a cross-agency financing and purchasing analysis guide, and presentations and related materials from the Policy Forum and other State meetings.[92]

Guiding Principle 5: Customize the Approach and Prioritize Targets

Each State has a different mix of available funding sources; thus, any funding approach must be adapted to a State's or community's current landscape. In general, States and localities today have considerably more authority than before to make policy and funding decisions that can significantly affect the provision of substance abuse treatment. One result of this increased State and local discretion, as stressed in the introduction to Section III, is that the way funds are actually used and allocated varies tremendously from community to community, governed in large part by State and local priorities, policies, politics, economics, leadership, and other extenuating factors.

Selecting the optimum targets for funding efforts needs to be carefully tailored to an agency and its locale. In some States, State resources rather than Federal grants may be the best bet for expanded funding for comprehensive treatment. In other States, private funding may offer more potential based on the presence of foundations or other sources with a special commitment to women and children's programs. In still other cases, funding from agencies and programs that have an indirect connection to treatment may be the most suitable, based on recent expansions or newly created funding sources (e.g., tobacco settlement funding, State treatment as an alternative to incarceration, other ballot initiatives). Take stock of all options, and target a few best bets based on where resources are most significant, where new flexibility may be available, and where champions of an integrated funding approach may already exist (National Center on Substance Abuse and Child Welfare, 2004).

Steps for Treatment Providers: Use the funding treatment inventory (described above) to assess what other treatment providers in the community have done and to prioritize possibilities. Use both funding inventories and other external resources (e.g., newsletters, quarterly reports, listservs, legislative updates, tracking services) to assess recent trends in funding, identify what existing sources are increasing and decreasing, unearth potential new sources in the public and private sectors, and monitor policy changes (e.g., TANF reauthorization) and their implications for funding of substance abuse services. As discussed in Section V, develop and nurture personal relationships with funders. Use these relationships to test ideas before submitting a proposal and to review positive and negative feedback received on past proposals to determine resubmission potential, rather than start anew.

Steps for State Agencies: Analyze how the State's funding streams are both similar to and different from other States as a means of exploring policy options for diversifying and using funding more effectively. Determine whether the State could better use Federal funds to expand coverage for substance use treatment services. Assess the State agency's current and potential use of entitlement funding for clients services and supports, including Medicaid, child care entitlements, and other income support and health-financing funding streams.

Florida learned that, through its local match program, county dollars can be redirected to expand local services and that the State alcohol and drug association can act as an intermediary between other State agency goals and local providers (Abbott, Bryant, Daigle, & Engelhardt, 2006).

In particular, draw from the experiences of other States (see box) and seek to maximize use of Medicaid by expanding the number of Medicaid substance abuse providers, increasing Medicaid reimbursement rates, establishing new Medicaid service codes and definitions, and developing a local match program to fund Medicaid specialized substance abuse services using local county tax funding. For example, gather data from other States on the extent to which the use of expanded Medicaid eligibility definitions has resulted in cost offsets of the kind documented in Washington and other States.[93]

Guiding Principle 6: Promote the Connections Between Funding and Outcomes

No matter who or what the funding source, evidence of effectiveness is frequently a prerequisite for initial and continued funding. Collection of outcomes data is now a necessary part of program design and service delivery. At both the community and the State levels, such data can document overlapping caseloads (e.g., welfare recipients, offenders) and the value that substance abuse treatment adds to other agencies' clients and services (Center for Substance Abuse Treatment, 2000; Resources for Recovery, n.d.). To successfully tap into resources from other service systems, the substance abuse treatment system will have to draw on more comprehensive outcomes data to show how the provision of such services is connected to a wider range of positive outcomes (e.g., improved parental functioning, employment retention) that are of concern and relevance to other provider and State agencies.

As solid evaluations of women's treatment and family treatment programs build up over time, the case for cost effectiveness becomes easier to make. Although this evidence will not necessarily ensure immediate increases in net allocations for comprehensive treatment models, it will build a solid foundation of effectiveness that—over the longer haul—will persuade funders and others to blend resources to support comprehensive services for women and their children and families. In addition, the more public and private funders require data on evidence-based practice treatment model, the greater the possibility that funding can be redirected away from less intensive, less effective models and applied to more comprehensive, effective models (see box).

Steps for Treatment Providers: Identify an individual (e.g., the program director or manager) who can take a leadership role to nurture and support the development, implementation, and institutionalization of an outcomes-based approach (Marton et al., 2005). Track clients beyond 12- and 18-month timeframes for longer term data on client impact of comprehensive treatment and aftercare services. In addition to quantitative data, gather qualitative data that brings families' stories of recovery to life. (These stories will also play a role in increasing public education and awareness about families' needs; see guiding principle 7 below.) Develop shared outcomes with collaborative service providers, with the understanding that cross-systems data will enable substance abuse providers to show child welfare, criminal justice, welfare, and other systems that their clients improve as a result of working with

To ensure that public funds were spent on effective services that produced positive outcomes, the Oregon Legislature passed SB 267 in 2003 to require the use of evidence-based practices by substance use treatment providers. The legislation, which went into effect in 2005, mandates that in the first year, 25 percent of State funding be spent on evidence-based programs; this increases to 50 percent in 2007 and 75 percent in 2009 and thereafter. The legislation also states that compliance with this requirement will be considered in the State appropriations process (Marton et al., 2005).

In 2002, Delaware implemented a performance-based contracting system (in place of cost-reimbursement contracts) with all of its outpatient treatment programs. From 2001 to 2006, average rates of patient capacity utilization increased from 54 to 95 percent, and the average proportion of patients who were actively engaged in more than 30 days of treatment increased from 53 to 70 percent. The State has recently entered into a similar performance-based contract with its largest detoxification clinic, with financial incentives subject to patients connecting to ongoing care after detoxification is completed (Treatment Research Institute, 2008).

substance abuse treatment providers. Use available Federal, State, and local data sources to establish benchmarks against which to gauge progress.

Steps for State Agencies: Strengthen State agency information systems to ensure compliance with—as well as the ability to meet and exceed—new federally mandated NOMs. Develop specific outcome measures for all State-supported substance use programs. Be sure to include outcome measures that reflect the predominant service needs of the client populations that both substance abuse and other systems serve. For example, if collaborating with criminal justice to provide services to offenders, document the appropriate outcomes related to reductions in recidivism or drug-related charges. Hold treatment agencies and contractors accountable by rewarding those that meet or exceed their stated objectives and penalizing those that do not (unless they can improve their program to achieve desired outcomes) (Join Together, 2006).

Guiding Principle 7: Work To Change the Rules and the Priority Given to Substance Abuse Funding

Decisions at the State and community levels can be changed by effective dissemination of baseline data and public education about the importance and effectiveness of substance abuse treatment. It is more important than ever for providers to become actively involved in the policymaking process and to take a stand when States and communities set priorities that overlook or adversely affect persons who need substance abuse treatment (Center for Substance Abuse Treatment, 2000). Effective advocacy rests, in large part, on the ability to present compelling quantitative and qualitative data that demonstrate the benefits of treatment not only to individuals but also to communities and society in general. Thus, this last guiding principle is inextricably linked to guiding principle 6 regarding accountability.

Advocacy is important in obtaining waivers or other related forms of discretion that result in greater funding and service delivery flexibility. Such advocacy can be aimed at administrative actions as well as legislative enactments, because it is often an individual's or single agency's narrow interpretation of the legislation rather than the actual language of the law that acts as the obstacle to funding flexibility. Dr. Kathryn Icenhower at SHIELDS for Families describes this problem as one of "categorical thinking, not categorical funding," noting that the difficulty often lies in how an agency applies the money or in having people mired in bureaucracy, rather than in too restrictive legislative mandates.

Steps for Treatment Providers: Build public awareness about the nature of substance use disorders, the need to improve treatment capacity, and the benefits of treatment by developing relationships with local news media as well as public relations or marketing firms that engage in pro bono work that might communicate your messages. Look into other possible resources in your community (e.g., local United Way, development firms) that might assist in these matters. Develop relationships with local and State legislators. Seek champions who will rally others. Invite them to community forums or request that they hold hearings on the impact of substance abuse and treatment effectiveness; ask them to visit your treatment program to meet and hear from clients; and include them on newsletter, fundraising, or other related mailing lists. Use graduates from the treatment program as spokespeople.

To increase State funding flexibility, explore with legislative staff the extent to which legislators support—and are willing to sponsor—legislation that will streamline application processes, blend funding streams, or institute other types of funding reforms. Join a provider network or association to stay informed, strengthen the agency's collective voice, and expand its reach. Ask local legislators for an annual summary of State funding that flows into their district to shed light on gaps in existing data and bolster arguments for the need both to consolidate funding streams and to create a comprehensive funding inventory that cuts across all State agencies.

Steps for State Agencies: Review the relevance of other States' legislative enactments that have made treatment funding streams more flexible through waivers, blended funding, and other approaches. Assess whether similar enactments or administrative flexibility can move the State toward more comprehensive services. Work with and support providers to build public awareness about substance use disorders and treatment. Examine the extent to which the State agency can implement new or modify existing policies and procedures that support comprehensive family-centered treatment.

A. Summary

This section began with the suggestion that treatment providers and State agencies use a "construction perspective" as they seek to implement a comprehensive funding strategy that supports the wide array of treatment and support services needed by women with substance use disorders and their children and families. As is true in construction, where putting up the first building is more challenging than subsequent structures that follow the same blueprint, providers and agencies will find the task more manageable as they move into the process. The principles outlined in this section *can* be followed and carried out, as made clear by the examples provided throughout this report. These are not theoretical approaches but practical methods of constructing a broad and deep effort to expand funding. Although challenging, the overall effort to secure and integrate multiple funding sources from the public and private sectors will ultimately reap better results and is a necessary and rewarding element of providing comprehensive treatment services.

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Notes

[1] In the last decade, the "theory of change" concept has become an increasingly valuable tool to help comprehensive community-based initiatives evaluate their efforts. A theory of change is a strategy or blueprint for how an initiative will achieve its large-scale, long-term goals. It identifies and maps all the preconditions, pathways, and interventions necessary for success and creates a commonly understood vision among stakeholders of desired long-term results, how they will be reached, and what will be used to measure progress along the way. A logical extension in the design and evaluation of comprehensive programs for women with substance use disorders is the inclusion of a "theory of resources." This added emphasis is needed because decisions about what resources it will take to launch, operate, sustain and take a project to scale are often underemphasized or even ignored in developing new initiatives. In developing a theory of resources, a wide lens must be used, since the fiscal needs of any comprehensive treatment initiative will change over a project's existence—from start-up to going full-scale to sustainability and replication. Information about the theory of change process is available from the Theory of Change Web site (http://www.theoryofchange.org [retrieved May 8, 2006]), a joint venture between ActKnowledge and the Aspen Institute Roundtable on Community Change.

[2] See, for example, SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) for program outcomes for strategies to decrease the incidence of alcohol, tobacco, and illegal drug use among youth at high risk (http://nrepp.samhsa.gov); findings from a review of programs that aim to increase the employment of individuals or populations at risk of serious criminal involvement (Bushway & Reuter, 1998); and findings from afterschool programs (Afterschool Alliance, 2005).

[3] The Finance Project (http://www.financeproject.org) develops and disseminates research, information, tools, and technical assistance for improved policies, programs, and financing strategies regarding children, families, and communities. The discussion and definitions on various funding strategies presented in this section of the paper are drawn from the many invaluable publications available from the Finance Project. In particular, a key source used in helping compile much of this information is Hayes, Flynn, and Stebbins (2004).

[4] Other resources that provide examples of effective financing strategies in related social services fields, but not necessarily specific to serving women with substance use disorders, include Stroul and colleagues (2008) and Pires, Lazear, and Conlan (2008).

[5] Although some formula or block grant programs can be pooled, other Federal funds, particularly those from discretionary grant programs, do not lend themselves to pooling because they require independent reporting to Federal agencies.

[6] DRA added Section 472(i) to Title IV-E to allow a State to claim allowable administrative costs under more limited circumstances. For more information, refer to Administration for Children, Youth and Families Program Instruction ACYF-CB-PI-06-06, issued August 23, 2006 (retrieved October 24, 2006, from http://www.acf.hhs.gov/programs/cb/laws_policies/policy/pi/pi0606.htm). DRA also makes several changes to the definition of Medicaid targeted case management and what can be billed as an administrative service (see Rosenbaum & Markus, 2006).

[7] This figure represents the average amount of State funds spent on substance abuse prevention and treatment in 2003, based on what States reported in their fiscal year 2006 SAPTBG applications (Office of National Drug Control Policy, 2006).

[8] As noted, a multitude of sources were consulted to develop this section of the report and determine potentially allowable uses of different Federal funding sources. This effort included a review of numerous funding papers and reports from various research and policy organizations, in particular, those published by the Finance Project (http://www.financeproject.org) and the Bazelon Center for Mental Health Law (http://www.bazelon.org), as well as a report to SAMHSA on funding for mental health and substance abuse services for children and adolescents (Bassin et al., 2006). Because determinations of allowable uses may be subject to the interpretation of a given organization and/or the report's authors depending on their focus and perspective, discrepancies were sometimes encountered in

the information reviewed. Where possible, the authors of this report sought to clarify information through other sources. The information presented here thus reflects our best summary judgment of all sources assessed.

[9] For more detailed information on any of the funding sources listed, refer to the *Catalog of Federal Domestic Assistance* at http://www.cfda.gov.

[10] SAPTBG funds can be used to screen and assess for mental health issues but cannot be used to provide direct mental health services; the latter may be provided using the Community Mental Health Services Block Grant. Several States (Arizona, Connecticut, Missouri, New Mexico, and Oregon) have used SAPTBG funds for mental health screening, clinical consultation, and assessment (see Substance Abuse and Mental Health Services Administration, 2002).

[11] In addition, the statute (Title 42, Chapter 6A, Subchapter XVII, Part B, Subpart ii, Sec. 300x-28) says that States must "coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services)" (retrieved from http://www.access.gpo.gov/uscode/title42/chapter6a_subchapterxvii_partb_subpartii_.html).

[12] A directory of SSAs is on the SAMHSA Web site at http://www.samhsa.gov/Grants/generalinfo/state_agencies.aspx (last updated April 5, 2007).

[13] More detailed information on the NOMs can be found at http://www.nationaloutcomemeasures.samhsa.gov.

[14] One State financing strategy used to increase Medicaid coverage and reimbursement of substance abuse treatment services is delegated management. With this approach, the State Medicaid agency arranges for the State substance abuse authority to perform certain Medicaid administration activities. The State substance abuse authority may provide the State Medicaid agency with substance abuse clinical guidance, manage the publicly funded specialty provider network, provide Medicaid matching funds, and support utilization management and outreach activities. Delegation is done in a manner that ensures that the State Medicaid agency retains required program administration and oversight responsibilities (McCarty, Edmundson, Green, & McFarland, 2003).

[15] For more information on Medicaid waiver programs, go to the CMS Web site, http://www.cms.hhs.gov/medicaid/waivers.

[16] The Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613) passed the House on April 23, 2008 and on April 28, 2008 (the latest major action at the writing of this report) was placed on the Senate Legislative Calender under General Orders, Calendar No. 719. The companion bill being considered in the Senate is S. 2819.

[17] Oregon and Iowa are examples of two States where moving to a managed substance abuse care model resulted in positive outcomes (D'Ambrosio, Mondeaux, Gabriel, & Laws, 2003; McCarty & Argeriou, 2003).

[18] States must maintain funding for qualified program expenditures at a level equivalent to at least 80 percent of the State's share of AFDC expenditures in FY 1994. If a State meets the minimum work participation rate requirements, the MOE requirement drops to 75 percent. Tribes are not subject to matching or MOE requirement.

[19] The Final Rule generally limits the counting of substance abuse treatment to the job search and readiness assistance activity. However, it states that if a portion of substance abuse treatment meets a common-sense definition of another work activity (such as community service or job skills training directly related to employment), then the hours of participation in that activity may count under the appropriate work category. In addition, if hours in unsubsidized, subsidized private-sector, and subsidized public-sector employment include treatment services, a State may count those paid hours under that work activity. See Section 261.2(g) of TANF Final Rule, available at http://www.acf.hhs.gov/programs/ofa/finalru.htm.

[20] The Final Rule defines 1 week as 20 hours for a work-eligible individual who is a single custodial parent with a child younger than age 6 and 30 hours for all other work-eligible individuals. Thus, 6 weeks equals 120 hours for the first group and 180 for all others.

[21] Personal correspondence, November 22, 2006, with Elena M. Carr, U.S. Department of Labor, Drug Policy Coordinator Office of the Assistant Secretary for Policy, Washington, DC.

[22] For a list of State and local Workforce Investment Boards, as well as other contacts, visit the U.S. Department of Labor Employment and Training Administration Web site at http://www.doleta.gov/regions.

[23] A list of Community-Based Family Resource and Support (CBFRS) State lead agency contacts is available on the FRIENDS National Resource Center for CBFRS at http://www.friendsnrc.org.

[24] *Maximizing Fiscal Resources for the CBCAP State Lead Agencies: A Guidebook and Tool Kit* includes practical information on leveraged fund claims, fundraising strategies, worksheets, and other tools and resources. It is available on the FRIENDS National Resource Center Web site at http://www.friendsnrc.org.

[25] Case assessments can be done in the context of case planning. According to the *Child Welfare Policy Manual*, "A case assessment might consider information regarding psychological, developmental, behavioral and educational factors; explore underlying or disguised issues such as family violence or substance abuse; examine the child and the family's needs, strengths, resources and existing support systems; and explore whether it is safe for the child to remain in or return to the home. Furthermore, it could include information on the child's past history, current adjustment, direct observations, and family history. Specialized assessments such as psychiatric, medical or educational assessments are medical or educational services, respectively, and are not, therefore, allowable under Title IV-E (45 CFR 1356.60(c)) and *Child Welfare Policy Manual* Section 8.1B. Time spent analyzing specialized assessments to inform the case plan, however, is allowable" (Administration for Children and Families, n.d.a).

[26] Examples of other unallowable social services include therapeutic child care, counseling and therapy with the child and biological family to resolve the problems that led to the need for out-of-home placement, counseling and therapy to plan for the child's return to the community, and psychological or educational testing, evaluation, and assessment. These costs may be claimed under other programs such as Title IV-B or the Social Services Block Grant (Administration for Children and Families, n.d.b).

[27] For example, the Proposed Child Welfare Program Option has been included in each of the President's budget proposals for FY 2004–2008 but has yet to be introduced into legislation. If passed, this legislation would offer States a choice between current IV-E program and a 5-year capped, flexible allocation of funds equivalent to anticipated IV-E program levels. Proponents believe this change would allow innovative State and local child welfare agencies not only to do away with burdensome and costly eligibility determination and claiming functions but also to redirect funds toward services and activities that more directly achieve safety, permanency, and well-being for children and families. Proponents argue that States would enjoy more flexibility while focusing on results for children and high-quality services, retaining existing child protections, and benefiting from a financial safety net (in the form of access to emergency funds under the TANF Block Grant) in the case of an unanticipated increase in their foster care population.

[28] The Deficit Reduction Act of 2005, passed in February 2006, provided a 1-year increase in mandatory funding for PSSF for FY 2006.

[29] In fiscal year 2002, eight States (Alaska, Arkansas, Idaho, Maine, Massachusetts, Nevada, Pennsylvania, and Utah) reported using some of their PSSF funds to provide substance abuse assessment and treatment services for some clients. Services included education and prevention, case management, and recovery and followup support. Idaho provided PSSF funds to a community coalition to assess the prevalence of pregnant women with substance use disorders and babies exposed to drugs and to develop a health care program to address maternal substance abuse (James Bell Associates, 2002).

[30] For information on State CCDF plans and reports, visit the National Child Care Information Center at http://www.nccic.org.

[31] Although EPSDT requires that children be provided all federally allowable Medicaid treatment services determined to be medically necessary, it does not automatically override every benefit restriction a State may have. It also does not require States to cover a particular type of service provided that the service is otherwise reasonably accessible and available to the child (Fox & McManus, 2005).

[32] As an example, Guilford Child Health in North Carolina uses CPT billing code 96110 when a social worker administers a secondary developmental screen or assessment in response to an at-risk score on the Ages and Stages Questionnaire or concern about other risk factors such as maternal substance abuse or depression (Rosman, Perry, & Hepburn, 2005).

[33] Minnesota created the Children's Therapeutic Services and Supports benefit for children who have been diagnosed with an emotional disturbance of any severity; the benefit includes a wide range of mental health services, including skills-building services for the child and his/her family (Kaye et al., 2006; see also Johnson & Knitzer, 2005).

[34] The National Conference of State Legislatures has compiled a State-by-State list of substance abuse treatment benefits in non-Medicaid SCHIP plans; it is available at http://www.ncsl.org/programs/health/schiptable06.htm (retrieved March 31, 2005).

[35] The reauthorized IDEA allows local education agencies (LEAs) to reduce their own local spending on special education by an amount equal to 50 percent of the increase in Federal funding from 1 year to the next. For example, if the LEA receives an increase of $5,000 in Federal funds from the previous year, it can reduce its own local funding by $2,500. Any reduction in the maintenance-of-effort level is permanent (U.S. House of Representatives Committee on Education and the Workforce, 2005).

[36] Part B-identified disabilities include mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, developmental delays, emotional or behavioral disorders, or specific learning disabilities that require special education and related services.

[37] In 2004, only eight States had exercised this option, and only half of those explicitly mentioned family or environmental risk factors, such as parental substance abuse, in their definitions (Johnson & Knitzer, 2005).

[38] P.L. 108-36. Keeping Children and Families Safe Act of 2003. Amendment to Section 106(b) of the Child Abuse Prevention and Treatment Act (42 USC 5105a(b)).

[39] Under the DSM-IV, "V" codes include such conditions as noncompliance with treatment; physical/sexual abuse of an adult or child; partner, sibling, or parent-child relational problem; occupational or academic problem; child, adolescent, or adult antisocial behavior; and religious or spiritual problem.

[40] Much of the information provided here can be found in Maternal and Child Health Bureau (n.d.).

[41] For a list of State contacts, go to https://performance.hrsa.gov/mchb/mchreports/link/state_links.asp.

[42] Information on State allotments is available at http://www.acf.hhs.gov/programs/ocs/ssbg/docs/allocs.html.

[43] A list of SSBG State officials is available from ACF at http://www.acf.hhs.gov/programs/ocs/ssbg/docs/stoff.htm.

[44] The Uniform Definitions of Services are available from the SSBG Web site at http://www.acf.hhs.gov/programs/ocs/ssbg/procedures/unifdef.html. Substance abuse services, as defined by the Uniform Definitions of Services, are those services or activities that are primarily designed to deter, reduce, or eliminate substance abuse or chemical dependence. Except for initial detoxification services, medical and residential services may be included but only as an integral but subordinate part of the service. Component substance abuse services or activities may include a comprehensive range of personal and family counseling methods, methadone treatment for people who abuse opioids, or detoxification treatment for people who abuse alcohol. Services may be provided in alternative living arrangements such as institutional settings and community-based halfway houses.

[45] The 12 States were Arkansas, Connecticut, Illinois, Minnesota, Mississippi, Nevada, North Carolina, Ohio, Rhode Island, Utah, Virginia, and Wyoming (Administration for Children and Families, 2007).

[46] For information on different State examples, see the Administration for Children and Families' *Social Services Block Grant Program Annual Report 2002* and the *Social Services Block Grant Program Annual Report 2003*.

[47] Most States have their plan available on their child welfare department Web sites; State fact sheets with information on State coordinators, administration of Chafee dollars, services for youth older than 18, and more are available from the National Child Welfare Resource Center for Youth Development at http://www.nrcys.ou.edu/yd/state_pages.html.

[48] For a list of the State JABG coordinators, go to http://ojjdp.ncjrs.org/jabg/jaibg.html (retrieved April 10, 2006).

[49] Much of the information on the Community Prevention Incentive Grants program was compiled from Office of Juvenile Justice and Delinquency Prevention (1994, 2001).

[50] Personal correspondence with Heidi Hsia, Program Manager, State Relations and Assistance Division, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. April 10, 2006.

[51] Contact information for each State's Title V Coordinator or Juvenile Justice Specialist is available from the Office of Juvenile Justice and Delinquency Prevention Web site, http://ojjdp.ncjrs.org/titlev/grant.html (retrieved November 10, 2006).

[52] The Title V Model Programs Guide and Database can be accessed through OJJDP's Title V Community Prevention Grants homepage at http://ojjdp.ncjrs.org/titlev/index.html.

[53] More information on the performance measures can be found from the U.S. Department of Housing and Urban Development's Office of Community Planning and Development at http://www.hud.gov/offices/cpd/aidshousing/programs/formula/index.cfm.

[54] Beginning in FY 2007, Title II formula grants will be awarded based on the prevalence of HIV disease; that is, reported AIDS cases and HIV infections that have not yet progressed to AIDS.

[55] According to the *Projects for Assistance in Transition From Homelessness 2004 Annual Report Data Summary*, 59 percent of persons served had a co-occurring substance use disorder in addition to a serious mental illness (retrieved April 12, 2006, from http://www.pathprogram.samhsa.gov/pdf/PATH_Facts_2004.pdf).

[56] A list of State agencies and PATH-funded service providers is available from SAMHSA's Center for Mental Health Services (retrieved February 20, 2007, from http://www.pathprogram.samhsa.gov/contacts/default.asp).

[57] Contact information on the State Administering Agency for the Byrne Justice Assistance Grant Program is available from the U.S. Department of Justice, Office of Justice Programs Web site (retrieved November 10, 2006, from http://www.ojp.usdoj.gov/saa).

[58] See, for example, SAMHSA's available technical assistance and training for grant applicants at http://www.samhsa.gov/Grants/technical_assistance.aspx.

[59] For an example of the annual State expenditure report, see National Association of State Budget Officers (2004).

[60] Four States—Florida, Minnesota, Mississippi, and Texas—entered into separate settlements and do not receive funds under the Master Settlement Agreement.

[61] This discussion of State tobacco settlement expenditures for substance abuse treatment focuses on funds allocated for alcohol and drug treatment; it does not include smoking or tobacco prevention or cessation programs, which many more States support with these funds.

[62] House File 862—An Act Relating to and Making Appropriations from the Healthy Iowans Tobacco Trust and the Tobacco Settlement Trust Fund (retrieved April 11, 2007, from http://coolice.legis.state.ia.us/legislation/enrolled/HF862.html).

[63] The 10 States are Arizona, Idaho, Kansas, Mississippi, Montana, New Jersey, Nevada, Oregon, Tennessee, and Utah (George Washington University Medical Center, 2003).

[64] See the 2005, 2006, and 2007 reports, *The Fiscal Survey of States*, prepared by the National Governors Association and the National Association of State Budget Officers, available at http://www.nasbo.org/publicationsReport.php. In FY 2006, one additional State made changes to its cigarette/tobacco taxes, but the result was a decrease in revenue.

[65] Sources for this section include California Campaign for New Drug Policies (2000), Drug Policy Alliance (n.d.), and Little Hoover Commission (2003).

[66] See the 2002, 2003, 2004, and 2007 reports, *Evaluation of the Substance Abuse and Crime Prevention Act,* prepared for the California Department of Alcohol and Drug Programs by the UCLA Integrated Substance Abuse Program, available at http://www.prop36.org/report_menu.html.

[67] Author Sid Gardner's personal correspondence with Mark Matlin, Little Hoover Commission, February 22, 2008.

[68] More information about Proposition 10 can be found on the California First 5 Web site at http://www.ccfc.ca.gov.

[69] Iowa HF 875—Appropriations—Health and Human Services, signed by Governor on June 14, 2005 (retrieved April 11, 2007, from http://coolice.legis.state.ia.us/legislation/enrolled/HF825.html).

[70] New Hampshire House HB 206—Final Version (retrieved November 11, 2005, from http://www.gencourt.state.nh.us/legislation/2005/HB0206.html).

[71] Search of the National Conference of State Legislatures State substance abuse legislation database conducted March 20, 2008 (http://www.ncsl.org/programs/health/substAbuse_bills.cfm).

[72] The Little Hoover Commission is an independent State oversight agency that was created in 1962. The commission's mission is to investigate State government operations and—through reports, recommendations, and legislative proposals—promote efficiency, economy, and improved service. More information is available at http://www.lhc.ca.gov/lhc.html.

[73] Background funding and program information and a link to California's FY 2005–06 Budget Allocation Summary is available at http://www.adp.cahwnet.gov/ADPLTRS/05-02.shtml.

[74] Information on both The Children's Budget and The Report Card can be found on the Philadelphia Safe and Sound Web site at http://pss.verveinternet.com/publications/publist_childrensbudget.php.

[75] See State Departments; Public Officers and Employees, Chapter 75, Article 37. Department of Administration, 75-3721. Governor's budget report; contents; submission to legislature; children's budget document; Kansas homeland security budget document, at http://www.lesterama.org/KS/Chapter_75/statutes/75-3721.html.

[76] Arkansas, Georgia, Kentucky, Louisiana, Michigan, Montana, West Virginia, and Wyoming, for instance, specifically mention funding-related system improvements in their brief project descriptions (U.S. Department of Health and Human Services, 2004; review of SAMHSA grant awardees conducted March 20, 2008, available through http://www.samhsa.gov/grants).

[77] Two sources that provide a good discussion of the benefits are Substance Abuse and Mental Health Services Administration (2005a) and National Technical Assistance Center for State Mental Health Planning (2000).

[78] Total charitable giving from four sources—individual (living) donors, bequests by deceased individuals, foundations, and corporations—was estimated to be $250 billion in 2004. Foundation giving accounts for only about 11 percent of charitable donations (Giving USA, 2005).

[79] Family foundations represent a subfield within the foundation world that is rapidly growing, in part because of rising wealth among second- and third-generation family members of pioneer philanthropists, against the background of an estimated $40 trillion in wealth transfers among generations from 2000 to 2050 (http://www.ncfp.org/advisor-research.html and http://www.economist.com/printedition/displayStory.cfm?Story_ID=2963247). One estimate puts this number as high as $136 trillion.

[80] Search of The Foundation Directory Online conducted April 30, 2006, using the following search terms under field of interest: "substance abusers," "substance abuse treatment," "substance abuse services," "substance abuse prevention," "mental health/addictions," and "alcoholism." This service is available by subscription through The Foundation Center: http://foundationcenter.org.

[81] For information on The Robert Wood Johnson Foundation's Substance Abuse Policy Research Program and its other national programs, go to http://rwjf.org/applications/solicited/npolist.jsp?interestAreaId=131.

[82] The Foundation Center also has a list of the top 50 U.S. foundations awarding grants for mental health (circa 2003) available at http://foundationcenter.org/findfunders/statistics/pdf/04_fund_sub/2003/50_found_sub/f_sub_f_03.pdf.

[83] Search of The Foundation Directory Online conducted April 30, 2006. The following search terms were used to identify child welfare-type services: "foster care"; "crime/violence prevention, child abuse"; "children services"; "children, foster care"; "children, adoption"; "child development services"; "child abuse"; and "abuse prevention." The following search terms were used to identify family services: "family services"; "family services, single parents"; "family services, parent education"; "family services, domestic violence"; "family services, counseling"; and "family services, adolescent parents." This service is available by subscription through The Foundation Center: http://foundationcenter.org.

[84] This section was written using material from sources that included De Vita & Fleming (2001); Grantsandfunding.com (2001); National Technical Assistance Center for State Mental Health Planning (2000); Nelsen (n.d.); Substance Abuse and Mental Health Services Administration (2005a); and United States Grants.org (n.d.).

[85] States that never had an exclusion law or have amended or repealed their exclusion laws to prohibit the denial of benefits include Colorado, Connecticut, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New

Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, South Dakota, Utah, Vermont, Washington, and Wisconsin (Alcohol Policy Information Systems; Insurer's liability for health/sickness losses due to intoxication as of January 1, 2007; retrieved March 21, 2008, from http://www.alcoholpolicy.niaaa.nih.gov).

[86] For reference of the various studies that have been conducted, see, for example, Azrin et al. (2007); Coalition in Fairness in Mental Health and Substance Abuse Insurance (2000); Curley (2003); Greenfield (2005); and Rosenbach, Lake, Young, Conroy, Quinn, Ingels, et al. (2003).

[87] See, for example, Daley et al. (2000); Flynn, Kristiansen, & Porto (1999); French, McCollister, Cacciola, Durell, & Stephens (2002); Lennox, Scott-Lennox & Holder (1992); McCaul & Furst (1994); and Svikis et al. (1997).

[88] Other bills have also been introduced that include language about mental health and substance abuse parity. For example, in April 2005, the Time for Recovery and Equal Access to Treatment in America (TREAT America) Act (H.R. 1258) was introduced. The bill included a section on substance abuse parity, but with certain exceptions (e.g., small employers), and was referred to the House Subcommittee on Employer–Employee Relations. A related bill, S. 803, was introduced in the Senate and referred to the Committee on Health, Education, Labor, and Pensions. In May 2005, the Health Security for All Americans Act (H.R. 2133) was introduced; section 2203 on health insurance coverage requirements includes mental health and substance abuse treatment benefits parity. The bill was referred to the House Subcommittee on Health. The summary and status of all bills can be searched at THOMAS – Library of Congress, http://thomas.loc.gov.

[89] To arrive at the number of States with full parity, minimum mandated benefits, or mandated offerings, it was necessary to compile information from multiple sources, some of which conflicted with one another. Sources consulted included, but were not limited to Alcohol Policy Information Systems (2007); American Academy of Child and Adolescent Psychiatry (2005); American Society of Addiction Medicine (2007); Bazelon Center for Mental Health Law (2007); Center for Policy Alternatives (2002); Mental Health America (2007); Nagy (2006); National Conference of State Legislatures. (2002, 2007); Perlman (2006); Robinson, Connolly, Whitter & Magaña, (2006); Rosenbach, Lake, Young, Conroy, Quinn, Ingels, et al. (2003); and Rosenberg (2005). Although a limited Internet search and review of selected State legislature Web sites was conducted to resolve some discrepancies among sources, an exhaustive search of all State statutes to address all inconsistencies was beyond the scope of this report. To the best of the authors' knowledge, the 13 States with full parity for substance abuse are Colorado, Connecticut, Delaware, Hawaii, Maine, Minnesota, North Carolina, Oregon, Rhode Island, South Carolina, Vermont, Virginia, and West Virginia. The five States that do not have any kind of laws governing substance abuse coverage parity are Arizona, Idaho, Iowa, Oklahoma, and Wyoming. The remaining States have either minimum mandated benefits or mandated offerings for substance abuse (though some are limited to only alcohol abuse): Alabama, Alaska, Arkansas, California, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Dakota, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington, and Wisconsin.

[90] One recent study found that improved access to employer-paid insurance did not translate into increased use of private insurance to pay for past-year treatment. Of people who said they had private insurance and got treatment, fewer than half reported they used their insurance to pay for treatment. Another 24 percent did not know whether their insurance covered treatment (Oggins, 2003).

[91] These guiding principles echo and indeed reinforce many of the recommendations put forth in other major reports; in particular Center for Substance Abuse Treatment (2000); Join Together (2006); and National Center on Substance Abuse and Child Welfare (2004).

[92] These and other resources can be found on various Web sites connected with the Resources for Recovery project. The Resources for Recovery homepage, http://www.resourcesforrecovery.org, contains national program and State contact information as well as an overview of State strategies and materials from Policy Forum meetings in which participating State teams came together to discuss, develop, and implement strategies to expand substance abuse

treatment access and resources. Other meeting materials are available through the Center for Health Care Strategies Purchasing Institute, http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=206329, which provided additional technical assistance on the project.

[93] See, for example, Cawthon & Schrager (1995); Estee & Nordlund (2003); French, Salomé, & Carney (2002); Maynard, Cox, Krupski, & Stark (1999); and Wickizer & Longhi (1997).

APPENDIX A.

Overview of Shields for Families, Inc.

APPENDIX A. OVERVIEW OF SHIELDS FOR FAMILIES, INC.

SHIELDS for Families, Inc. (SHIELDS), is a comprehensive, community-based agency that serves 3,000 South Central Los Angeles annually. Since its inception in 1987, SHIELDS has focused on child welfare, family reunification, and family preservation issues, while evolving to meet other priority needs of this inner-city community. SHIELDS employs more than 270 full-time employees and 30 consultants and has an annual budget of more than $15.5 million to operate 26 programs, including four collaborative networks for which SHIELDS acts as the lead agency. SHIELDS uses a center-based one-stop shopping model with home visitation. Core services include substance abuse treatment; outreach, intake, and assessment; case management; child development; youth services; mental health; family preservation; vocational services; housing; transportation; and aftercare. SHIELDS is a contracted CalWORKs (California's Temporary Assistance for Needy Families [TANF] program) treatment program, a certified Medi-Cal provider for mental health and substance abuse treatment, and a United Way agency.

SHIELDS's primary goals are to (1) promote family reunification and support families remaining intact in the community, (2) strengthen families through the provision of comprehensive and collaborative services, (3) improve the general well-being of families through comprehensive health programs and preventive social services, and (4) promote self-sufficiency and economic independence.

The agency was formed in 1987 in response to the high incidence of infants born at Martin Luther King Hospital in South Central Los Angeles who were prenatally exposed to drugs. Using a fiscal intermediary, SHIELDS implemented three programs to target the special needs of these infants. In 1991, SHIELDS incorporated as a State of California private, nonprofit organization focusing on family-based services addressing issues inherent to the South Central Los Angeles community.

SHIELDS provides services to families who reside in South Central Los Angeles, including the Watts/Willowbrook and Compton communities. This area has the largest percentage of minorities in Los Angeles County with an ethnic breakdown of approximately 16.5 percent Caucasian, 65.0 percent Latino, 33.0 percent African American, and 2.1 percent other. This area also has the highest rates of unemployment and overcrowded housing units in the county; its residents have a medium income of $14,944.[93]

SHIELDS receives Federal, State, and county funds, as well as funding from private foundations. Federal support includes grants from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (CSAT), U.S. Department of Housing and Urban Development (HUD), Administration for Children and Families, and Health Resources and Services Administration. Local support includes funding from the Los Angeles County Department of Mental Health, Los Angeles County Department of Children and Family Services (DCFS), Los Angeles County Alcohol and Drug Program Administration, Los Angeles First Five Commission, and Los Angeles City Community Development Department.

The organization has received numerous awards and recognition for its work with families including the C. Everett Koop Award, International Athena Award, the Office of National Drug Control Policy Special Recognition Award, and HOPE Award. It has been featured on television (e.g., *48 hours*, CNN, and local news) and in the print media, with special publications by the Children's Defense Fund, the Washington Health Foundation, and the *Los Angeles Times*. Staff members of SHIELDS sit on numerous local, State, and Federal coalitions and task forces and provide direct input to policy initiatives regarding child development, family preservation, and substance abuse issues.

SUBSTANCE ABUSE TREATMENT SERVICES

SHIELDS offers seven substance abuse treatment programs with a total capacity to serve 375 families. Programming includes outpatient, day-treatment, and residential services. Special programs are provided for individuals with co-occurring disorders, perinatal clients, adolescents, General Relief and TANF recipients, CARE voucher recipients[93], Compton Drug Court participants, and Substance Abuse and Crime Prevention Act referrals (also known as Proposition 36, California's treatment instead of incarceration initiative).

Housing is offered as a component of the residential program, and satellite housing is available for families enrolled in day treatment. Currently, SHIELDS is the only program in the country that allows an entire family to reside in housing and enroll in program services. All treatment programs incorporate individual, group, and family counseling; intensive case management; life skills training; educational classes on alcohol and drugs, HIV/AIDS, health, anger management, and relapse prevention; mental health services; special issue groups on sexual abuse, grief and loss, and family reunification; vocational and educational courses; parenting and child development education; child development centers; a therapeutic nursery; afterschool youth services; and transportation. SHIELDS's Adolescent Treatment Program provides comprehensive mental health and substance abuse treatment services to youth identified by the Department of Probation and DCFS as having substance use problems. SHIELDS also has a grant from CSAT to provide HIV/AIDS outreach, education, testing, and counseling services in collaboration with the Drew AIDS Project.

The agency also offers the following components to enhance treatment access and availability, and support long-term recovery:

- *Outreach*. Outreach services are provided in the targeted community through street outreach staff. In addition, SHIELDS has four outreach staff members in two local Department of Public Social Services offices, two full-time staff members in the Compton Superior Court, and one full-time staff member in the Edelman Juvenile Dependency Court.
- *Community Access Services Center.* SHIELDS operates an assessment center 5 days a week to provide for substance abuse, mental health and domestic violence assessment, referral, and placement services.

- *Aftercare*. Lifetime aftercare services are provided to all program graduates. Services include counseling, case management, support groups, advocacy and leadership training, access to job placement and housing services, and social activities.

SHIELDS's substance abuse treatment programs have been used as national models for CSAT and HUD, with treatment completion rates of more than 70 percent (compared with the national average of 25 percent), family reunification rates at 85 percent, and ongoing recovery rates at 90 percent, with 80 percent of program graduates employed or enrolled in school or training 1 year after discharge.

CHILDREN AND YOUTH SERVICES

SHIELDS is the only program in the country that enrolls all children in services with their mother or father, enabling families to remain intact and reducing out-of-home placement rates, particularly for children of color. Specific programs for children and youth include the following:

- Four Child Development Centers that serve children ages 0 to 5 of families in substance abuse treatment, with approximately 160 children enrolled in services at any given time. All children receive ongoing developmental screenings and assessments, Individual Education Plans, and intensive center and home-based early childhood education services.
- The SHIELDS's Healthy Start program, which provides comprehensive services to 200 pregnant and postpartum women with substance use disorders and their children (ages 0 to 2) annually. These services include all the core components of Healthy Start: outreach and client recruitment, case management, health education, screening for perinatal depression, and intergenerational continuity of care. Since Healthy Start services were implemented in 1998, 924 high-risk pregnant and postpartum with substance use disorders and their children through 2 years of age have enrolled in and received comprehensive Healthy Start services.
- The Heroes and Sheroes youth programs, which provide prevention and early intervention services for children ages 6 to 18 whose parents are enrolled in SHIELDS programs. The youth programs provide culturally based, afterschool and weekend programming that includes self-awareness, tutoring, mentor services, and social and recreational activities.

Because of the various services provided, the following achievements have been made:

- The rate of substance-exposed births has dropped to less than 1 percent in the population served.
- Ninety percent of the children are current on all immunizations.
- All (100 percent) of mothers and children have a medical home.
- None of the children were born at very low birth weight.
- Sixty percent of youth have improved attitudes toward school and education.

- Three-fourths (75 percent) of youth have improved their grades in math and English.
- More than three-fourths (77 percent) of youth have both increased their self-esteem and self-confidence and improved their cultural awareness or identity and community mobilization activities.

MENTAL HEALTH SERVICES

SHIELDS has been a principal mental health services provider in South Central Los Angeles since 1997, focusing efforts on some of the most underserved communities in the County of Los Angeles. SHIELDS provides center-, home-, and community-based services as well as extensive outreach to increase client and family access and use of services. Mental health services include individual, group, and family counseling; case management; psychological testing; psychiatric evaluation; medication support; and crisis intervention. Programs are provided for children, youth, and adults; in addition, specialized programming is provided to specific populations including youth in the juvenile justice system and individuals with co-occurring disorders. Mental health services for children and youth include the following:

- *Therapeutic Nursery.* A day-treatment program for children ages 3 to 5 with severe emotional/behavioral disturbances that prevent adaptive functioning in a regular preschool or nursery school setting.
- *HUB Clinic* .An outpatient program that specifically works in concert with the King/Drew Medical HUB to provide services to children 18 years and younger who are involved with DCFS, particularly children in foster care.
- *School-Based Mental Health.* Outpatient services for school-age children (elementary through high school) provided on site at 17 schools located in the Los Angeles Unified and Compton Unified School Districts.
- *Multi-Systemic Therapy.* Intensive in-home, evidence-based services provided to a targeted subpopulation (e.g., certain criminal offenders) of Los Angeles County youth ages 12 to 17 on probation.
- *Functional Family Therapy.* Intensive in-home, evidenced-based family therapy provided to youth ages 11 to 17 who are on informal probation with the Los Angeles County Department of Probation.
- *Revelations Dual Diagnosis Program.* An intensive outpatient program that provides services to youth ages 13 to 21 with co-occurring substance use and mental disorders.

Specific mental health programs for adults include the following:

- *Eden Dual Diagnosis Program.* A 5-day-a-week day-treatment program that offers mental health services and substance abuse treatment to adult women with co-occurring disorders and their children.
- *CalWORKs Mental Health.* Outpatient services for CalWORKs participants who have mental health problems identified as barriers to employment.

- *CalWORKs Homeless Families.* Outpatient services to assist CalWORKs clients who are homeless or at risk for being homeless in developing the skills needed to sustain permanent independent housing.
- *GROW*. Outpatient services for General Relief recipients that have mental health problems identified as barriers to employment.

CHILD WELFARE SERVICES

SHIELDS has been providing child welfare services to families in Compton, Watts, and surrounding areas since 1992, as one of the original nine family preservation programs in Los Angeles County. As one of the first providers, SHIELDS was instrumental in the design of the program, development of policies and procedures, and implementation of services. During the program's first 4 years, the City of Compton's foster care rate decreased by 29 percent. As a result of these positive outcomes, SHIELDS was selected to implement several pilot programs in Compton, including Families First (Alternative Response) and the Points of Engagement Assessment Program. Both programs have become the prototypes for Los Angeles County and have assisted in decreasing the out-of-home placement rate by nearly one-third (31 percent). SHIELDS's child welfare programs include the following:

- *Point of Engagement.* SHIELDS staff work directly and in collaboration with the emergency response DCFS staff when a high-risk family is identified during a child abuse investigation. A clinical staff member goes to the home and conducts a standardized assessment of the caregivers to determine their capability to provide a safe environment for their children.
- *Multidisciplinary Assessment and Treatment Program.* The program provides comprehensive assessment and linkages to resources for children who are wards of the court and are in out-of-home placement under DCFS jurisdiction, as well as their families or caregivers.
- *Family Support.* A collaborative program that provides supportive services to families to prevent their involvement with the child welfare system. Services include case management; emergency basic support services; structured parent/child and family-centered activities; employment services; health, parenting, and educational classes; and linkage services.
- *Partnership for Families (PFF).* This program provides a one-stop, comprehensive, collaborative, and culturally competent continuum of services targeted to pregnant women and high-risk families referred from the Wateridge DCFS Office. PFF includes external capacity building in the community, as well as an internal capacity-building component to enhance the seven partner agencies involved in the collaborative.
- *Family Preservation.* This collaborative, community-based program works with high-risk families referred by DCFS. SHIELDS provides, in collaboration with three community

partners, intensive and comprehensive services to families to reduce the risk of out-of-home placement.

- *Adoption Promotion and Support Services (APSS).* This program enhances opportunities for the healthy development of children and youth by increasing permanency and stability through adoption. APSS provides a continuum of care including individual and family therapy, mentor program, support and discussion groups, case management, and linkage services.

SUPPORTIVE SERVICES

Since its inception, SHIELDS has been providing supportive services to meet families' basic needs and ensure their success during and after program completion. Supportive services include the following:

- *Housing*. Low-income housing is provided for eligible program participants enrolled in one of SHIELDS's programs. Currently, SHIELDS has 126 units of housing at 3 sites. Each site has resident managers and housing case managers to provide 24-hour availability, onsite property management, and intensive housing case management services to all residents. Security is provided at each site, in addition to onsite teaching and demonstration of homemaking services. SHIELDS also works collaboratively with the Department of Mental Health, Beyond Shelter, and the Housing Authority of the City and County of Los Angeles to assist clients in accessing Section 8 and other permanent housing. In addition, SHIELDS has access to emergency hotel vouchers through its Federal Emergency Management Agency (FEMA) and Family Preservation programs for homeless families. Approximately 250 families who are homeless are provided with housing annually.
- *Transportation*. SHIELDS has 16 vans to transport eligible families to program services, medical appointments, and related services. Bus tokens are also provided to clients to assist with transportation.
- *Food Bank*. A Food Bank provides hot meals daily to SHIELDS's program participants. Nonperishable food is also available and distributed weekly to SHIELDS's participants and the community. Nearly 197,000 hot meals are served annually.
- *Vocational and Educational Services***.** A continuum of vocational training and job placement services is a component of all treatment programs and is offered through SHIELDS's Vocational Services Center site. All primary services are provided by SHIELDS and its collaborating partners, which include the Los Angeles Unified School District, Department of Rehabilitation, Housing Authority of the City of Los Angeles, DCFS, and Los Angeles Community Colleges. In addition, SHIELDS provides onsite high school equivalency degrees, as well as certification programs in child development and fiber optics (RF Technician). SHIELDS also works in collaboration with the GAIN (Greater Avenues for Independence) program, the City of Hawthorne, the City of Los Angeles, and the Housing Authority of the City of Los Angeles to provide clients with subsidized work experience and on-the-job training. In the past 3 years, more than 300

individuals have become gainfully employed, and more than 100 students received their high school diplomas.

SHIELDS EXODUS and TAMAR VILLAGE PROGRAMS

Among SHIELDS most unique programs are Exodus and TAMAR Village, which incorporate housing and basic needs with family-centered treatment and onsite related social services.

The Exodus Family Day Treatment program is an 86-unit apartment complex in Compton for pregnant and parenting women and their families. It provides comprehensive care for women and their children, including family support and reunification. Annually, approximately 60 women and 250 children are served; the average length of stay is 18 to 24 months. Families may remain in housing for 1 year after program completion to transition back to the community. Onsite services include substance abuse and mental health treatment, a child development center, a youth program, medical care, and a vocational services center. The facility also houses two playgrounds, a community room, and laundry facilities for its residents.

Originally funded in 1994 with a grant from CSAT, the goals for Exodus are to:

- Achieve positive perinatal outcomes.
- Improve the well-being of children and families and promote family reunification.
- Treat physical, psychological, and addictive disorders.
- Assist families in achieving economic and social self-sufficiency.
- Assist families with stable and affordable housing.

The results of a rigorous national evaluation and SHIELDS's local evaluation found that for the women enrolled in Exodus:

- Program completion rates averaged between 65 to 75 percent.
- An average of 80 percent remained drug-free at 6 and 12 months after treatment.
- Criminal justice involvement was reduced by 90 percent.
- Nearly two-thirds (65 percent) were employed or enrolled in school or job training at time of discharge.
- Eighty-five percent were reunified with their children who had been placed in foster or kinship care.
- All (100 percent) had high school diplomas.

Positive outcomes for children involved with the Exodus program included the following:

- Increased numbers of babies born drug free (95 percent healthy births annually).
- Improved physical, mental, and social health of children.
- Improved gross and fine motor skills.
- Improved language development and cognition.

- Reduced behavioral problems.
- Improved school performance.
- Improved family bonding and social functioning.

TAMAR Village is SHIELDS's newest housing program and provides a nontraditional family-centered residential treatment program to families in South Central Los Angeles who are involved with the child welfare system because of parental abuse of methamphetamine or other substances. TAMAR opened in 2008 with funding from the Children's Bureau and is a partnership of SHIELDS, the Los Angeles County DCFS, the Los Angeles County Sheriff's Department, the Los Angeles County Public Defender's Office, and the Corporation of Supportive Housing. TAMAR can house 30 families using the Exodus program treatment model.

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APPENDIX B.

Examples of Federal Discretionary Grant Programs That Support Substance Abuse Treatment and Related Support Services

APPENDIX B. EXAMPLES OF FEDERAL DISCRETIONARY GRANT PROGRAMS THAT SUPPORT SUBSTANCE ABUSE TREATMENT AND RELATED SUPPORT SERVICES

Below is a sampling—not an exhaustive list—of current major Federal discretionary programs that could support clinical treatment and community support services for women and their children and families. Because various opportunities change with budget cycles and shifts in priorities, routine monitoring of funding prospects is needed. Please refer to the *Catalog of Federal Domestic Assistance* (http://www.cfda.gov) for more information about these programs. Additional Web-based resources (e.g., http://www.grants.gov) provide information about new funding opportunities and identify and track discretionary programs.

GRANT PROGRAMS THAT SUPPORT SUBSTANCE ABUSE TREATMENT AND RELATED SUPPORTIVE SERVICES FOR PARENTS/ADULTS

- Access to Recovery (ATR)
- Addiction Treatment for Homeless (AT-HM)
- HIV Outreach
- Pregnant and Postpartum Women/Residential Treatment for Women and Their Children (PPW/RWC)
- Promoting Safe and Stable Families (PSSF) Discretionary Grant Program
- Recovery Community Services Program (RCSP)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Targeted Capacity Expansion (TCE)
- Targeted Capacity Expansion/HIV (TCE/HIV)
- Targeted Grants To Increase the Well-Being of, Improve the Permanency Outcomes for, and Enhance the Safety of Children Affected by Parental Methamphetamine or Other Substance Abuse (also under Children's Services below)
- Treatment Drug Court (TDC)

GRANT PROGRAMS THAT SUPPORT CHILDREN'S SERVICES

- Abandoned Infants Assistance Program

- Adoption Opportunities
- Child Abuse and Neglect Discretionary Activities
- Child Welfare Services Training Grants
- Comprehensive Community Mental Health Services for Children With Serious Emotional Disturbances (SED)
- Drug Prevention Program
- Healthy Start Initiative
- Head Start
- Foster Grandparent Program
- Gang-Free Schools and Communities—Community-Based Gang Intervention
- Gang Resistance Education and Training
- Linking Actions for Unmet Needs in Children's Health (Project LAUNCH)
- Special Education Grants for Children with Disabilities
- State Early Childhood Care Systems (ECCS)
- Targeted Grants To Increase the Well-Being of, Improve the Permanency Outcomes for, and Enhance the Safety of Children Affected by Parental Methamphetamine or Other Substance Abuse (also under Parent/Adult Services above)

GRANT PROGRAMS THAT SUPPORT SERVICES THAT BROADLY ADDRESS THE NEEDS OF WOMEN, CHILDREN, AND FAMILIES

- Community Capacity Development Office
- Consolidated Health Centers
- Drug-Free Community Grants
- Family and Community Violence Prevention Program
- Healthy Communities Access Program
- Healthy Marriage Promotion and Responsible Fatherhood Grants
- Safe and Drug-Free School and Communities
- Shelter-Plus Care
- Social Services Research and Demonstration Grants

GRANT PROGRAMS THAT SUPPORT SERVICES FOR SPECIFIC POPULATIONS OF WOMEN AND/OR CHILDREN

Criminal/Juvenile Justice

- Criminal and Juvenile Justice and Mental Health Collaboration
- Demonstration Cooperative Agreements for Development and Implementation of Criminal Justice Treatment Networks
- Drug Court Discretionary Grant Program
- Juvenile Mentoring Program
- Mentoring Children of Prisoners
- Offender Reentry Program

American Indian

- Indian Child Welfare Act—Title II Grants
- Indian Country Alcohol and Drug Prevention
- Tribal Youth Program
- Urban Indian Health Services

HIV/AIDS

- Coordinated Services and Access to Research for Women, Infants, Children, and Youth—Ryan White CARE Act, Title IV Program
- HIV Emergency Relief Project Grants (Ryan White CARE Act, Title I)
- HIV Prevention Activities—Non-Governmental Organization Based

Homeless

- Basic Center Grant (Runaway, Homeless Children)
- Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth
- Supportive Housing Program
- Transitional Housing Assistance for Victims of Domestic Violence, Stalking, or Sexual Assault
- Transitional Living for Homeless Youth