

A RECLAIMING FUTURES
NATIONAL PROGRAM REPORT

Financing Treatment of Substance Use Disorders

FOR ADOLESCENTS IN THE JUVENILE JUSTICE SYSTEM

by
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HEALTH POLICY INSTITUTE
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RECLAIMING FUTURES

Communities helping teens
overcome drugs, alcohol and crime

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SECTION ONE:

Introduction

Expanding and improving the quality of substance use disorder treatment for adolescents involved with the juvenile justice system is essential. For many years the Robert Wood Johnson Foundation has been in the vanguard of efforts to develop comprehensive approaches to treating substance use problems.

In the forefront of these efforts, Reclaiming Futures—a five-year, \$21-million initiative of the Robert Wood Johnson Foundation—promotes new opportunities and standards of care for adolescents in the juvenile justice system by bringing communities together to improve drug and alcohol treatment, expand and coordinate services, and find jobs and volunteer work for young people in trouble with the law.

Like many similar community-based, grant-funded programs, Reclaiming Futures grantees are challenged to institutionalize an infrastructure and maintain the advances in services and systems after the grant funds end. From the inception of any time-limited initiative, it is important for grantees to identify additional resources that may sustain the program over time.

To assist communities and states in this task, this monograph details information on selected federal funding streams that may be used to support the treatment of adolescents with substance use disorders who are involved with the juvenile justice system. Federal funding is available to states, communities, and providers through a number of different mechanisms—including public health insurance, block grants, and discretionary programs—yet challenges remain.

Although both publicly funded health insurance programs, Medicaid and the State Children’s Health Insurance Program, may cover treatment of substance use disorders, some states are still not using these resources for adolescent treatment. Federal block grants to states enable officials to make funding choices, but they often bundle multiple competing priorities into one funding stream with insufficient funds. Discretionary programs allow government to respond directly to emerging needs, but they often differ in eligibility requirements, application processes, length of participation, and covered services. In an attempt to address the developmental risks in adolescence, the federal government continues to invest resources. However, funds are scattered across a number of policy domains, resulting in a proliferation of federal agencies and programs that address adolescent substance use. As a result, publicly funded services for adolescents and their families are often fragmented. This is particularly true for adolescents who are involved with the juvenile justice system and may receive services from numerous agencies and programs.

That said, federal funds are an important source of support for the treatment of adolescent substance use disorders in the United States. Although possible funding sources may be

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Introduction

found in policy areas as disparate as housing, labor, child welfare, and education, this policy brief focuses on selected federal programs in the two principal areas, health and juvenile justice. Each program was selected for inclusion in this paper based on its relevance to the population of interest and the funding level of the program. This brief includes information on the purpose of each federal program, the authorized applicant for the funds, and the approved uses of the available resources. Appendix A summarizes this information.

SECTION TWO:

Health

Federal funding sources in the health sector form the core of support for treating low-income and/or medically needy adolescents who qualify for publicly funded services.

This section discusses two child and adolescent public health insurance programs, Medicaid and the State Children's Health Insurance Program, as well as the Substance Abuse Prevention and Treatment Performance Partnership Block Grant and selected federal discretionary programs administered by the United States Department of Health and Human Services (DHHS). With certain exceptions, funds from these programs may be used to improve access to and the quality of substance use disorder treatment for youth in the juvenile justice system.

MEDICAID

Medicaid, administered by the Centers for Medicare and Medicaid Services (CMS), DHHS, is a public insurance program jointly funded on a formula basis by the federal government and the states. It provides medical and behavioral health care services to address a broad range of health care problems. It is the largest single program for children's health care in the nation, insuring both low-income and disabled children. In 2006, over 28 million children were enrolled in Medicaid (CBPP, 2006).

Under Medicaid, the federal government partially reimburses state expenditures for medically necessary services.¹ In FY 2005, federal spending on the Medicaid program was estimated at \$182 billion (Kaiser Commission, 2004a). The Deficit Reduction Act (DRA) of 2005 (P.L. 109-362), signed into law by President George W. Bush in February 2006, made some important changes in Medicaid and included a number of state

options that may significantly alter existing Medicaid programs. Possible changes resulting from the DRA will be highlighted in this text.

Federal funds are transferred to the states, and within federal requirements, each state determines which groups their Medicaid programs will cover, the criteria for Medicaid eligibility,² and the services covered. States must submit state plans to CMS that detail the state's eligibility criteria and service array. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have "state-only" Medicaid programs to provide medical assistance for specified low-income people who do not qualify for federal Medicaid funds. The federally mandated Medicaid "categorically needy" eligibility groups include:

- Individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996
- Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL)
- Pregnant women whose family income is below 133 percent FPL (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)

- Supplemental Security Income (SSI) recipients in most states (Some states use more restrictive Medicaid eligibility requirements that predate SSI.)
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act
- Special protected groups (Typically, these are individuals who lose their cash assistance because of earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time.)
- All children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL
- Certain Medicare beneficiaries (CMS, 2004a).

Optional eligibility categories³ include but may not be limited to:

- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their state on July 16, 1996
- Pregnant women and infants up to age one who are not covered under the mandatory rules and whose family income is no more than 185 percent FPL (The percentage of FPL is set by each state.)
- Individuals who would be eligible if institutionalized, but who are receiving care under home- and community-based services (HCBS) waivers
- Recipients of state supplemental income payments
- “Optional targeted low-income children” included within the State Children’s Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (P.L.105-33)
- “Medically needy” people⁴ (CMS, 2004a).

The Balanced Budget Act of 1997 included two provisions that give states additional options for increasing children’s health care coverage through the Medicaid program (HCFA, 1999). The first option, presumptive eligibility for low-income children, allows the enrollment of certain children under age 19 in Medicaid on a temporary basis if they appear to be eligible based on age and family income.

The second option, 12-month continuous eligibility, allows states to guarantee up to 12 months of coverage to children enrolled in Medicaid even if a child experiences changes in family income or other circumstances that would make the child ineligible for Medicaid during the 12-month period. A state may place an age limit on the children eligible for continuous eligibility; however, the state must cover all children whom the state determines are eligible under the state plan.

As a result of the passage of the DRA, effective January 1, 2007, states will have the option to extend Medicaid to children under age 19 with family incomes up to 300 percent FPL, with federal financial participation phased in by age of children.

Medicaid-Covered Services

“Title XIX of the Social Security Act allows considerable flexibility within the Medicaid state plans. However, some federal requirements are mandatory if federal matching funds are to be received. Federal Medicaid law requires that a state’s Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children
- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for people age 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for people eligible for skilled nursing services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health center (FQHC) services and ambulatory services of an FQHC that would be available in other settings” (CMS, 2004a).

In addition, federal Medicaid law allows states to provide certain optional services. The following are the most relevant of the 34 currently approved optional Medicaid services for youth in the juvenile justice system:

- Diagnostic services
- Clinic services
- Rehabilitation and physical therapy services
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Home- and community-based care to certain people with chronic impairments (CMS, 2004a).

DRA Sections 6041 through 6043 modify the Medicaid law regarding premiums and cost-sharing for services. In the case of children whose coverage is mandatory, prior protections continue to apply. In the case of children whose coverage is optional, both premiums and cost-sharing are considerably expanded.⁵ States may continue to exempt all children or take advantage of these new options, either in part or in whole.

Although states are precluded from using federal Medicaid funds to provide services to “inmates of a public institution,”⁶ qualified youth involved with the juvenile justice system may receive services in Medicaid-eligible 24-hour care settings (such as hospitals) as well as in community-based settings.

Benchmark and Benchmark-Equivalent Plans

The DRA adds a new Section 1937 to Medicaid law, effective March 31, 2006, which permits states to revise and restructure medical assistance as a state plan option without any special waivers. This section applies only to certain population groups. Children in foster care or who are receiving foster care or adoption assistance, children who are residents of institutions, children with special needs status as defined by the Secretary of HHS, and children whose coverage is based on their eligibility under Temporary Assistance for Needy Families appear to be exempt. This Section allows states the option of providing

benchmark or benchmark-equivalent coverage for any nonexempt child under age 19. The benchmark coverage, similar to the SCHIP provision, includes coverage equal to one of the following:

- The federal employees health benefit plan
- The state employees health benefit plan
- The health maintenance organization in the state with the largest number of commercially insured members in the state
- Secretary-approved coverage, i.e., any coverage that the Secretary of HHS determines, upon application by the state, to provide appropriate coverage for the population to be covered.

Benchmark-equivalent coverage would require certain basic services including:

- Inpatient and outpatient hospital services
- Physician’s surgical and medical services
- Laboratory and X-ray services
- Well-baby and well-child care, including age-appropriate immunizations
- Other appropriate preventive services, as designated by the Secretary of HHS.

The DRA states that, for several additional services offered at state option including mental health services and prescription drugs, the benchmark-equivalent coverage must have an actuarial value that is equal to at least 75 percent of the coverage of that service in the benchmark package.

Mandatory and Optional Benefits

One mandatory and a number of optional Medicaid benefits are particularly important in the treatment of mental health and substance use disorders. They are presented below.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT—MANDATORY BENEFIT.

“The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is the comprehensive Medicaid child health entitlement that provides for initial and periodic examinations and medically necessary follow-up care for Medicaid-eligible children and adolescents. Its purpose is to find health problems through early screening services, and to diagnose and treat the problems before they harm children and

become too expensive to remediate” (CMS, 2004a). The EPSDT program was enacted in response to research that identified the prevalence of a range of preventable problems among children. The screening component was introduced in 1967, and in 1989, the Omnibus Budget Reconciliation Act amendments to Medicaid’s EPSDT provisions required states to reimburse health care providers not only for screening, but also for diagnostic and treatment services resulting from screening to ameliorate physical and mental conditions (Fox et al., 1997). It also expanded the mandate to provide all treatment services allowed under the federal Medicaid program, regardless of whether they were in the state plan (Rosenbach and Gavin, 1998). States and territories are precluded by federal law from requiring a copayment for any EPSDT service for a child under age 18 but may, at their option, impose a copayment for medically needy beneficiaries between ages 18 and 21.

The DRA cites that, for states that choose to offer a benchmark or benchmark-equivalent package, the state must offer the package and “... for any child who is under 19 years of age who is covered under the state plan ... wrap-around benefits to the benchmark coverage or benchmark-equivalent coverage consisting of early and periodic screening, diagnostic and treatment services defined in section 1905(r)” (DRA, Section 1937 1Aii). Section 1937 C allows states that offer a benchmark or benchmark-equivalent benefit package the option to provide “... additional benefits as the state may specify.”

The language of this section is unclear; however, a letter to Congress from Dr. Mark McClellan, the former CMS Administrator, states that his agency has determined that children under age 19 will still be entitled to receive EPSDT benefits if enrolled in benchmark or benchmark-equivalent coverage. The letter goes on to explain that a Medicaid state plan that does not include the provision of EPSDT services for children under age 19 will not be approved by CMS. The letter interprets Section 1937 C to allow states the option of providing services to children under age 19 that are in addition to the EPSDT-required services.

Optional Medicaid benefits most relevant for youth in the juvenile justice system are presented below.

REHABILITATION SERVICES. Services that may be covered through this option may be essential elements in a comprehensive continuum of care for youth with mental health and/or substance use disorders. Services covered under this option include any medical or remedial services recommended by a physician or other licensed practitioner.⁷ By their nature, services are rendered in a number of different settings by virtually the entire spectrum of health care providers” (Kaiser Commission, 2003a).

PRESCRIPTION DRUGS. Because all states offer coverage for prescription drugs, it is easy to overlook that prescription drug coverage is an optional benefit. States typically require prior approval for any drug product not normally covered by a state or territory’s Medicaid program when prescribed for “off-label use” (i.e., for a condition not typically treated with the product) and for compounded prescriptions. Prior approval is generally required, as well, for exceptions to the limits stated, such as days’ supply or number of prescriptions in a month. In addition, several states have established preferred drug lists that include products determined to be clinically effective and available at a lower cost; prior approval is not required for these products. To have additional products included on the lists, manufacturers often agree to rebate to the state a portion of the product cost or to provide services of comparable value. Some states require using generic drugs when available, unless the prescriber orders that a specific product be dispensed as written (Kaiser Commission, 2003b).

To encourage the use of preferred drugs (the least or less costly effective prescription drugs within a class of drugs, as defined by the state), the DRA allows a state to impose cost sharing⁸ for nonpreferred drugs in a class, as well as to waive or reduce cost sharing for preferred drugs. States may not impose cost sharing for preferred drugs for recipients exempt from cost sharing for services.

TARGETED CASE MANAGEMENT. “Targeted case management is a service that assists Medicaid

clients in gaining and coordinating access to necessary medical, social, and educational care and other services appropriate to their needs. It is intended for clients who do not reside in institutions. The service may be provided as an integral and inseparable part of another covered service, or it may be provided by Medicaid agency staff through utilization review, prior approval, or other administrative activities. It may also be provided as a separate service by appropriately qualified case managers. All of the states except one make the service available to at least one eligibility group, and several states offer targeted case management services to a number of different groups, including but not limited to severely emotionally disturbed or neurologically impaired children, children in foster care or state custody or who are at risk of out-of-home placement, and beneficiaries of any age at risk of abuse or neglect” (Kaiser Commission, 2003c).

Under the DRA changes, the Congressional Budget Office estimates that \$760 million in Targeted Case Management dollars will be saved in a five-year period. Preliminary analysis indicates that these savings come mostly from holding other public programs responsible for third-party liability. This means that other public programs may be considered the primary payer in situations involving the provision of covered case management services to children who are enrolled in Medicaid and receiving services under other programs (Rosenbaum and Markus, 2006).

OTHER PROVIDERS. Federal law allows states and territories to include the services of a variety of licensed health care practitioners in their Medicaid state plan coverage. “The most common practitioners include psychologists, podiatrists, chiropractors, optometrists, and certified registered nurse anesthetists. However, there are other practitioners whose services are covered and directly reimbursed in selected states. Such practitioners include physician assistants, nutritionists, dieticians, dental hygienists, acupuncturists, mechanotherapists, naturopaths, respiratory therapists, pharmacists, medical social workers, behavioral health practitioners and counselors, pastoral counselors, marriage and family thera-

pists, and sign and other language interpreters. States and territories that include these services generally establish copayment and prior approval requirements as well as coverage limitations consistent with other similar services” (Kaiser Commission, 2003d).

HOME- AND COMMUNITY-BASED SERVICES (HCBS).

“Home- and community-based services may be provided either through an optional service category or through a 1915c waiver. The Tax Equity and Fiscal Responsibility Act (TEFRA) optional benefit is often referred to as the Katie Beckett option, named after a young girl whose situation led to its implementation. Adopted in 1982, the law gives states the option to cover children whose family incomes are too high to be eligible for Medicaid. These children must have physical or mental disabilities that would be eligible for Medicaid institutional services but might be better served at home. States may cover the cost of community-based treatment for these children as long as the care does not exceed the estimated cost of institutional care. Children who qualify for TEFRA are eligible for the same services as all other Medicaid-eligible children. The option also creates an entitlement for qualified children” (NGA, 2005).

ALTERNATIVE TO RESIDENTIAL TREATMENT

DEMONSTRATION. A new provision in the DRA may extend access for some children. Section 6063 of the DRA authorizes the Secretary of HHS to conduct demonstration projects in up to ten states to test the effectiveness in improving or maintaining a child’s functional level and the cost-effectiveness of providing coverage of home- and community-based alternatives to psychiatric residential treatment for children enrolled in Medicaid.

Waivers

For a number of years Medicaid has allowed certain waivers to the federal Medicaid law to provide states with greater flexibility in administering the program. In many cases, because of changes resulting from the DRA, waivers may no longer be required. Existing waivers include the three described below.

HCBS WAIVERS. Often referred to as 1915c waivers, these may expand Medicaid eligibility to children with behavioral health problems who would not generally be covered by the program because of higher family income. “The waivers allow states to expand Medicaid services to a specified population (as determined by the state) beyond the benefits normally covered. Benefits apply to the waiver population only, not to other Medicaid-eligible children. This eligibility pathway allows youth to be treated in the community, so long as the cost of that care does not exceed the estimated cost of Medicaid-eligible institutional care. While 49 states have adopted a waiver to serve the developmentally disabled, only three states have adopted a waiver to cover home- and community-based services for children with mental health disorders. There are a few differences between HCBS waivers and the TEFRA option. With HCBS waivers, states may establish a limited number of slots, and may even restrict the waiver to children with certain disabilities. States may also restrict eligibility to a certain geographical area” (NGA, 2005).

SECTION 1115 WAIVERS, RESEARCH AND DEMONSTRATION PROJECTS. “Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary, [are] likely to assist in promoting the objectives of [the Medicaid statute]. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. States commit to a policy experiment that will be evaluated. Under Section 1115 states should demonstrate something that has not been demonstrated on a widespread basis. The authority provides flexibility for the provision of services which are not otherwise eligible for a federal match and allows for the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program. Projects are generally approved to operate for a five-year period. The demonstration must be budget neutral over the life of the project (generally 5 years) and cannot be expected to cost the federal government more than it would cost without the waiver” (CMS, 2004b).

HIFA WAIVERS. The Health Insurance Flexibility and Accountability (HIFA) waiver initiative, started in 2001, promoted the use of Section 1115 waivers to increase the number of individuals with health insurance coverage within the current level of Medicaid and SCHIP resources. In the first few years following the HIFA waiver initiative, some states obtained waivers to expand coverage. However, several of these waivers were never or only partly implemented. In a few states where new coverage was offered, enrollment was later closed because of state fiscal pressures or federal financing caps. Without additional federal financing, increased programmatic flexibility does not appear to be sufficient to support ongoing substantial coverage expansions (Mann and Artiga, 2005).

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SCHIP⁹ is a federal block grant program that entitles participating states, commonwealths, and territories to an enhanced federal funds match to provide health insurance to targeted low-income youth under age 19 who are ineligible for other insurance coverage, including Medicaid and private insurance (Kaiser Commission, 2004b). To receive federal SCHIP funds, a state must put up a matching amount equal to 70 percent of its matching rate under Medicaid (CDF, 1998).

Eligibility

To receive grants under the SCHIP program, states must maintain the Medicaid eligibility standards for children that were in effect in June 1997. States may elect to expand their Medicaid programs, develop a freestanding SCHIP program, or have a combination of the two. States that choose a Medicaid expansion will receive enhanced federal funds at Medicaid matching rates for the new SCHIP enrollees. A Medicaid expansion, in effect, creates an EPSDT entitlement to services even if funds specifically allocated for SCHIP are exhausted. A state that chooses to implement a non-Medicaid plan and exceeds its SCHIP allotment will not receive federal funding beyond the

allotted amount. If a state opts for a separate child health program, certain rules can affect client eligibility.¹⁰

States operating SCHIP programs must screen applicants for possible Medicaid coverage and enroll all eligible children in that program (CDF, 1998). SCHIP funds must serve children who live in families with incomes either at or below 200 percent of the federal poverty level or at 150 percent of a state's Medicaid income-eligibility level, whichever is higher. "Certain groups of children cannot be covered under SCHIP. These ineligible groups include: children covered under a group health plan or under health insurance coverage; children who are members of a family that is eligible for state employee insurance based on employment with a public agency; children who are residing in an Institution for Mental Diseases¹¹; and, children who are eligible for Medicaid" (CMS, 2005, p.4). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA; P.L. 104-193), as amended, made significant changes to the eligibility of immigrants for SCHIP.¹²

States are permitted to impose cost-sharing provisions¹³ (premiums and copayments) on SCHIP enrollees; however, states may not charge cost sharing for preventive services or immunizations. For states that opt for a Medicaid expansion, the services provided under SCHIP mirror the Medicaid services provided by that state. For states that opt for a separate child health program, there are four options for determining coverage.¹⁴

The SCHIP legislation requires only limited mental health coverage and does not require that treatment for substance use disorders is an included benefit. According to Gehshan (2000), a state's choice of whether or not to expand Medicaid with its SCHIP funds has broad implications for the benefits available to youth in need of treatment for mental health or substance use disorders. The SCHIP stand-alone benefits package is often less rich than the Medicaid benefit, resembling a benefit package and cost sharing more in line with private, employer-sponsored health coverage in the state (GAO, 1999a). Like private insurance, EPSDT requirements are not mandated for SCHIP stand-alone programs. These SCHIP

stand-alone programs may not cover a continuum of services specifically for mental health or substance use disorder treatment or may offer only a limited number of annual outpatient services or lifetime benefits (GAO, 1999a).

Regarding treatment for substance use disorders, a study by Howell et al. reported that "... all states but one cover some form of substance abuse treatment in their SCHIP plan" (p. 41). However, the specific covered services may vary. The majority of states generally cover detoxification and outpatient treatment, with limits on the length of treatment being common, especially in separate state SCHIP programs (Howell et al., 2000).

Recent state fiscal constraints have led to SCHIP program cutbacks. Many states have increased premiums and cost-sharing amounts (Kaiser Commission, 2004b). Eight states implemented freezes on SCHIP enrollment for at least a portion of the time period from April 2003 to July 2004. As a result of these changes, SCHIP enrollment fell for the first time in the program's history during the second half of 2003. Many states are hard-pressed to come up with the matching funds required from the federal government in order to receive their SCHIP allocations (Cavanaugh, 2004). As a result, 22 states have had to implement tougher eligibility requirements and add other restrictions on their programs in the past 18 months and are expected to continue to make reductions over the coming year (Kaiser Family Foundation, 2003). Howell (2004) also found that recent state budget pressures have led states to reexamine SCHIP coverage for mental health services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT PERFORMANCE PARTNERSHIP BLOCK GRANT

The Substance Abuse Prevention and Treatment Block Grant was reauthorized and renamed the Substance Abuse Prevention and Treatment Performance Partnership (SAPTPP) Block Grant in the Children's Health Act of 2000, P.L. 106-310.

The SAPTPP Block Grant supports services for the prevention and treatment of substance abuse. The prevention funds in SAPTPP Block Grant are administered by the Center for

Substance Abuse Prevention (CSAP), and the treatment funds are administered by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS. In FY 2005, SAPTPP Block Grant was funded at \$1.78 billion (SAMHSA, 2005a).

SAPTPP Block Grant funds are allocated to each state using a formula.¹⁵ Although states have broad latitude in addressing alcohol and substance abuse problems, the block grant language does include several mandates. States that receive block grant funds are required to set aside 20 percent of block grant funds for prevention activities, 5 percent for treatment of women with substance use disorders and their children, 5 percent for an independent peer review to review the quality and appropriateness of treatment services, and 70 percent for treatment for individuals with substance use disorders. The program authorized \$15 million for grants, contracts, or cooperative agreements with public and nonprofit entities to provide alcohol and drug prevention or treatment services for American Indians and Alaska Natives (AI/AN) (P.L. 106-310, 2000).

This block grant includes no specific requirements for states to provide substance abuse treatment services for youth. However, states are not precluded from using funds for treatment of most youth with substance use disorders in the juvenile justice system. Funds may be used to provide an array of substance use disorder treatment including but not limited to outpatient, intensive outpatient, day treatment, and residential care.

The existence of separate block grants for substance abuse and mental health affects the delivery of services to individuals with co-occurring substance use and mental health disorders.¹⁶ The use of block grant funds for co-occurring clients is determined by the states.

FAMILY AND JUVENILE TREATMENT DRUG COURTS

This discretionary grant program administered by CSAT, in SAMHSA (DHHS), is authorized by Section 509 of the Public Health Service Act, as amended, and is subject to the availability of funds.

The Family and Juvenile Treatment Drug Courts Grant Program is one of SAMHSA's Services Grant programs. The purpose of Family and Juvenile Treatment Drug Courts grants is to provide funds to be used by the Courts and treatment providers to provide assessment, alcohol and drug treatment, wrap-around services supporting substance abuse treatment, case management, and program coordination to those in need of treatment drug court services. Approximately \$3.15 million was available for about eight awards for juvenile treatment drug courts in FY 2005 (SAMHSA, 2005b).

Grantees are expected to provide a coordinated, multisystem approach designed to combine the sanctioning power of the courts with effective treatment services to break the cycle of child abuse and neglect or criminal behavior, alcohol and/or drug use, and incarceration or other penalties. Drug courts require regular appearances of the client before a judge who is part of, or guided by, a team of relevant professionals. Family treatment drug courts provide services to parents who have been charged with child abuse and/or neglect, as well as to the children and other important family members. Juvenile treatment drug courts provide services to juveniles who are found delinquent and may provide services to their parents, siblings, and other important family members. For the purposes of this program, juvenile treatment drug courts may include those courts that deal with juveniles in pre-adjudicated or adjudicated status or under post-detention judicial supervision (SAMHSA, 2005b).

Family and Juvenile Treatment Drug Courts have eleven key elements in their program design.¹⁷ Juvenile Treatment Drug Court applicants must include "... strategies to motivate juvenile offenders to change; a continuum of family-based treatment and ancillary services using a strength-based approach; and appropriate confidentiality requirements that are specific to juveniles under court supervision" in their program design (SAMHSA, 2005b).

THE CHILD AND ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE STATE INFRASTRUCTURE GRANT PROGRAM

This program is authorized by Section 520A of the Public Health Service Act, as amended, and administered jointly by the Center for Mental Health Services (CMHS) and CSAT in SAMHSA, DHHS. The purpose of SAMHSA's Child and Adolescent State Infrastructure Grant (SIG) is to strengthen the capacity of states, territories, and Native American tribal governments to develop, expand, and sustain substance abuse and mental health services including early intervention, treatment, and/or continuing services and supports at the local level for children, adolescents, and youth in transition who have a serious emotional disturbance, substance use disorder, and/or co-occurring disorders, and their families. Applicants are expected to use grant funds to build the infrastructure necessary to promote, support, and sustain local service and treatment intervention capabilities for the target population across service delivery systems. The program is intended to provide sufficient flexibility and scope to enable states to determine whether they will focus on the entire target population or on demographic or geographic subsets of the population (SAMHSA, 2005c).

The Child and Adolescent SIG Program is a critical part of the SAMHSA/CMHS effort to implement the recommendations of The President's New Freedom Commission on Mental Health Report (Hogan et al., 2002). Therefore, activities carried out under this announcement must be focused on strengthening the capacity of states to transform their mental health system to meet the complex needs of children and youth with serious emotional disturbances and/or co-occurring substance abuse and mental health disorders and their families within home- and community-based settings.

In FY 2004 up to \$5.3 million was available to fund up to seven awards. No state match is required. Eligible applicants are limited to states, the District of Columbia, territories, and tribal governments. The application must be submitted by the Office of the Chief Executive of the state, territory, or tribe (SAMHSA, 2005c).

THE ADOLESCENT SUBSTANCE ABUSE TREATMENT COORDINATION STATE INFRASTRUCTURE GRANT PROGRAM

Authorized by Section 509 of the Public Health Service Act, as amended, this grant program is administered by CSAT in SAMHSA, DHHS. The purpose of the Adolescent Substance Abuse Coordination Grants (SAC) is to build the capacity in states to provide effective, accessible, and affordable treatment for youth with substance use and co-occurring disorders and their families. Grants provide funding to support a staff position (a state official whose sole responsibility is ensuring the effectiveness of adolescent substance abuse treatment) and a state process to assess, facilitate, and coordinate ongoing, self-sustaining, cross-system planning for effective adolescent substance abuse treatment (SAMHSA, 2005d).

Grantees are required to hire and/or dedicate a full-time employee at the state level¹⁸ to convene and coordinate all of the state agencies that may provide funding and other support for adolescents needing early intervention and treatment services for substance abuse disorders and their families. The state adolescent substance abuse treatment coordinator must form linkages with other service systems that provide mental health, education, health, child welfare, and juvenile justice services for youth and their families and identify opportunities to coordinate funding and treatment resources across these systems. States receiving these grants must use funds to carry out several required activities.¹⁹

In FY 2005 up to \$7.1 million was available for this program. Fifteen states and the District of Columbia were awarded grants. No state match is required. Funding is limited to states, the District of Columbia, territories, and federally recognized tribal governments (SAMHSA, 2005d).

YOUNG OFFENDER REENTRY PROGRAM

Another initiative addressing substance use problems among young people in the juvenile justice system is the Young Offender Reentry Program (YORP), which was authorized under Section 5 of the Public Health Service Act. Under this initiative, administered by CSAT in

SAMHSA (DHHS), grants are awarded to agencies that are currently providing services and/or supervision for youth who are reentering the community after being incarcerated for a crime. This money enables the agencies to expand their community-based treatment programs to help young offenders transition smoothly from the correctional setting. Grantees receive up to \$500,000 per year for a four-year period. Eleven YORP grants were awarded in FY 2005 (SAMHSA, 2006).

- 1 Medicaid reimburses states at state-specific rates that may not be lower than 50 or higher than 83 percent, with poorer states receiving a higher rate than wealthier states (Kaiser Commission, 2001). The federal government usually matches administrative expenses at a rate of 50 percent (HCFA, 2001).
- 2 The DRA modifies current law by requiring individuals seeking Medicaid coverage to furnish written proof of citizenship. Effective July 1, 2006, all federal financial participation in Medicaid will be ended for individuals whose eligibility determination or redetermination does not include written proof of citizenship. Certain groups such as SSI recipients or dual enrollees will be exempt as a result of alternative pathways through the Social Security Administration (Rosenbaum and Markus, 2006).
- 3 These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.
- 4 The medically needy (MN) option allows states to extend Medicaid eligibility to people who would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state. Persons may qualify immediately or may “spend down” by incurring medical expenses that reduce their income to or below their state’s MN income level.

“Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a state elects to have a MN program, there are federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A state may elect to provide MN eligibility to

certain additional groups and may elect to provide certain additional services within its MN program. As of August 2002, thirty-five states plus the District of Columbia have elected to have a MN program and are providing at least some MN services to at least some MN beneficiaries. All remaining states utilize the ‘special income level’ option to extend Medicaid to the ‘near poor’ in medical institutional settings” (CMS, 2004a).

- 5 Details of the optional coverage cost-sharing provisions implemented by the DRA include:
 - Less than 100 percent FPL:
 - No premiums; cost sharing not to exceed 10 percent of cost of service.
 - Total amount of cost sharing may not exceed 5 percent of family income.
 - Greater than 150 percent FPL:
 - Total amount of premiums and cost sharing may not exceed 5 percent of family income.
 - Cost sharing may not exceed 20 percent of cost of service.
 - No premiums for youth under 18 years of age who are eligible under Section 1902(a)(10)(A)(1), Title IV B or E, institutionalized or for emergency services as defined by the Secretary.

For states imposing premiums, the DRA allows states to terminate eligibility on the basis of failure to pay the premium within 60 days. States may waive the payment of a premium in any case where the state determines that requiring the payment would create undue hardship.

Allowable co-insurance can be up to 10 percent of the cost of services for families with incomes between 100 and 150 percent FPL and up to 20 percent in the cases of families with incomes over 150 percent FPL. The DRA permits states to allow participating providers to require payment of any allowable cost sharing before providing care, including nonemergency services sought in emergency departments, while also authorizing providers to reduce or waive payment on a case-by-case basis (Rosenbaum and Markus, 2006). The DRA does specify aggregate upper limits on the amount of permissible premiums and cost sharing in relation to family income.

States may permit a hospital to impose cost sharing for nonemergency care received in an emergency room for an individual who has access to a nonemergency room provider. Once a determination has been made that the care needed is of a nonemergency nature, the hospital must inform the individual of the following:

- The hospital may require the payment of state-specified cost sharing before the service can be provided
- The name and location of an alternate nonemergency services provider that is available and accessible
- The alternate provider can provide the services without the imposition of cost sharing
- The hospital provides a referral to coordinate scheduling of this treatment.

States may choose to waive cost sharing for nonemergency care received in an emergency room. For individuals at 100–150 percent FPL, cost sharing may not exceed twice the amount of the nominal cost-sharing amount. For individuals exempt from other cost-sharing requirements, the state may impose cost sharing up to the nominal cost-sharing limit, provided care is not delivered in an outpatient department or other alternative health care provider in the geographic area of the hospital involved. Cost sharing under this section is subject to the aggregate cap on cost sharing.

- 6** For juveniles, an “inmate of a public institution” is defined as youth in juvenile correctional facilities and in detention programs. The detention rules are less clear, and readers are advised to check with the appropriate regional CMS office for clarification.
- 7** Rehabilitation services must also promote a reduction in a physical or mental disability. This optional benefit allows Medicaid to cover services that restore a youth to his or her best possible functional level. These services may be delivered in a wide range of settings by many different types of health care providers. Examples of covered services include any practitioner of the healing arts, within the scope of his or her practice under state or territory law.
- 8** Cost sharing for nonpreferred drugs may not exceed:
- Less than 150 percent FPL: the amount of nominal cost sharing.
 - Greater than 150 percent FPL: 20 percent of the cost of the drug.
 - For those exempt from cost sharing for preferred drugs: the amount of nominal cost sharing.
- Any cost sharing continues to be subject to the aggregate cap on cost sharing.
- 9** Also known as Title XXI of the Social Security Act, SCHIP became law as part of the Balanced Budget Act of 1997.
- 10** States can allow for self-declarations of citizenship; states are prohibited from enforcing duration of residency requirements; states may not enact lifetime caps or other limits to eligibility; states can, at their option, choose to offer children twelve continuous months of eligibility; and, states may enforce enrollment caps and waiting lists for coverage, if these provisions are in the approved state plan (CMS, 2005, p.4).
- 11** An Institution for Mental Diseases is defined as a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases, including medical attention, nursing care, and related services (Section 1905(i) of the Social Security Act; 42 U.S.C. Section 1396 d(i)).

12 Following PRWORA:

- Only citizens and “qualified aliens” are eligible for the full range of benefits provided under SCHIP.
- Certain immigrants who entered the United States on or after August 22, 1996, are barred from receiving SCHIP benefits for five years.

In determining the eligibility of some immigrants for SCHIP, the income and resources of the immigrant’s sponsor must be counted. This is commonly referred to as “alien sponsor deeming” (CMS, 2004c).

- 13** States may not impose cost sharing that exceeds 5 percent of a family’s gross or net income (CMS, 2005). American Indians and Alaska Native children who are members of a federally recognized tribe must not be charged any cost sharing. At their option, states may allow for self-declaration of tribal membership to exempt families from cost-sharing provisions. Each SCHIP enrollee’s family must be told of the maximum yearly cost-sharing limit for each child. The state plan must describe the methodology used to determine cost-sharing amounts, the consequences of not paying cost-sharing charges, and the disenrollment protections that are provided for families that do not pay cost-sharing obligations. States must allow eligible families to pay any past-due cost-sharing charges before the disenrollment process begins. States must allow families an opportunity to show that their family income has declined before being disenrolled for failure to meet cost-sharing obligations.

Several other cost-sharing rules for children at or below 150 percent of the federal poverty level apply: states may not impose more than one type of cost sharing for a service; states may impose only one cost-sharing charge for all services delivered during a single office visit; and cost sharing for these children is limited to nominal amounts as set forth in the SCHIP regulation. For states that elect to implement a Medicaid expansion, the Medicaid cost-sharing rules apply (CMS, 2005).

14 The four coverage options are:

Benchmark coverage: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan or a health benefits plan that the state offers and makes generally available to its own employees, or to a plan offered by a health maintenance organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.

Benchmark-equivalent coverage: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians’ surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations.

Existing state-based comprehensive coverage: In states where existing state-based comprehensive coverage existed prior to the enactment of SCHIP (i.e., New York, Pennsylvania, and Florida), the existing health benefits package is deemed to be meeting the coverage requirements of the SCHIP program.

Secretary-approved coverage: This may include coverage that is the same as the state's Medicaid program; comprehensive coverage for children offered by the state under a Medicaid demonstration project approved by the Secretary of HHS; coverage that either includes full EPSDT benefit or the benefit that the state has extended to the entire Medicaid population in the state; coverage that includes benchmark coverage plus any additional coverage; coverage that is the same as the coverage provided by New York, Florida, or Pennsylvania; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans as determined by benefit-by-benefit comparison (CMS, 2005).

Regardless of the type of health benefits coverage provided by a state, the program must provide coverage for well-child care, immunizations, and emergency services (CMS, 2005). Other federal rules may affect which behavioral healthcare services are to be covered under SCHIP. In general, states cannot permit the implementation of pre-existing condition exclusions, and if SCHIP plans provide coverage through group health plans, pre-existing condition exclusions are permitted only in so far as HIPAA rules allow (CMS, 2005).

States that opt for a separate child health program must implement procedures to ensure that coverage provided under the SCHIP program does not substitute for private group health plan coverage. The potential for substitution of SCHIP coverage for private group coverage exists because SCHIP coverage may cost less or provide better coverage. States providing SCHIP coverage through premium assistance for group health plan coverage must adopt specific protections against substitution of coverage. These protections include a required waiting period without group health plan coverage and a minimum employer contribution (CMS, 2005).

15 The formula is based on the Population at Risk, the Cost of Services Index, and the Fiscal Capacity Index (*Federal Register*, 1996).

16 In a position statement concerning co-occurring substance abuse and mental health disorders, SAMHSA stated that SAPTPP Block Grant and Community Mental Health Services Performance Partnership (CMHSPP) Block Grant funds may be used to provide treatment services for individuals with a dual diagnosis (MBHN, 2000). However, SAPTPP and CMHSPP Block Grant funds may not be "... blended in such a way that would render use of those funds subject to only the statute and regulations governing one or the other sources of funding" (MBHN, 2000, p. 4).

17 The eleven key elements of the Family and Juvenile Treatment Drug Courts are:

- "A Steering Committee composed of key stakeholders to provide advice in the design and operation of the Treatment Drug Court
- Alcohol and other drug treatment services that are integrated with justice system case processing
- Use of a non-adversarial approach, with prosecution and defense counsel promoting public safety while protecting participants' due process rights
- Early identification and prompt placement of eligible participants
- Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
- Frequent team meetings, where each client's progress, strengths, obstacles, and options are discussed individually, and case plans are updated as needed
- Frequent alcohol and other drug testing
- A coordinated strategy that governs drug court responses to participants' compliance
- Judicial interaction that is ongoing with each drug court participant
- Interdisciplinary education that promotes effective planning, implementation, and operations
- Partnerships among drug courts, public agencies, and community based organizations" (SAMHSA, 2005b).

18 It is incumbent upon the grantee to create a position vested with the authority necessary to accomplish these tasks, and to hire or designate an individual who has the necessary skills and experience appropriate for the position, including an understanding of the correlation of co-occurring mental health and substance use disorders (SAMHSA, 2005d).

19 The SAC-required activities are:

- Develop a full-time position within a unit of state government to oversee and coordinate the adolescent substance abuse treatment system statewide.
- Link and coordinate with other service systems to promote comprehensive, integrated services for youth with substance abuse and/or co-occurring problems. Such service systems include mental health, health, juvenile justice, education, child welfare, and Medicaid.
- Coordinate the budget formulation and benefit plans (e.g., Medicaid services for adolescent treatment) of all state agencies that have responsibility for funds that may be used to support adolescent substance abuse treatment services, including screening, assessment, early intervention, treatment, family involvement in treatment, case management, and continuing care/aftercare.
- Identify barriers (fiscal, regulatory, and policy) that impede the adoption and provision of accessible evidence-based treatment across the full continuum of care recommended by the American Society of Addiction Medicine (ASAM).

- Devise and implement strategies, in concert with all other state agencies that may fund and/or regulate these services, to improve access to treatment, increase capacity and quality, and expand the available continuum in communities and throughout the state implementing treatment interventions with a scientific evidence base for the population to be served.
- Import tools, coordinate training, and support providers in the adoption of screening and assessment protocols that cross-walk to DSM-IV/ICD 10 criteria for substance abuse dependence, mental health diagnoses, and ASAM Patient Placement Criteria, Version 2-Revised.
- Develop or improve state standards for licensure, certification, or accreditation of programs that provide substance abuse treatment services for adolescents and their families.
- Develop or improve state standards for licensure, certification, or accreditation of adolescent substance abuse treatment counselors.
- Identify and provide linkages across the universe of discretionary federally and foundation-funded adolescent substance abuse treatment grant programs for the purpose of supporting and disseminating learning across the statewide treatment system and to provide assistance to ensure sustainability and adoption of best evidence-based practices identified in these programs.
- Identify, disseminate, and support training and technical assistance resources that expand the capacity and quality of adolescent substance abuse treatment throughout the state provider system, including cross-training for adolescent mental health and substance abuse treatment providers.
- Participate in and actively share learning across the community created by the states funded in this grant program to leverage training, support, dissemination, intervention adoption, and evaluation and research to improve the treatment system for youth and their families, both intrastate and interstate.
- Promote coordination and collaboration with family support organizations to strengthen services for youth with or at risk of substance abuse and/or co-occurring problems.
- Facilitate the development of a statewide provider association for adolescent substance abuse treatment across programs and for counselors engaged in providing these services, regardless of the state or local system within which they work.
- Keep abreast of the research findings related to adolescent substance abuse treatment and disseminate this information statewide in a form that is easily digested by clinical staff, providing insight on the application of the research to improve clinical practice at the program level (SAMHSA, 2005d).

SECTION THREE:

Juvenile Justice

This section discusses eight selected federal policies and programs that may provide treatment for adolescents with substance use disorders in the juvenile justice system.

They are the Juvenile Accountability Block Grant, the Tribal Youth Program, the Tribal Youth Program Mental Health Initiative, the Justice Assistance Formula Grant, the Edward Byrne Discretionary Grant Program, Operation Weed and Seed, the Residential Substance Abuse Treatment Program for State Prisoners, and the Drug Court Discretionary Grant Program.

JUVENILE ACCOUNTABILITY BLOCK GRANT

The Juvenile Accountability Block Grant (JABG), formerly known as the Juvenile Accountability Incentive Block Grant, is administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs (OJP), U.S. Department of Justice (DOJ). Through the JABG program, funds are provided as block grants to states for programs that promote greater accountability in the juvenile justice system. Local and tribal governments can then apply to the states for funds to support local programs. In addition, OJJDP offers competitive grants directly to federally recognized tribes to strengthen tribal juvenile justice systems and to hold youth accountable (OJJDP, 2005a). In FY 2005 this program was funded at \$49 million.²⁰

Each state is required to subgrant not less than 75 percent of the state's allocation to units of local government.²¹ If a state does not qualify or apply for JABG funds in a given fiscal year, OJJDP will distribute up to 75 percent of the state's allocation for that fiscal year and provide

grants to specially qualified units that meet state or local eligibility requirements (OJJDP, 2005b).

The goal of the JABG program is to reduce juvenile offending through accountability-based programs focused on both the offender and the juvenile justice system. The basic premise underlying the JABG program is that both the individual juvenile offender and the juvenile justice system must be accountable. In implementing the program, OJJDP seeks to reduce juvenile offending through both offender-focused and system-focused activities that promote accountability (OJJDP, 2005c).

Grant funds may be used to support any of 16 program purpose areas. Two of those areas are Purpose #8, Juvenile Drug Courts, and Purpose #12, Risk and Needs Assessment. Purpose #12 includes early intervention and the provision of comprehensive services, including mental health screening and treatment and substance abuse testing and treatment for juvenile offenders (OJJDP, 2005d).

TRIBAL YOUTH PROGRAM

OJJDP, DOJ, manages and supports the Tribal Youth Program (TYP), a joint initiative of the U.S. Departments of Justice and the Interior. TYP provides resources to federally recognized tribes and Alaska Native villages. The funding distribution is based on service population on or near reservations (OJJDP, 2005d).

One purpose of the Tribal Youth Program is to support and enhance tribal efforts to prevent and

control delinquency and improve the juvenile justice system for AI/AN youth. Another focus is to provide mental health and substance abuse services to AI/AN youth for both alcohol and drugs (OJJDP, 2005e).

In FY 2006 \$10 million was appropriated for TYP. Of this amount, OJJDP uses \$8 million for discretionary grants, 10 percent of which supports program-related research, evaluation, and statistics, and 2 percent provides training and technical assistance to tribal programs. The remaining funds enhance other tribal efforts and provide program support. Applicants selected for awards are funded for a three-year period (OJJDP, 2006).

TRIBAL YOUTH PROGRAM MENTAL HEALTH INITIATIVE

To address the serious problems of substance use and mental health disorders in adolescent AI/AN youth, the TYP Mental Health Initiative was established to promote mental health and substance abuse services for AI/AN youth and to support juvenile delinquency prevention and intervention efforts by creating and implementing culturally sensitive mental health programs. This special initiative helps tribes provide a range of youth support services and programs to address the mental health and related needs of AI/AN youth and their families in various community settings (e.g., schools, violence prevention education programs, healthcare treatment programs, and the juvenile justice system).

Interagency programs included in this federal effort support combining the potential of community groups to address mental health, juvenile justice, and related issues in a comprehensive manner. As part of the Mental Health Initiative, tribes are encouraged to promote coordination and collaboration among the local programs in their communities that serve young people. Applicants selected for awards are funded for a three-year period (OJJDP, 2005e).

JUSTICE ASSISTANCE FORMULA GRANT

In 2004 P.L. 108-447 created the Justice Assistance Formula Grant (JAFG) by combining two existing grant programs, the Edward Byrne Memorial Justice Assistance Formula Grant Program and the Local Law Enforcement Block Grant (LLEBG),²² creating a single funding mechanism intended to simplify the administration process for grantees.²³ JAFG purpose areas include:

- Law enforcement programs
- Prosecution and court programs
- Prevention and education programs
- Corrections and community corrections programs
- Drug treatment programs
- Planning, evaluation, and technology improvement programs (BJA, 2006).

State and local jurisdictions are eligible for JAFG funding. Any law enforcement or justice initiative formerly funded under the Byrne Formula or LLEBG Programs is eligible for funding under the JAFG Program's six purpose areas. JAFG funds can be used to pay for personnel, overtime, and equipment. Funds provided for the states can be used for statewide initiatives, technical assistance and training, and support for local and rural jurisdictions (BJA, 2006).

EDWARD BYRNE DISCRETIONARY GRANT PROGRAM

Administered by the BJA, OJP, DOJ, the Byrne Program was created by the Anti-Drug Abuse Act of 1998 (P.L. 100-690). The Byrne Program "... emphasizes controlling violent and drug-related crime and serious offenders and fosters multijurisdictional and multistate efforts to support national drug control policies" (BJA, 2001).

The Byrne Program's principal objectives are "... undertaking educational and training programs for criminal justice personnel; providing technical assistance to state and local units of government; promoting projects that are national or multijurisdictional in scope; and, demonstrating programs that, in view of previous research or experience, are likely to be successful

in more than one jurisdiction” (BJA, 2001). Program funds may also be used to fund any of the legislatively authorized purposes including Purpose 13: “Programs to identify and meet the treatment needs of adult and juvenile drug and alcohol dependent offenders” (BJA, 2001).

Public and private agencies as well as private nonprofit organizations are eligible to receive funding from this discretionary grant program. Although eligible entities may receive funding up to 100 percent of cost, the BJA “... promotes leveraging of state, local, and private resources and to emphasize the need for early the need for early sustainment planning by grant recipients” (BJA, 2001). The Byrne Program received \$231 million in funding in FY 2005.

OPERATION WEED AND SEED

Authorized under the Omnibus Crime Control and Safe Streets Act of 1968, as amended in 1988, Operation Weed and Seed was initiated by the DOJ in 1991 to “... combat violent crime, drug use, and gang activity in high-crime neighborhoods” (EOWS, 2000, p. 1). The program is administered by the Community Capacity Development Office (CCDO), DOJ OJP.

Operation Weed and Seed is a strategy, rather than a grant program. Operation Weed and Seed is a community-based initiative that has four required elements: “(1) law enforcement; (2) community policing; (3) crime and substance abuse prevention, intervention, and treatment; and (4) neighborhood restoration” (GAO, 1999b, p. 4; OJP, 2005f). In FY 2005, Operation Weed and Seed was funded at \$62 million.

Operation Weed and Seed’s principal program objectives are to “... coordinate, concentrate, and integrate public and private resources in target areas; empower residents to solve neighborhood problems; and increase investment. The strategy involves a two-pronged approach: law enforcement agencies and prosecutors cooperate in ‘weeding out’ violent crime and drug abuse; and ‘seeding’ brings human services to the area, encompassing prevention, intervention, treatment, and neighborhood revitalization. A community-oriented policing component bridges the

weeding and seeding strategies. Officers obtain helpful information from area residents for weeding efforts, while they aid residents in obtaining information about community revitalization and seeding resources” (OJP, 2005f).

The program objectives are intended to help bring about Operation Weed and Seed’s program goals, which include: drug abuse prevention, especially activities for youth; expansion of community policing efforts, including strengthening community–police relations and increasing resident and business owner participation in crime prevention; and neighborhood restoration, such as code enforcement, improving housing stock, and attracting new investment (Dunworth and Mills, 1999). Weed and Seed communities are also encouraged to designate a Safe Haven, which is a multiservice center where a variety of youth and adult services are coordinated in a highly visible, accessible facility that is secure against crime and illegal drug activity (OJP, 2005f). Weed and Seed sites are encouraged to coordinate with other DOJ programs that may be underway in the locality, and include that coordination in the Weed and Seed strategic plan.

An applicant must be a coalition of community residents; local, county, and state agencies; federal agencies; and the private sector. Eligible Weed and Seed sites must have a high incidence of violent crime; existing, workable community infrastructure; cooperative governmental partnerships; good cooperation among governmental and private civic and social service organizations; a cooperative business community; a strong U.S. Attorney’s Office; and a history of innovative programming at the local level. If a large city is being considered, the project site should be a clearly and easily identifiable section of the metropolitan area.

Applicants must apply and meet the requirements for official recognition of their applicable strategy. Once official recognition is received, sites may compete for Weed and Seed discretionary grant funding to help implement their strategy. Communities that develop their own community-based Weed and Seed initiatives in coordination with their U.S. Attorney’s Office are eligible to apply for official recognition by the CCDO

(OJP, 2005f). Once a site is chosen, it may receive preference for discretionary funding from participating federal agencies as well as technical assistance and Operation Weed and Seed funds.

So that CCDO may assess Weed and Seed sites' leveraging and sustainability efforts during their five-year strategy implementation, Weed and Seed funding applicants are required to identify other funding sources at a level five times the CCDO core funding contribution.

RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM FOR STATE PRISONERS

Administered by the BJA, OJP, DOJ, the Residential Substance Abuse Treatment (RSAT) Program was created by the Violent Crime Control and Law Enforcement Act of 1994 (P. L. 103-322). RSAT "... assists states and units of local government in developing and implementing residential substance abuse treatment programs within state and local correctional and detention facilities in which prisoners are incarcerated" (OJP, 2000, p. 2).²⁴ In FY 2005, RSAT was funded at \$24.7 million.

Participating states must provide urinalysis and/or other drug testing for program participants who "... remain in the custody of the state [as well as] give preference to sub-grant applicants who will provide aftercare services to program participants" (OJP, 2000, p. 3). The participating correctional treatment programs are also required to coordinate with state and/or local substance abuse treatment programs and develop a discharge plan for each program participant.

RSAT grant funds are "... awarded to the states to assist them in implementing and enhancing residential substance abuse programs that provide individual and group treatment activities for offenders in residential facilities operated by state and local correctional agencies" (OJP, 2000, p. 2). To be eligible for grant funds, the substance abuse programs must:

- Last between six and twelve months, during which each offender must participate in the program for not less than six nor more than twelve months, unless he or she drops out or is terminated

- Be provided in residential treatment facilities set apart from the general correctional population
- Focus on the substance abuse problems of the inmate
- Develop the inmate's cognitive, behavioral, social, vocational, and other skills to solve the substance abuse and related problems
- Implement or continue to require urinalysis and/or other proven reliable forms of drug and alcohol testing (OJP, 2001).

The block grant imposes several spending set-asides and maintenance requirements.²⁵ Funds from this grant program may be used to provide treatment for substance use disorders to Medicaid-eligible individuals who are excluded from treatment because of their status as "inmates of a public institution."

States, as well as the District of Columbia, Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands, may apply for a formula grant award under this program.

THE DRUG COURT DISCRETIONARY GRANT PROGRAM

Administered by the OJP, DOJ, this program was established to provide training, financial and technical assistance, and related programmatic guidance and leadership to communities interested in drug courts. This drug court program is meant to provide seed money for drug courts but not long-term support. In FY 2005 the Drug Court Program was funded at \$43 million.

Communities are allowed to use the drug court funds for several populations including youth as defined by community need. The overall goal of juvenile programs "... is to provide immediate intervention in the lives of children and/or parents using drugs or exposed to substance addiction through their family members as well as structure the litigants through the ongoing, active involvement and oversight of the drug court judges" (OJP, 1998, p. 5). Juvenile drug courts serve as an alternative to the traditional juvenile court in which high caseloads, inadequate access to treatment

resources, and a focus on punitive sanctions rather than rehabilitation creates a process that does not effectively deal with the problem of juvenile substance abuse (OJP, 1998, p. 7).

The National Association of Drug Court Professionals (NADCP) reports that of the 804 drug courts in operation in the United States, 207 are juvenile drug courts and 41 are family drug courts. Another 507 drug courts are currently in the planning process, of which 123 are designated to serve youth and 62 to serve families. To date, 12,500 juveniles are enrolled in drug courts (NADCP, 2004).

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- 20** For the state grants, each state receives a base amount of 0.5 percent of the funds available, with the remainder of the funds divided among the states, based on a state's population under age 18 relative to the national population under age 18. The total amount available changes for each year of the program. Overall, the total federal share of a project cannot exceed 90 percent of the total program cost. Consequently, the state or local recipient of an award under this program must contribute a cash match of 10 percent of the total program cost. In the case of construction of permanent juvenile corrections facilities, the cash match is 50 percent of the total program cost (OJJDP, 2005b).
- 21** States may apply to OJJDP for a waiver of this requirement if the state demonstrates that the state government incurs more than 25 percent of the costs of juvenile justice administration. For example, if a state can certify that it bears 90 percent of the financial burden of juvenile justice administration, the state could request a reduction of the required local pass-through from 75 percent to 10 percent (OJJDP, 2005b).
- 22** JAFG has simplified the procedures of the Byrne and LLEBG programs in the following six ways:
- Awards are distributed up front instead of on a reimbursement basis, giving recipients immediate control over their funds.
 - Direct recipients can earn interest on their awards, generating additional funding for future justice projects.
 - Projects can be funded beyond a four-year period, allowing successful initiatives to receive funding to continue and expand their efforts.
 - Fewer fiscal and programmatic reports are required, saving state administering agencies and local programs valuable staff time and resources.
 - Mandatory set-asides are eliminated, encouraging states and communities to spend justice funds where they are most needed (BJA, 2006).
- 23** The procedure for allocating JAFG funds is a formula based on population and crime statistics, in combination with a minimum allocation to ensure that each state and territory receives an appropriate share. Traditionally, under the Byrne Formula and LLEBG Programs, funds were distributed 60/40 between state and local recipients. This distribution continues under JAFG (BJA, 2006).
- 24** The RSAT grant is a matching grant, with the federal government providing 75 percent of the total cost of the project and the state providing the remaining 25 percent (OJP, 2000). Each participating state is allocated a base amount of 0.4 percent of the total funds available for the program. The remaining funds are allocated to each participating state in the same ratio that its prison population represents relative to the total prison population of all states. The most recent National Prisoner Statistics collected by the Bureau of Justice Statistics is used to make these allocations.
- 25** At least 10 percent of the total state allocation for FY 2005 will be available to local correctional and detention facilities for either residential or jail-based substance abuse treatment programs. No more than 10 percent of the total award may be used for treatment of those released from a state facility.

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SECTION FOUR:

Conclusions & Recommendations

THE CURRENT STATE OF AFFAIRS

This monograph reviewed selected federal policies and programs in the health and justice policy sectors that affect the delivery of publicly funded substance use disorder treatment for adolescents in the juvenile justice system.²⁶ This analysis has identified strengths within current policies as well as a number of challenges that constrain the provision of substance use disorder treatment to juvenile offenders.

Opportunities exist. First, it is apparent from this review that there is increased awareness at the federal level that adolescent substance use disorders must be effectively treated to enable success in school, family life, the workplace, and community. Government is making a major contribution, and advances have been made over the last decade.

There are challenges. Federal programs that may provide treatment for substance use disorders for adolescents in the juvenile justice system are spread over several policy domains and federal government agencies. This study has identified several areas needing further action at the federal level and points to strategies needed at the state level, as well.

Funding for treatment for all adolescents with substance use disorders is inadequate. Efforts at the federal level must continue in order to ensure parity for substance use disorder treatment commensurate with treatment for mental health and physical health disorders in both commercial and public health insurance programs. CMS should assure at least a uniform minimum substance use disorder treatment benefit in all states. Medicaid should examine the current policy of excluding federal financial participation for “inmates of public institutions” under age 21, and should consider an exception similar to the Institution

of Mental Diseases exclusion for youth. The language of the Medicaid EPSDT benefit should specify screening, diagnosis, and treatment of substance use disorder as well as mental health disorders. The Medicaid benchmark and benchmark equivalent plans allowed by the DRA should require coverage for mental health and substance abuse treatment equal to at least 100 percent of the coverage in the benchmark plans. The SCHIP program should also require states to cover substance use disorder treatment at 100 percent of the benchmark plans.

The federally administered SAPTPP Block Grant provides opportunities for supporting treatment for youth in the justice system. Treatment dollars could be set aside specifically for adolescent services, or states could be required to submit separate annual plans and reports on how funds from the block grant are used to treat adolescents.

Both block grant and discretionary programs administered by the DOJ could emphasize the need to develop and support treatment for juvenile offenders. These changes at the federal level could result in significant improvements in access and appropriateness of care at both the state and local levels.

Federal financing is often a partnership with the states. In most cases, states are the applicant for federal funds that may be used for treatment. Thus state policies are also critical to increasing access and improving the quality of juvenile offender treatment. Comprehensive planning and coordinated budgeting across policy areas at the state level could support the development of an array of services for adolescents with substance use disorders, including youth in the juvenile justice system. Several federal grant programs, including the Child and Adolescent State Infrastructure Grants

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and the CSAT-sponsored Adolescent Substance Abuse Treatment Coordination State Infrastructure Grant Program, can be major catalysts for change at the state level.

In some cases, communities and/or providers may apply directly for federal funding; however, the purposes of the grants change over time, the grant process is highly competitive, and funding is time-limited. Community-based initiatives such as the Robert Wood Johnson Foundation-sponsored Reclaiming Futures, whether publicly or privately funded, have a number of challenges to ensure that improvements made during the grant period are sustained thereafter. Foundations and the federal government have been concerned about these issues for a number of years. Although a discussion of sustainability is beyond the scope of this document, some issues invite further discussion.

Funders targeting programs at a local level must consider these questions:

- Where is the best leverage point for creating sustainable improvements in treatment delivery?
- What are the best ways for public and private funders to work together to increase the availability of treatment, to improve treatment, and to provide the necessary community and environmental supports especially for youth in the juvenile justice system?
- How can state–local community links be strengthened to sustain existing locally funded projects?

Local communities and programs applying for funds must address these questions:

- What is the local program’s potential for writing and winning future competitive federal or foundation grants?
- What is the local program’s relationship to relevant state agencies?
- How strong is the local program’s business case for continuing; in other words, what is its comparative advantage? Why should a funding source pick up the program?
- Who are the local “champions” for this project? How is their credibility viewed by state leaders?

- How will the population in the rest of the state benefit from an investment of resources in only one geographic area? What can the program do to improve treatment statewide?

CONCLUDING THOUGHTS

Increasing access and improving the quality of substance use disorder treatment for youth in the juvenile justice system will take concerted efforts by multiple partners. The issue needs a comprehensive, systemic approach to developing solutions that can be institutionalized and sustained. There are significant resources to draw on and many building blocks are in place in both the public and private sectors. Enhanced collaboration among funders will maximize resources and create the synergy necessary to achieve lasting change.

26 Federal programs and other policy domains including child welfare, education, labor and housing also have funding streams that may support substance abuse treatment for adolescents in the juvenile justice system.

Appendix A

Selected Federal Policies and Programs Affecting the Treatment of Adolescents with Substance Use Disorders

HEALTH PROGRAMS

Medicaid

Location in Federal Government: Administered by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized as Title XIX of the Social Security Act, as amended.

Program Description and Target Population:

Medicaid is a Federal–State matching entitlement program providing medical and behavioral health assistance to low-income people who are aged, blind, disabled, members of families with dependent children, and certain pregnant women and children. It is the single largest program for children’s health-care in the nation. In 2006, over 28 million children were enrolled in Medicaid (CBPP, 2006). States also have the option of providing Medicaid coverage for other “categorically related” groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are more liberally defined. The Balanced Budget Act of 1997 included two provisions that give states additional options for increasing children’s healthcare coverage through Medicaid: presumptive eligibility and 12-month continuous eligibility. As the result of the passage of the Deficit Reduction Act (DRA) of 2005, effective January 1, 2007, states will have the option to extend Medicaid to children under age 19 with family incomes up to 300 percent FPL, with federal financial participation phased in by age of children.

A state’s Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children, inpatient

hospital, outpatient hospital, and prenatal care, among others. Some optional services that are relevant to the juvenile justice population include rehabilitation services, prescription drug coverage, targeted case management, other provider services, and home- and community-based services.

Funding Type: Federal matching grant. The Federal government reimburses state expenditures for medically necessary services at state-specific rates that may not be lower than 50 percent or higher than 83 percent, with poorer states receiving a higher rate than wealthier states. The federal government usually matches administrative expenses at a rate of 50 percent.

In February 2006, the President signed the DRA. This act provides states with new options that could result in significant changes in state Medicaid policy. The DRA made changes to Medicaid in areas such as eligibility, recipient financial responsibility, and benefits.

Funding Level: \$182 billion in FY 2005 (federal funding).

Performance Measures: This program requires ongoing monitoring, tracking, and process assessment.

State Latitude for Implementation: States have flexibility in designing and operating their Medicaid programs. Within broad national guidelines, which the Federal government provides, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.

The State Children's Health Insurance Program (SCHIP)

Location in Federal Government: Administered by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized as a part of the Balanced Budget Act of 1997.

Program Description and Target Population: SCHIP entitles participating states to an enhanced federal funds match to provide health insurance to targeted low-income youth under age 19 who are ineligible for other insurance coverage. States may elect to expand their Medicaid programs, develop a free-standing SCHIP program, or have a combination of the two. For states that opt for a Medicaid expansion, the services provided under SCHIP mirror the Medicaid services provided by that state. States that opt for a separate child health program have four options for determining coverage: benchmark coverage, benchmark-equivalent coverage, existing state-based comprehensive coverage, or secretary-approved coverage. Regardless of the type of health benefits coverage provided by a state, it must provide coverage for well-child care, immunizations, and emergency services.

SCHIP legislation requires only limited mental health coverage and has no requirement that treatment for substance use disorders is an included benefit. Howell, Roschwalb, and Satake (2000) found that all states but one cover some form of substance abuse treatment, but services vary among states. The majority of states generally cover detoxification and outpatient treatment, with limits on the length of treatment being common. EPSDT requirements are not mandated for SCHIP stand-alone programs.

Funding Type: Federal block grant. To receive federal SCHIP funds, states must put up a matching amount equal to 70 percent of its matching rate under Medicaid. SCHIP funds must serve children who live in families with incomes at or below 200 percent FPL or 150 percent of a state's Medicaid income-eligibility level (the higher of the two). States that choose a Medicaid expansion will receive enhanced federal funds at Medicaid matching rates for the new SCHIP enrollees.

States are permitted to impose cost-sharing provisions on enrollees, but states may not charge cost sharing for preventive services or immunizations. States may not impose cost sharing that exceeds 5 percent of a family's gross or net income. American Indians/Alaska Native (AI/AN) children who are members of a federally recognized tribe must not be charged any cost sharing. For states that elect to implement a Medicaid expansion, the Medicaid cost-sharing rules apply.

Recent state fiscal constraints have led to SCHIP program cutbacks. Many states have increased premiums and cost-sharing allocations. Many states are hard-pressed to come up with the matching funds required from the federal government to receive their SCHIP allocations. Twenty-two states have had to implement tougher eligibility requirements and add other restrictions to their programs in the past 18 months and are expected to continue to make reductions over the coming year.

Funding Level: \$40 billion in federal funds over ten years (1997–2007).

Performance Measures: This program requires ongoing monitoring, tracking, and process assessment, including measuring the number of children enrolled in the program.

State Latitude for Implementation: States must use the funds in accordance with program guidance.

Substance Abuse Prevention and Treatment Performance Partnership (SAPTPP) Block Grant

Location in Federal Government: Administered by the Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Reauthorized in the Children's Health Act of 2000.

Program Description and Target Population: The SAPTPP Block Grant supports services for the prevention and treatment of substance abuse.

This grant includes no specific requirements for states to provide substance abuse treatment services for youth. However, states are not precluded from using funds for treatment of youth with substance use disorders, including most youth in the juvenile justice system. Funds may be used to provide an array of substance use disorder treatment including but not limited to outpatient, intensive outpatient, day treatment, and residential care.

Funding Type: Federal block grant. Funds are allocated to each state using a formula based on the Population at Risk, the Cost of Services Index, and the Fiscal Capacity Index. States that receive block grant funds are required to set aside 20 percent of block grant funds to provide prevention services, 5 percent for treatment of women with substance use disorders and their children, 5 percent for an independent peer review to review the quality and appropriateness of treatment services, and 70 percent for treatment for individuals with substance use disorders. The program authorizes \$15 million for grants, contracts, or cooperative agreements with public and nonprofit entities to provide alcohol and drug prevention or treatment services for AI/AN youth.

Funding Level: \$1.78 billion in FY 2005 (federal funds).

Performance Measures: The SAPTPP Block Grant requires 5 percent of a state's grant money to be used for an independent peer review to review the quality and appropriateness of treatment services.

State Latitude for Implementation: States have broad latitude in addressing alcohol and substance abuse problems.

Family and Juvenile Treatment Drug Courts

Location in Federal Government: Administered by the Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized by Section 509 of the Public Health Service Act, as amended, and subject to the availability of funds.

Program Description and Target Population: The purpose of the Family and Juvenile Treatment Drug Courts grant is to provide funds to be used by treatment providers and the courts to provide alcohol and drug treatment, wrap-around services supporting substance abuse treatment, assessment, case management, and program coordination to those in need of drug court treatment services. Family treatment drug courts provide services to parents who have been charged with child abuse and/or neglect, as well as to the children and other important family members. Juvenile treatment drug courts provide services to juveniles who are found delinquent, and can also provide services to the parents, siblings, and other important family members.

Funding Type: Federal discretionary grant. Funding for up to eight awards was available for juvenile treatment courts in FY 2005. Priority for the use of funding should be given to addressing gaps in the continuum of treatment.

Funding Level: \$3.15 million in FY 2005 (federal funds).

Performance Measures: Grantees of the Family and Juvenile Treatment Drug Courts are required to report performance data in several areas. Data must be collected at baseline, six months after baseline, and twelve months after baseline. Adolescents must also have data collected three months after baseline.

State Latitude for Implementation: Family and Juvenile Drug Courts have several well-defined elements that must be addressed. Family and juvenile courts must address eleven key elements. Juvenile courts must address an additional three elements, and they are encouraged to address three other optional elements.

The Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grant Program (Child and Adolescent SIG Grants)

Location in Federal Government: Administered jointly by the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized by Section 520A of the Public Health Service Act, as amended.

Program Description and Target Population: The purpose of the SIG grants is to strengthen the capacity of states, territories, and Native American tribal governments to develop, expand, and sustain substance abuse and mental health services, including early intervention, treatment, and/or continuing services and supports at the local level for children, adolescents, and youth in transition who have a serious emotional disturbance, substance use disorder, and/or co-occurring disorders, and their families. Activities carried out under this program must be focused on strengthening the capacity of states to transform their mental health systems to meet the complex needs of children and youth with serious emotional disturbances and/or co-occurring substance use and mental health disorders and their families within home- and community-based settings.

Funding Type: Federal discretionary grant. No state match is required. Up to seven awards were available. Eligible applicants are limited to states, the District of Columbia, territories, and tribal governments.

Funding Level: \$5.3 million in FY 2004 (federal funds).

Performance Measures: This program requires ongoing monitoring, tracking, and process assessments.

State Latitude for Implementation: Applicants are expected to use grant funds to build the infrastructure necessary to promote, support, and sustain local service and treatment intervention capabilities for the target population across service delivery systems. The program is intended to provide sufficient flexibility and scope to enable states to determine whether they will focus on the entire target population or particular demographic or geographic subsets of the population.

The Adolescent Substance Abuse Treatment Coordination State Infrastructure Grant Program (Adolescent SAC Grants)

Location in Federal Government: Administered by the Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized by Section 509 of the Public Health Service Act, as amended.

Program Description and Target Population: The purpose of the SAC grants is to build capacity in states to provide effective, accessible, and affordable treatment for youth with substance use and co-occurring disorders and their families. Grants will provide funding to support a staff position and a state process to assess, facilitate, and coordinate ongoing, self-sustaining, cross-system planning for effective adolescent substance abuse treatment. Grantees are required to hire and/or dedicate a full-time employee at the state level with the authority to convene and coordinate all of the state agencies that allocate public health resources that may provide funding and other support for adolescents and their families who need early intervention and treatment services for substance use disorders.

Funding Type: Federal discretionary grant. No state match is required. Funding is limited to states, the District of Columbia, territories, and federally recognized tribal governments.

Funding Level: \$7.1 million in FY 2005 (federal funds).

Performance Measures: This program requires ongoing monitoring, tracking, and process assessments.

State Latitude for Implementation: Grantees must use the funds to carry out activities in five topic areas: interagency collaboration, financing, parent support, workforce development (licensure, credentialing, and training), and the dissemination of evidence-based practices.

Young Offender Reentry Program (YORP)

Location in Federal Government: Administered by the Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

Date of Authorization: Authorized under Section 509 of the Public Health Service Act.

Program Description and Target Population: YORP was introduced because of the need to successfully return and reintegrate youth from the juvenile justice system into the community. YORP grantees provide substance abuse treatment and other reentry services while also ensuring public safety for the community and the offender.

Funding Type: Federal discretionary grant. Eleven YORP grants were awarded in FY 2005.

Funding Level: \$6 million in FY 2004 (federal funds).

Performance Measures: Grantees are required to collect and report data that measures the results of program performance.

State Latitude for Implementation: Grantees must use the funds in accordance with program guidance.

JUVENILE JUSTICE PROGRAMS

Juvenile Accountability Block Grant (JABG)

Location in Federal Government: Administered by the State Relations and Assistance Division of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Office of Justice Programs (OJP), U.S. Department of Justice (DOJ).

Date of Authorization: Authorized by the Omnibus Crime Control and Safe Streets Act of 1968, as amended by the Department of Justice Authorization Act for Fiscal Year 2003.

Program Description and Target Population: Through the JABG program, funds are provided as block grants to states for programs promoting greater accountability in the juvenile justice system. Grant funds may be used to support any of 16 program purpose areas. Two of those areas are Purpose #8, Juvenile Drug Courts, and Purpose #12, Risk and Needs Assessment. Purpose #12 includes early intervention and the provision of comprehensive services, including mental health screening and treatment, and substance abuse testing and treatment for juvenile offenders.

Funding Type: Federal block grant. Each state receives 0.5 percent of the total block grant, and the remaining money is distributed under a formula based on a state's population under age 18 relative to the national population under age 18. Of the state grant, 75 percent must go to local agencies, but local agencies must provide 10 percent of the total funds to be expended or 50 percent of the total funds if the proposed project is construction related.

Funding Level: \$49 million in FY 2005 (federal funds).

Performance Measures: OJJDP developed a system to measure the effectiveness of the JABG using 298 performance indicators arranged around the 16 program purpose areas.

State Latitude for Implementation: States must use the funds in accordance with program guidance.

Tribal Youth Program (TYP)

Location in Federal Government: Administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice (DOJ).

Date of Authorization: Authorized under Title I—Departments of Commerce, Justice, State, the Judiciary, and Related Agencies Appropriations Act—of the Omnibus Consolidated Emergency and Supplemental Appropriations Act of 1999.

Program Description and Target Population: One purpose of TYP is to support and enhance tribal efforts to prevent and control delinquency and improve the juvenile justice system for AI/AN youth. Another focus is provision of mental health and substance abuse services to AI/AN youth.

Funding Type: Federal discretionary grant. Applicants selected for awards will be funded for a three-year budget period and project period. Up to \$300,000 in funding is available.

Funding Level: \$10 million in FY 2006 (federal funds).

Performance Measures: OJJDP requires award recipients to collect and report performance data including information on prevention, intervention, tribal juvenile justice system improvement, alcohol and drug abuse prevention programs, and mental health program services.

State Latitude for Implementation: Tribes must use the funds in accordance with program guidance.

Tribal Youth Program Mental Health Initiative

Location in Federal Government: Administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice (DOJ).

Date of Authorization: Authorized under Title I—Departments of Commerce, Justice, State, the Judiciary, and Related Agencies Appropriations Act—of the Omnibus Consolidated Emergency and Supplemental Appropriations Act of 1999.

Program Description and Target Population: The TYP Mental Health Initiative was established to promote mental health and substance abuse services for AI/AN youth and to support juvenile delinquency prevention and intervention efforts by creating and implementing culturally sensitive mental health programs. It is intended to help tribes provide a range of youth support services and programs to address the mental health and related needs of AI/AN youth and their families in various community settings.

Funding Type: Federal discretionary grant. Applicants selected for awards will be funded for a three-year budget period and project period.

Funding Level: \$1 million in FY 2005 (federal funds).

Performance Measures: OJJDP requires award recipients to collect and report performance data including information on prevention, intervention, tribal juvenile justice system improvement, alcohol and drug abuse prevention programs, and mental health program services.

State Latitude for Implementation: Tribes must use the funds in accordance with program guidance.

Justice Assistance Formula Grant (JAFG)

Location in Federal Government: Administered by the Bureau of Justice Assistance (BJA), Office of Justice Programs (OJP), U.S. Department of Justice (DOJ).

Date of Authorization: The Consolidated Appropriations Act of 2005 (Division B, Title I) created the JAFG by combining two existing grant programs, the Edward Byrne Memorial Justice Assistance Grant Program and the Local Law Enforcement Block Grant.

Program Description and Target Population: The JAFG is a partnership among federal, state, and local governments to create safer communities and to improve the functioning of the criminal justice system. JAFG funds can be used for state and local initiatives, technical assistance, training, personnel, equipment, supplies, contractual support, and information systems for criminal justice.

Funding Type: Federal formula grant. The procedure for allocating JAFG funds is a formula based on population and crime statistics, in combination with a minimum allocation to ensure that each state and territory receives an appropriate share. Funds are distributed 60/40 between state and local recipients. JAFG purpose areas include: law enforcement programs, prosecution and court programs, prevention and education programs, corrections and community corrections programs, drug treatment programs, and planning evaluation and technology improvement programs.

Funding Level: \$590 million in FY 2005 (federal funds).

Performance Measures: JAFG grantees are required to collect and report data that measures the results of program performance.

State Latitude for Implementation: Grantees must use the funds in accordance with program guidance.

Edward Byrne Discretionary Grant Program

Location in Federal Government: Administered by the Bureau of Justice Assistance (BJA) in the Office of Justice Programs, U.S. Department of Justice (DOJ).

Date of Authorization: Authorized through the Anti-Drug Abuse Act of 1998.

Program Description and Target Population: The Edward Byrne Discretionary Grant Program's principal objectives are undertaking educational and training programs for criminal justice personnel; providing technical assistance to state and local units of government; promoting projects that are national or multijurisdictional in scope; and demonstrating programs that, in view of previous research or experience, are likely to be successful in more than one jurisdiction. Program funds may also be used for programs to identify and meet the treatment needs of adult and juvenile drug- and alcohol-dependent offenders.

Funding Type: Federal discretionary grant. Public and private agencies as well as private nonprofit organizations are eligible to receive funding. Although eligible entities may receive funding up to 100 percent

of cost, the BJA promotes leveraging of state, local, and private resources and emphasizes the need for early sustainability planning by grant recipients.

Funding Level: \$231 million in FY 2005 (federal funds).

Performance Measures: BJA grantees are required to collect and report data that measures the results of program performance.

State Latitude for Implementation: Grantees must use funds in accordance with program guidance.

Operation Weed and Seed

Location in Federal Government: Administered by the Community Capacity Development Office (CCDO) in the Office of Justice Programs (OJP), U.S. Department of Justice (DOJ).

Date of Authorization: Authorized through the Omnibus Crime and Control and Safe Streets Act of 1968, as amended in 1988, and initiated by the DOJ in 1991.

Program Description and Target Population: Operation Weed and Seed aims to prevent, control, and reduce violent crime, drug abuse, and gang activity in designated high-crime neighborhoods across the country. It is a community-based initiative with four required elements: (1) law enforcement; (2) community policing; (3) crime and substance abuse prevention, intervention, and treatment; and (4) neighborhood restoration. The strategy involves a two-pronged approach: law enforcement agencies and prosecutors cooperate in "weeding out" violent crime and drug abuse, and "seeding" brings social services to the area, encompassing prevention, intervention, treatment, and neighborhood revitalization.

Funding Type: Federal strategy. All Weed and Seed budgets must include a 25 percent site match. Weed and Seed applicants are required to identify other funding sources at a level five times the CCDO core funding contribution. An applicant must be a coalition of community residents; local, county, and state agencies; federal agencies; and the private sector. Applicants must apply and meet the requirements for official recognition of their applicable strategy.

Funding Level: \$62 million in FY 2005 (federal funds).

Performance Measures: CCDO expects the local sites to identify performance measures that will guide their own strategy development and implementation activities in addition to the national Weed and Seed performance measures.

State Latitude for Implementation: Grantees must use the funds in accordance with program guidance.

Residential Substance Abuse Treatment (RSAT) Program for State Prisoners Program

Location in Federal Government: Administered by the Bureau of Justice Assistance (BJA) in the Office of Justice Programs (OJP), U.S. Department of Justice (DOJ).

Date of Authorization: Authorized through the Violent Crime Control and Law Enforcement Act of 1994.

Program Description and Target Population:

The RSAT Formula Grant assists states and units of local government within state and local correctional and detention facilities in which prisoners are incarcerated. Grant funds are awarded to the states to assist them in implementing and enhancing residential substance abuse programs that provide individual and group treatment activities for offenders in residential facilities operated by state and local correctional agencies.

Funding Type: Federal matching grant. The RSAT grant is a matching grant: the federal government provides 75 percent of the total cost of the project, and the state provides the matching 25 percent. Each participating state is allocated a base amount of 0.4 percent of the total funds available. The remaining funds are allocated to each participating state in the same ratio its prison population represents relative to the total prison population of all states.

Funding Level: \$24.7 million in FY 2005 (federal funds).

Performance Measures: BJA grantees are required to collect and report data that measures the results of program performance.

State Latitude for Implementation: The grant imposes several spending set-asides and maintenance requirements. At least 10 percent of the total state allocation for FY 2005 will be available to local correctional and detention facilities for either residential substance abuse treatment programs or jail-based substance abuse treatment programs. No more than 10 percent of the total award may be used for treatment of those released from a state facility.

The Drug Court Discretionary Grant Program

Location in Federal Government: Administered by the Office of Justice Programs (OJP) in the U.S. Department of Justice (DOJ).

Date of Authorization: Authorized by the Violent Crime and Control and Law Enforcement Act of 1994.

Program Description and Target Population: The Drug Court Discretionary Program was established to provide training, financial and technical assistance, and related programmatic guidance and leadership to communities interested in drug courts. The overall goal of juvenile drug courts is to provide immediate intervention in the lives of children and/or parents using drugs or exposed to substance addiction through their family members, as well as structure the litigants through the ongoing, active involvement and oversight of the drug court judges.

Funding Type: Federal discretionary grant. This drug court program is meant to provide seed money for drug courts, but not long-term support.

Funding Level: \$43 million in FY 2005 (federal funds).

Performance Measures: Grantees are required to collect and report data that measures the results of program performance.

State Latitude for Implementation: Communities are allowed to use drug court funds as defined by community need.

Appendix B

Abbreviations, Acronyms, and Selected Legislation

AFDC	Aid to Families with Dependent Children	NADCP	National Association of Drug Court Professionals
AI/AN	American Indian/Alaska Native	NGA	National Governors Association
ASAM	American Society of Addiction Medicine	OJJDP	Office of Juvenile Justice and Delinquency Prevention (in DOJ)
BBA	Balanced Budget Act of 1997 (P.L. 105-33)	OJP	Office of Justice Programs (in DOJ)
BJA	Bureau of Justice Assistance (in OJP, DOJ)	P.L.	public law
CBPP	Center on Budget and Policy Priorities	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)
CCDO	Community Capacity Development Office	RSAT	Residential Substance Abuse Treatment
CDF	Children's Defense Fund	RWJF	Robert Wood Johnson Foundation
CMHS	Center for Mental Health Services	SAC	Substance Abuse Coordination
CMHSPP	Community Mental Health Services Performance Partnership (Block Grant)	SAMHSA	Substance Abuse and Mental Health Services Administration (in DHHS)
CMS	Centers for Medicare and Medicaid Services	SAPTPP	Substance Abuse Prevention and Treatment Performance Partnership (Block Grant)
CSAP	Center for Substance Abuse Prevention	SCHIP	State Children's Health Insurance Program
CSAT	Center for Substance Abuse Treatment	SIG	State Infrastructure Grant
DHHS	U.S. Department of Health and Human Services	SSI	Supplemental Security Income
DRA	Deficit Reduction Act of 2005 (P.L. 109-362)	TANF	Temporary Assistance for Needy Families
DOJ	U.S. Department of Justice	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248)
EOWS	Executive Office of Weed and Seed	TYP	Tribal Youth Program
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment	YORP	Young Offender Reentry Program
FPL	federal poverty level		
FQHC	federally qualified health center		
FY	fiscal year		
GAO	General Accounting Office		
HCBS	home- and community-based services		
HCFA	Health Care Financing Administration		
HHS	Health and Human Services (U.S. Department of)		
HIFA	Health Insurance Flexibility and Accountability		
HMO	health maintenance organization		
JABG	Juvenile Accountability Block Grant		
JAFG	Justice Assistance Formula Grant		
LLEBG	Local Law Enforcement Block Grant		
MN	medically needy		

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