Section II: Aggregate Findings

Structure and Function

Typically, the Single State Agency (SSA) is designated to receive and administer the Substance Abuse Prevention and Treatment (SAPT) Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Most SSAs are located in departments of health and/or human services, but some SSAs are located in departments of mental health or are independent State agencies. Some SSAs work closely with the Governor's office and other State agencies, whereas others work more independently.

> ***Pennsylvania*** oversees a system of 49 single county authorities (SCAs) to provide publicly funded prevention and treatment services. SCAs are responsible for program planning and service provision throughout Pennsylvania's 67 counties and often contract with local programs to deliver services.

Most SSAs do not deliver treatment and prevention services directly. Rather, SSAs usually deliver their services through a substate delivery system at a regional, county, and/or local level. Substate entities include geographically determined planning districts, regional community substance abuse/mental health centers, public/private planning and action councils, county government, regional State authorities, private nonprofit or for-profit organizations, community-based agencies or coalitions, colleges and universities, and tribal entities.

> ***South Carolina*** contracts with 33 county alcohol and drug abuse authorities to provide direct services to citizens in all 46 counties. It also partners with public, private, and social sector organizations to provide quality ATOD services.

The substate entities receiving funding from the SSAs maintain an important role in planning, implementing, and evaluating substance abuse prevention and treatment programs. States either contract exclusively with regional or local entities or contract with a combination of State, regional, and local entities. Although SSAs do not generally provide direct services, they do provide training and technical assistance to their substate providers to plan for, deliver, and monitor the alcohol, tobacco and other drug (ATOD) services.

Additional information regarding the structure and function of SSAs can be found in the prevention, treatment, and resource development sections of this report.

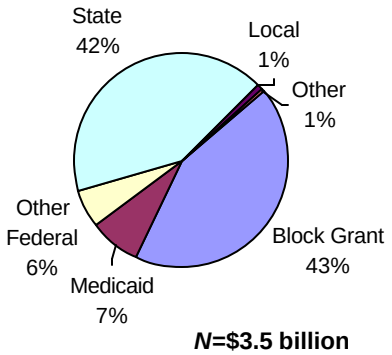
> ***Indiana*** has local coordinating councils in each of its 92 counties that are responsible for planning ATOD prevention, treatment, and law enforcement-related services.

SSAs have multiple funding streams, including the SAPT Block Grant, SAMHSA discretionary grants, other Federal monies, State funds, private foundations, and other sources. The next section summarizes SSA funding sources and distribution of funds by activity.

Single State Agency Funding Overview

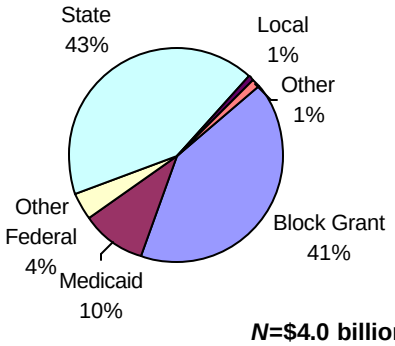
Nationally, SSA expenditures increased steadily from FYs 2000 to 2003 from $3.5 to $4.0 million, and the proportion of expenditures from the different funding sources remained stable[1] (figures 2.1–2.3, table 2.1). The expenditures from the Block Grant and from State funds were roughly equal, with the Block Grant contributing between 41 and 43 percent of total expenditures (and increasing from $1.5 billion in FY 2000 to $1.6 billion in FY 2003) and State funds consistently contributing 42 to 44 percent of expenditures (increasing from $1.5 to $1.7 billion during the same period).

Figure 2.1. Expenditures by Funding Source, FY 2000



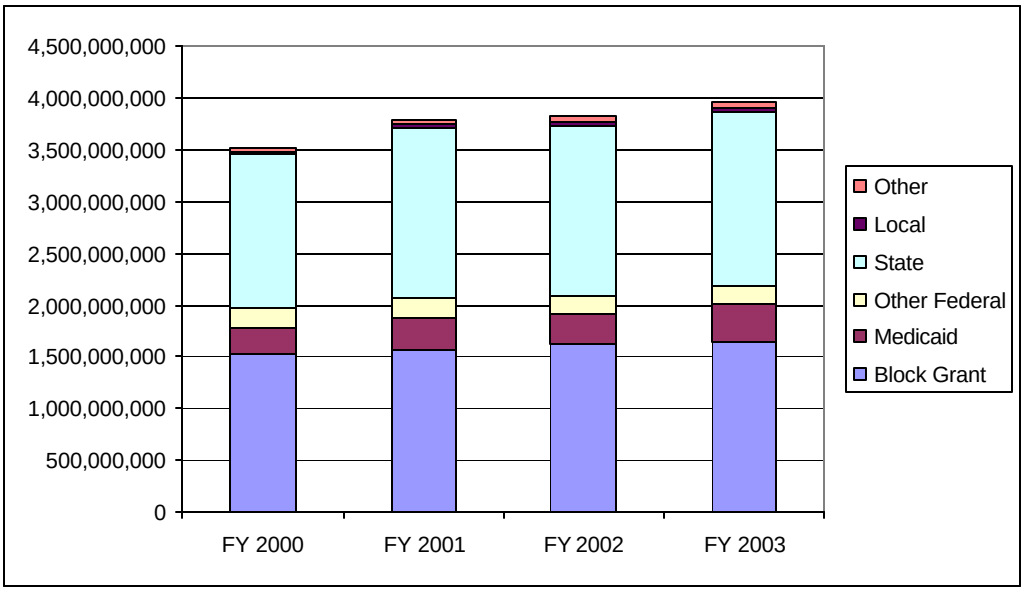
***N*=$3.5 billion**

Figure 2.2. Expenditures by Funding Source, FY 2003



***N*=$4.0 billion**

Figure 2.3. National Expenditures for All Single State Agencies by Funding Source, FYs 2000–2003 (n=51)



[1] The Inventory does not include expenditure or financial information from private third-party payers such as commercial health insurers.

Table 2.1. Sum of Expenditures for All Single State Agencies by Funding Source, FYs 2000–2003

Funding Source	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Block Grant	1,513,832,485	43	1,554,930,564	41	1,608,109,297	42	1,638,665,605	41
Medicaid	262,845,138	7	306,791,483	8	322,400,472	8	387,624,547	10
Other Federal	199,884,140	6	206,855,944	5	170,311,286	4	164,681,453	4
State	1,484,216,227	42	1,651,132,311	44	1,630,772,174	43	1,679,088,556	43
Local	27,896,629	1	35,990,172	1	40,185,629	1	40,632,387	1
Other	22,229,354	1	38,765,827	1	49,079,776	1	43,081,669	1
TOTAL*	**3,510,903,973**	**100**	**3,794,466,301**	**100**	**3,820,858,634**	**100**	**3,953,774,217**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
NOTE: Not all FY 2006 Block Grant applications were approved by SAMHSA at time of publication.
* Totals may not equal 100 percent due to rounding.

While the cumulative snapshot of States show a roughly even split between expenditures of Block Grant and State funds, individual States varied greatly in the proportion of expenditures by funding source (table 2.2). For example, in FY 2003, 19 States reported that most (50 percent or more) of their total expenditures derived from the SAPT Block Grant, and 13 States reported that most (50 percent or more) derived from State funds:

- States indicating that the vast majority (75 percent or more) of their expenditures came from Block Grant funds included Wisconsin (for which Block Grant funds accounted for 87 percent of total expenditures), Texas (86 percent), Alabama (77 percent), and Mississippi (75 percent). States spending the smallest proportion of Block Grant funds, when compared with other States, included Wyoming and Alaska (at 13 percent each), and the District of Columbia (18 percent).

- States indicating that the majority of their expenditures derived from State funds included New York, the District of Columbia, and Alaska (for which State funds accounted for 69 percent of total expenditures), and Connecticut (65 percent). States spending the smallest proportions of State funds included Texas (12 percent), Wisconsin (13 percent), and Alabama (15 percent).

- One-half of the States reported spending Medicaid funds on substance abuse treatment in their Block Grant application and half did not. For those that did not report Medicaid expenditures, it is possible that their Medicaid funds flowed through a different State agency, other than the SSA. For the 25 States reporting Medicaid expenditures along with their Block Grant and other funds, the States spending the highest proportions of Medicaid funds, when compared with other States, included Vermont (for which Medicaid accounted for 41 percent of total expenditures), Oregon (37 percent), Arizona (36 percent), and Kansas (32 percent). Those reporting the smallest proportions included Oklahoma (less than 1 percent), and Alaska, Colorado, and Maryland (at 1 percent each).

- Several of the States had a substantial proportion of funds coming from other sources, including other Federal, local, and other sources. States with the higher proportion of funds coming from other sources included Wyoming (56 percent, of which 38 percent were from tobacco settlement monies and 18 percent were from other Federal sources), South Carolina (20 percent from other Federal and other sources), Maine (19 percent from other Federal sources), and Minnesota (18 percent from local and other sources).

Table 2.2. Single State Agency Expenditures From All Funding Sources, FY 2003

State	Block Grant		Medicaid		State		All Other*		Total
	$	%	$	%	$	%	$	%	$
Alabama	23,970,196	77	2,548,051	8	4,726,255	15	0	0	31,244,502
Alaska	4,492,456	13	181,547	1	23,476,081	69	5,816,294	17	33,966,378
Arizona	30,548,743	39	28,092,326	36	14,750,878	19	5,473,374	7	78,865,321
Arkansas	12,169,977	63	0	0	5,561,349	29	1,538,451	8	19,269,777
California	250,772,440	44	115,743,764	21	191,858,917	34	5,419,284	1	563,794,405
Colorado	23,366,008	66	341,854	1	11,039,209	31	565,836	2	35,312,907
Connecticut	16,879,723	21	0	0	52,773,004	65	12,074,646	15	81,727,373
Delaware	6,577,245	34	0	0	12,163,775	63	458,511	2	19,199,531
Dist. of Columbia	6,266,666	18	0	0	24,177,215	69	4,446,944	13	34,890,825
Florida	95,064,189	50	7,490,671	4	68,182,836	36	19,826,826	10	190,564,522
Georgia	47,462,679	49	0	0	46,378,871	48	2,407,940	3	96,249,490
Hawaii	7,083,900	39	0	0	9,045,643	49	2,252,096	12	18,381,639
Idaho	6,787,163	62	0	0	3,819,401	35	379,476	3	10,986,040
Illinois	67,994,327	28	45,445,971	19	121,083,194	50	6,914,612	3	241,438,104
Indiana	33,446,723	73	0	0	10,594,118	23	1,682,810	4	45,723,651
Iowa	12,915,707	28	12,459,958	27	15,552,074	34	4,783,870	10	45,711,609
Kansas	12,343,401	39	10,265,226	32	7,742,315	24	1,417,371	4	31,768,313
Kentucky	20,752,134	57	0	0	13,991,159	38	1,717,358	5	36,460,651
Louisiana	25,959,665	45	0	0	22,605,911	39	9,176,686	16	57,742,262
Maine	6,462,370	21	7,535,560	24	10,857,890	35	5,959,290	19	30,815,110
Maryland	32,114,739	29	1,509,383	1	65,241,515	59	12,206,447	11	111,072,084
Massachusetts	34,174,108	41	0	0	45,637,409	55	3,047,432	4	82,858,949
Michigan	58,143,061	51	28,144,755	25	21,923,111	19	5,131,953	5	113,342,880
Minnesota	21,783,707	22	2,014,998	2	58,088,886	58	17,582,485	18	99,470,076
Mississippi	14,139,924	75	0	0	4,184,548	22	499,409	3	18,823,881
Missouri	26,268,669	33	22,346,941	28	28,046,792	35	3,815,059	5	80,477,461
Montana	6,577,245	48	1,200,971	9	3,830,948	28	1,962,639	14	13,571,803
Nebraska	7,926,182	38	2,109,870	10	10,314,101	49	779,312	4	21,129,465
Nevada	12,860,149	68	0	0	3,651,093	19	2,424,466	13	18,935,708
New Hampshire	6,577,245	50	0	0	6,038,503	46	440,972	3	13,056,720
New Jersey	47,139,236	44	0	0	56,553,000	53	2,602,085	2	106,294,321
New Mexico	8,614,912	25	0	0	22,243,367	63	4,226,704	12	35,084,983
New York	115,999,936	25	0	0	318,739,459	69	29,545,085	6	464,284,480
North Carolina	38,135,024	41	0	0	50,884,907	55	4,126,931	4	93,146,862
North Dakota	4,984,093	30	3,133,330	19	6,721,455	40	1,931,534	12	16,770,412
Ohio	66,942,269	40	34,174,236	20	58,286,164	35	7,355,204	4	166,757,873
Oklahoma	17,788,840	40	189,727	0	22,564,922	51	3,402,519	8	43,946,008
Oregon	16,098,172	35	17,236,406	37	11,360,557	24	1,676,494	4	46,371,629
Pennsylvania	59,336,807	52	0	0	41,976,000	37	12,759,980	11	114,072,787
Rhode Island	6,577,245	24	5,099,558	18	12,451,874	45	3,636,268	13	27,764,945
South Carolina	20,661,633	57	875,635	2	7,128,044	20	7,337,061	20	36,002,373
South Dakota	4,608,895	48	0	0	3,302,009	35	1,645,246	17	9,556,150
Tennessee	29,391,224	70	0	0	7,966,574	19	4,615,891	11	41,973,689
Texas	133,322,329	86	0	0	18,467,532	12	3,358,783	2	155,148,644
Utah	16,914,130	53	0	0	11,488,452	36	3,320,604	10	31,723,186
Vermont	4,927,888	27	7,368,676	41	5,259,682	29	440,872	2	17,997,118
Virginia	42,526,592	52	0	0	39,859,035	48	0	0	82,385,627
Washington	35,125,673	30	31,346,544	27	48,253,834	41	2,437,558	2	117,163,609
West Virginia	8,564,801	53	0	0	7,577,063	47	0	0	16,141,864
Wisconsin	25,877,350	87	0	0	3,897,323	13	0	0	29,774,673
Wyoming	3,193,795	13	678,589	3	6,770,302	28	13,595,841	56	24,238,527

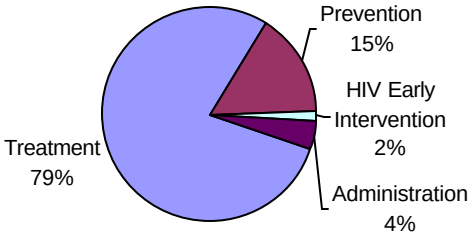
SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

*Other funding sources include other Federal, local, and other sources such as private foundations and the tobacco Master Settlement Agreement.

Expenditures and Activities from All Funding Sources

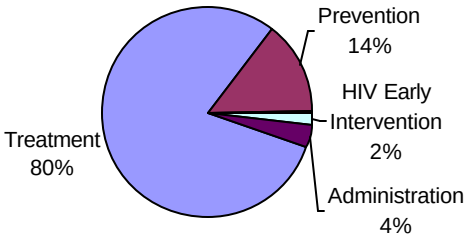
Nationally, the majority of SSA expenditures went toward treatment and rehabilitation services, accounting for 79 to 80 percent of total expenditures between FYs 2000 and 2003 (figures 2.4–2.6, table 2.3). Prevention services consistently accounted for 14 to 15 percent of expenditures during this time period, and administrative costs and HIV early intervention received 4 percent and 2 percent, respectively.

Figure 2.4. Expenditures by Activity, FY 2000



***N*=$3.5 million**

Figure 2.5. Expenditures by Activity, FY 2003



***N*=$4.0 million**

Figure 2.6. National Expenditures From All Funding Sources by Activity, FYs 2000–2003 (n=51)

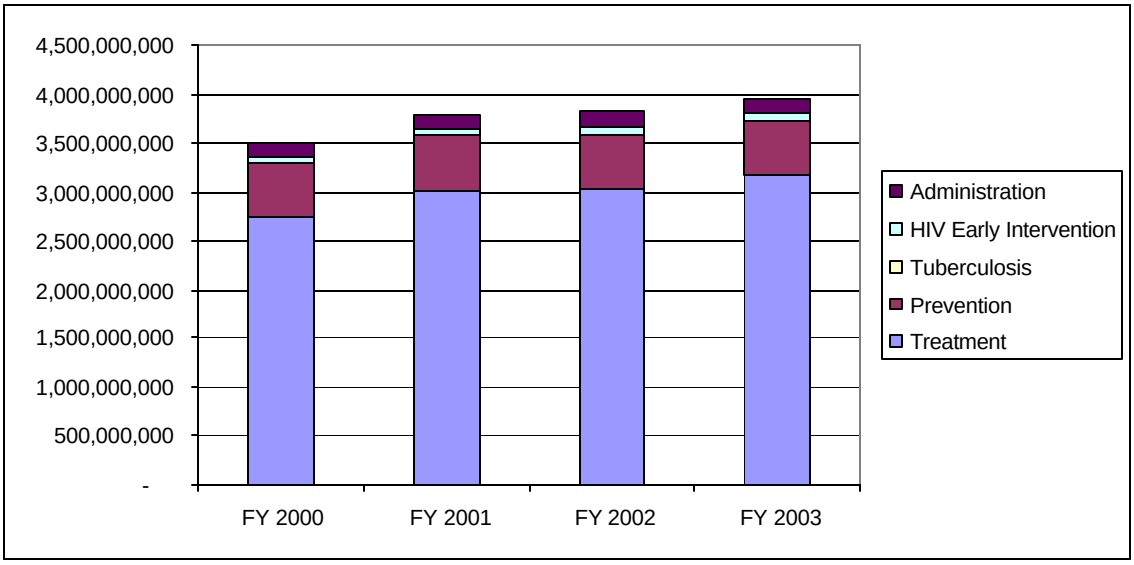


Table 2.3. Sum of Expenditures (in billions of dollars) for All Single State Agencies by Activity, FYs 2000–2003 (n=51)

Activity	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Treatment	2,753,404,373	79	3,003,554,843	79	3,034,892,821	79	3,168,430,731	80
Prevention	538,163,654	15	575,751,775	15	552,362,815	14	559,967,101	14
Tuberculosis	2,405,072	0	2,601,125	0	2,375,284	0	2,385,672	0
HIV Early Intervention	64,332,629	2	64,588,100	2	68,807,191	2	68,089,871	2
Administration	152,598,245	4	147,970,458	4	162,420,523	4	154,900,842	4
TOTAL*	**3,510,903,973**	**100**	**3,794,466,301**	**100**	**3,820,858,634**	**100**	**3,953,774,217**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
NOTE: States with a specified HIV/AIDS case rate (10 or more per 100,000) must spend a portion of their SAPT Block Grant funds (usually 5%) on HIV early intervention activities.
* Totals may not equal 100 percent due to rounding.

All States, with the exception of Alaska, spent most of their funding on treatment and rehabilitation services[2] in FY 2003 (range 39 to 93 percent)(table 2.4). While all States met the 20 percent set-aside requirement by spending 20 percent or more of Block Grant funds for primary prevention activities[3], prevention expenditures from *all funding sources* (including State, other Federal, and other sources) comprised a substantially smaller proportion. In fact, most States spent less than 20 percent of their funds from all sources on prevention services (range 5 to 29 percent) and less than 10 percent on other services or activities (range 0 to 33 percent). Specifically:

- States spending the highest proportion of funds *from all sources* on prevention services, when compared with other States, included Wyoming (29 percent), Alaska (28 percent), and Maine and Rhode Island (at 27 percent each). States spending the lowest proportions of funds from all sources on prevention services included Minnesota (5 percent), Maryland (7 percent), and Arizona (8 percent).

- States spending the highest proportion of funds from all sources on treatment and rehabilitation services included Minnesota (93 percent), Arizona (89 percent), North Dakota (88 percent), and Vermont (88 percent). States spending the lowest proportion on treatment services included Alaska (33 percent), Wyoming (63 percent), and New Mexico (63 percent).

- Most States spent less than 10 percent on other activities, and only 4 States indicated spending more than 10 percent on other activities. These States included Alaska (which spent 33 percent on administrative activities), Pennsylvania (which spent 14 percent on administration and 3 percent on HIV early intervention), New Mexico (which spent 15 percent on administration), and Hawaii (which spent approximately 7 percent on administration and 3 percent on HIV early intervention).

[2] On the FY 2006 SAPT Block Grant application, Form 4, Alaska indicated spending 39 percent of funds on treatment services, 33 percent on administrative activities, and 28 percent on prevention services in FY 2003.
[3] DHHS Block Grant 45 CFR Section 96.124 (2005)

Table 2.4 Single State Agency Expenditures From All Funding Sources by Activity, FY 2003

State	Treatment and Rehabilitation		Prevention		Other*		Total
	$	%	$	%	$	%	$
Alabama	24,129,432	77	4,930,210	16	2,094,860	7	31,154,502
Alaska	13,157,654	39	9,510,064	28	11,298,660	33	33,966,378
Arizona	70,096,302	89	6,261,531	8	2,507,488	3	78,865,321
Arkansas	15,280,827	79	2,406,920	12	1,582,030	8	19,269,777
California	481,632,747	85	61,791,700	11	20,369,958	4	563,794,405
Colorado	28,963,031	82	6,181,247	18	168,629	0	35,312,907
Connecticut	65,261,577	80	15,154,964	19	1,310,832	2	81,727,373
Delaware	14,530,937	76	4,075,557	21	593,037	3	19,199,531
District of Columbia	28,268,893	81	4,681,009	13	1,940,923	6	34,890,825
Florida	153,859,450	81	27,493,129	14	9,211,943	5	190,564,522
Georgia	79,868,994	83	13,244,426	14	3,136,070	3	96,249,490
Hawaii	12,301,075	67	4,117,265	22	1,963,299	11	18,381,639
Idaho	8,357,348	76	2,413,305	22	215,387	2	10,986,040
Illinois	208,006,565	86	21,734,501	9	11,697,038	5	241,438,104
Indiana	34,210,952	75	8,667,531	19	2,845,168	6	45,723,651
Iowa	37,161,700	81	6,948,442	15	1,601,487	4	45,711,629
Kansas	27,020,852	85	3,732,685	12	1,014,776	3	31,768,313
Kentucky	26,168,067	72	8,967,526	25	1,325,058	4	36,460,651
Louisiana	49,954,362	87	5,191,933	9	2,595,967	4	57,742,262
Maine	20,344,891	66	8,323,201	27	2,147,018	7	30,815,110
Maryland	96,230,477	87	7,885,787	7	6,955,820	6	111,072,084
Massachusetts	72,270,519	87	7,825,701	9	2,762,729	3	82,858,949
Michigan	85,880,552	76	17,953,763	16	9,508,565	8	113,342,880
Minnesota	92,788,214	93	5,465,144	5	1,216,718	1	99,470,076
Mississippi	14,359,497	76	2,827,985	15	1,636,399	9	18,823,881
Missouri	67,434,569	84	8,311,621	10	4,731,271	6	80,477,461
Montana	10,913,500	80	1,980,822	15	677,481	5	13,571,803
Nebraska	18,050,881	85	2,576,895	12	501,689	2	21,129,465
Nevada	12,730,406	67	4,918,396	26	1,286,906	7	18,935,708
New Hampshire	9,145,582	70	2,729,283	21	1,181,855	9	13,056,720
New Jersey	90,709,111	85	11,332,318	11	4,253,165	4	106,294,594
New Mexico	22,203,382	63	7,588,143	22	5,293,458	15	35,084,983
New York	357,775,191	77	74,922,798	16	31,586,491	7	464,284,480
North Carolina	75,522,116	81	9,947,685	11	7,731,061	8	93,200,862
North Dakota	14,874,104	88	2,044,914	12	31,394	0	16,950,412
Ohio	130,209,265	78	24,806,999	15	11,741,609	7	166,757,873
Oklahoma	35,627,533	81	5,510,949	13	2,807,526	6	43,946,008
Oregon	40,399,863	87	5,166,858	11	804,908	2	46,371,629
Pennsylvania	73,283,402	64	21,223,136	19	19,566,249	17	114,072,787
Rhode Island	18,261,896	66	7,403,938	27	2,099,111	8	27,764,945
South Carolina	26,948,891	75	7,953,854	22	1,099,628	3	36,002,373
South Dakota	7,554,638	79	1,495,705	16	505,807	5	9,556,150
Tennessee	29,062,010	69	9,228,890	22	3,682,789	9	41,973,689
Texas	105,369,967	68	38,564,386	25	11,214,291	7	155,148,644
Utah	22,749,973	72	7,955,561	25	1,017,652	3	31,723,186
Vermont	15,830,540	88	1,727,071	10	439,507	2	17,997,118
Virginia	69,711,951	85	8,511,634	10	4,162,042	5	82,385,627
Washington	102,176,682	87	10,095,235	9	4,891,692	4	117,163,609
West Virginia	14,000,418	87	1,784,561	11	358,885	2	16,143,864
Wisconsin	22,430,769	75	7,244,160	24	99,744	0	29,774,673
Wyoming	15,351,449	63	6,976,763	29	1,910,315	8	24,238,527

SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

*Other activities include HIV early intervention, TB services, and administrative costs.

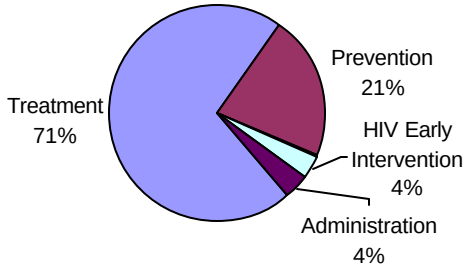
Expenditures of Block Grant and State Funds

Nationally, States spent a greater proportion of State funds on treatment services (88 percent) than they did Block Grant funds (70 percent). Conversely, States spent more Block Grant funds on prevention services (23 percent) than they did State funds (6 percent).

Expenditures of Block Grant Funds

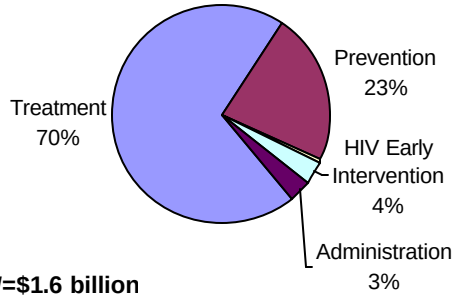
Nationally, the majority of Block Grant expenditures went toward treatment and rehabilitation services, accounting for 70 to 71 percent of total Block Grant expenditures from FY 2000 to 2003 (figures 2.7–2.8). Block Grant expenditures for treatment services increased steadily during this time from $1.1 billion nationwide in FY 2000 to $1.2 billion in FY 2003 (figure 2.9, table 2.5). Expenditures on prevention services accounted for 21 to 23 percent of Block Grant expenditures and increased from from $324 million in FY 2000 to $372 million in FY 2003. On average, States spent between 3 and 4 percent of expenditures each on HIV early intervention services and administrative costs.

Figure 2.7. Expenditures of Block Grant Funds by Activity, FY 2000



***N*=$1.5 billion**

Figure 2.8. Expenditures of Block Grant Funds by Activity, FY 2003



***N*=$1.6 billion**

Figure 2.9. National Expenditures of Block Grant Funds by Activity, FYs 2000–2003 (n=51)

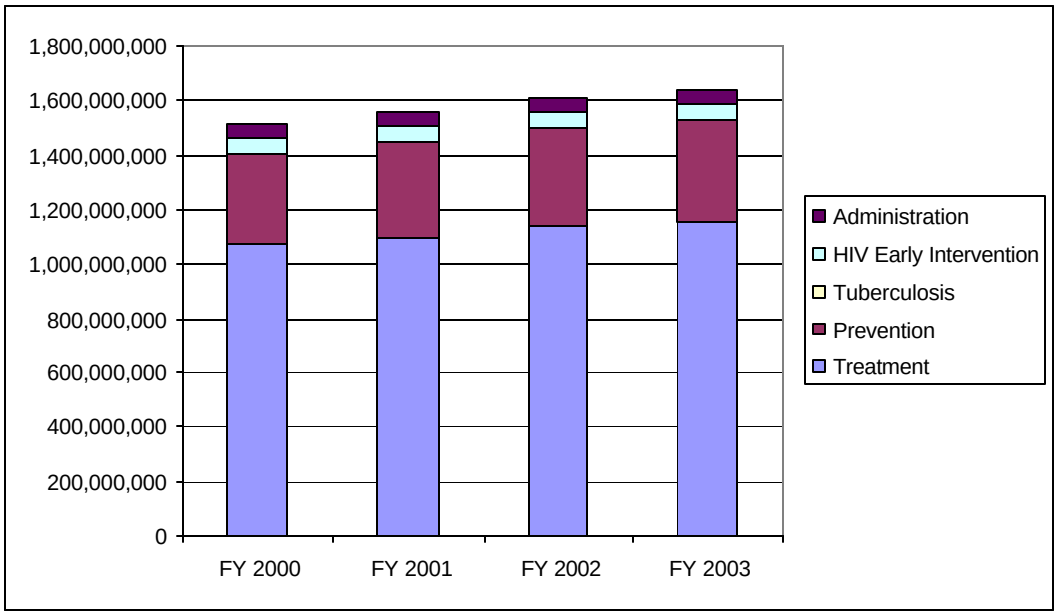


Table 2.5. Sum of Block Grant Expenditures for All Single State Agencies by Activity, FYs 2000–2003 (n=51)

Activity	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Treatment	1,077,449,834	71	1,096,467,378	71	1,140,561,755	71	1,154,602,763	70
Prevention	324,333,222	21	351,498,950	23	357,719,619	22	371,997,015	23
Tuberculosis	1,910,753	0	1,872,945	0	1,791,262	0	1,772,419	0
HIV Early Intervention	56,500,716	4	55,529,386	4	55,956,302	3	57,636,309	4
Administration	53,637,960	4	49,561,905	3	52,080,359	3	52,657,099	3
TOTAL*	**1,513,832,485**	**100**	**1,554,930,562**	**100**	**1,608,109,297**	**100**	**1,638,665,605**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
NOTE: States with a specified HIV/AIDS case rate (10 or more per 100,000) must spend a portion of their SAPT Block Grant funds (usually 5%) on HIV Early Intervention activities.
*Totals may not equal 100 percent due to rounding.

Examination of individual State expenditures is similar to the national average. SSAs spent an average of 70 percent of Block Grant funds on treatment and rehabilitation services (range 61 to 80 percent), 23 percent on prevention services (range 20 to 31 percent), 7 percent on other services and activities (range 0 to 14 percent) in FY 2003 (table 2.6). Specific findings include the following:

- All States met the SAPT Block Grant 20-percent set-aside requirement: all States spent 20 percent or more of Block Grant funds on primary prevention activities.

- Thirty-three States exceeded the 20-percent set-aside requirement for 2003 expenditures. States spending a greater proportion of Block Grant funds on prevention services when compared with other States included Idaho (31 percent), Hawaii (29 percent), and Kentucky, Nebraska, Connecticut, New Mexico, and Texas (27 percent each).

- Eighteen States met the 20 percent set-aside requirement, but did not exceed it.

- States spending the greatest proportions of Block Grant expenditures on treatment, when compared with other States, included North Dakota (80 percent), Colorado (78 percent), and Alaska, Arkansas, Missouri, and West Virginia (76 percent each). States spending the smallest proportions included Hawaii (61 percent), Texas (65 percent), and Tennessee, North Carolina, and Idaho (66 percent each).

- Twenty-one States spent 5 percent or more of Block Grant funds on HIV early intervention in FY 2003.

Table 2.6. Single State Agency Expenditures of Block Grant Funds by Activity, FY 2003

State	Treatment		Prevention		HIV Early Intervention*		Other**		BG Total
	$	%	$	%			$	%	$
Alabama	17,152,741	72	4,930,210	21	1,249,858	5	637,387	3	23,970,196
Alaska	3,408,015	76	899,135	20	0	0	185,306	4	4,492,456
Arizona	22,343,290	73	6,115,130	20	1,527,437	5	562,886	2	30,548,743
Arkansas	9,192,448	76	2,406,920	20	0	0	570,609	5	12,169,977
California	176,162,084	70	57,199,375	23	12,187,398	5	5,223,583	2	250,772,440
Colorado	18,280,906	78	4,916,473	21	0	0	168,629	1	23,366,008
Connecticut	11,418,255	68	4,617,482	27	843,986	5	0	0	16,879,723
Delaware	4,469,272	68	1,514,936	23	328,862	5	264,175	4	6,577,245
Dist. of Columbia	4,398,806	70	1,330,593	21	120,016	2	417,251	7	6,266,666
Florida	63,319,338	67	24,719,689	26	4,753,209	5	2,271,953	2	95,064,189
Georgia	33,490,123	71	10,836,486	23	2,484,821	5	651,249	1	47,462,679
Hawaii	4,341,242	61	2,080,096	29	360,071	5	302,491	4	7,083,900
Idaho	4,484,320	66	2,087,456	31	0	0	215,387	3	6,787,163
Illinois	47,434,191	70	13,768,851	20	3,399,717	5	3,391,568	5	67,994,327
Indiana	24,620,121	74	7,185,330	21	0	0	1,641,272	5	33,446,723
Iowa	9,543,565	74	2,726,377	21	0	0	645,785	5	12,915,707
Kansas	8,973,931	73	2,852,110	23	0	0	517,360	4	12,343,401
Kentucky	15,197,700	73	5,550,682	27	0	0	3,752	0	20,752,134
Louisiana	18,171,765	70	5,191,933	20	1,297,984	5	1,297,983	5	25,959,665
Maine	4,870,969	75	1,363,847	21	0	0	227,554	4	6,462,370
Maryland	22,480,317	70	6,422,948	20	1,605,737	5	1,605,737	5	32,114,739
Massachusetts	23,660,678	69	7,825,701	23	1,490,933	4	1,196,796	4	34,174,108
Michigan	42,021,077	72	13,249,022	23	0	0	2,872,962	5	58,143,061
Minnesota	16,324,664	75	4,610,981	21	0	0	848,062	4	21,783,707
Mississippi	9,897,947	70	2,827,985	20	706,996	5	706,996	5	14,139,924
Missouri	19,841,893	76	5,253,735	20	0	0	1,173,041	4	26,268,669
Montana	4,913,384	75	1,316,159	20	0	0	347,702	5	6,577,245
Nebraska	5,545,248	70	2,134,625	27	0	0	246,309	3	7,926,182
Nevada	8,999,740	70	2,573,503	20	643,008	5	643,898	5	12,860,149
New Hampshire	4,895,715	74	1,352,668	21	0	0	328,862	5	6,577,245
New Jersey	32,660,983	69	10,679,913	23	2,356,962	5	1,441,378	3	47,139,236
New Mexico	5,882,851	68	2,343,564	27	0	0	388,497	5	8,614,912
New York	83,470,927	72	23,845,680	21	5,800,010	5	2,883,319	2	115,999,936
North Carolina	25,017,161	66	7,954,361	21	1,960,751	5	3,256,751	9	38,135,024
North Dakota	3,970,641	80	1,013,452	20	0	0	0	0	4,984,093
Ohio	47,461,285	71	16,270,812	24	0	0	3,210,172	5	66,942,269
Oklahoma	13,341,630	75	3,557,768	20	0	0	889,442	5	17,788,840
Oregon	12,073,630	75	3,219,634	20	0	0	804,908	5	16,098,172
Pennsylvania	41,341,898	70	12,627,524	21	3,178,073	5	2,189,312	4	59,336,807
Rhode Island	4,738,905	72	1,727,982	26	0	0	110,358	2	6,577,245
South Carolina	15,429,544	75	4,136,827	20	1,033,082	5	62,180	0	20,661,633
South Dakota	3,450,509	75	927,941	20	0	0	230,445	5	4,608,895
Tennessee	19,452,248	66	6,973,848	24	1,514,511	5	1,450,617	5	29,391,224
Texas	87,289,044	65	35,844,543	27	6,666,557	5	3,522,185	3	133,322,329
Utah	12,690,265	75	3,693,865	22	0	0	530,000	3	16,914,130
Vermont	3,695,916	75	985,578	20	0	0	246,394	5	4,927,888
Virginia	29,852,916	70	8,511,634	20	2,126,330	5	2,035,712	5	42,526,592
Washington	24,587,971	70	9,118,562	26	0	0	1,419,140	4	35,125,673
West Virginia	6,468,098	76	1,784,561	21	0	0	312,142	4	8,564,801
Wisconsin	19,496,217	75	6,281,389	24	0	0	99,744	0	25,877,350
Wyoming	2,376,379	74	637,139	20	0	0	180,277	6	3,193,795

SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

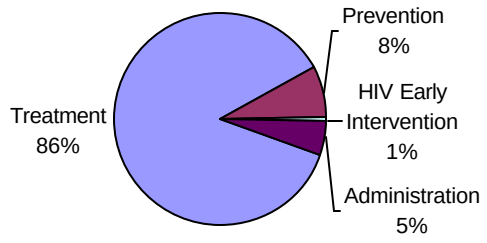
*States with a specified HIV/AIDS case rate of 10 or more per 100,000 must spend a portion of their SAPT Block Grant funds (usually 5%) on HIV early intervention activities.

**Other activities include HIV early intervention, TB services, and administrative costs.

Expenditures of State Funds

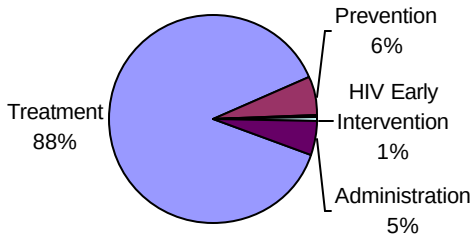
Nationally, SSA expenditures of State funds increased from $1.5 billion in FY 2000 to $1.7 billion in FY 2003 (figure 2.12, table 2.7). The largest proportion of expenditures consistently went toward treatment and rehabilitation activities, accounting for 86 to 88 percent of State funding, and increasing from $1.3 billion in FY 2000 to $1.4 billion in FY 2003 (figures 2.10–2.11). Expenditures on prevention services consistently accounted for 6 to 8 percent of total State funding during this time period, and administrative costs accounted for 5 to 6 percent of total State expenditures.

Figure 2.10. Expenditures of State Funds by Activity, FY 2000



***N*=$1.5 billion**

Figure 2.11. Expenditures of State Funds by Activity, FY 2003



***N*=$1.7 billion**

Figure 2.12. National Expenditures of State Funds by Activity, FYs 2000–2003 (n=51)

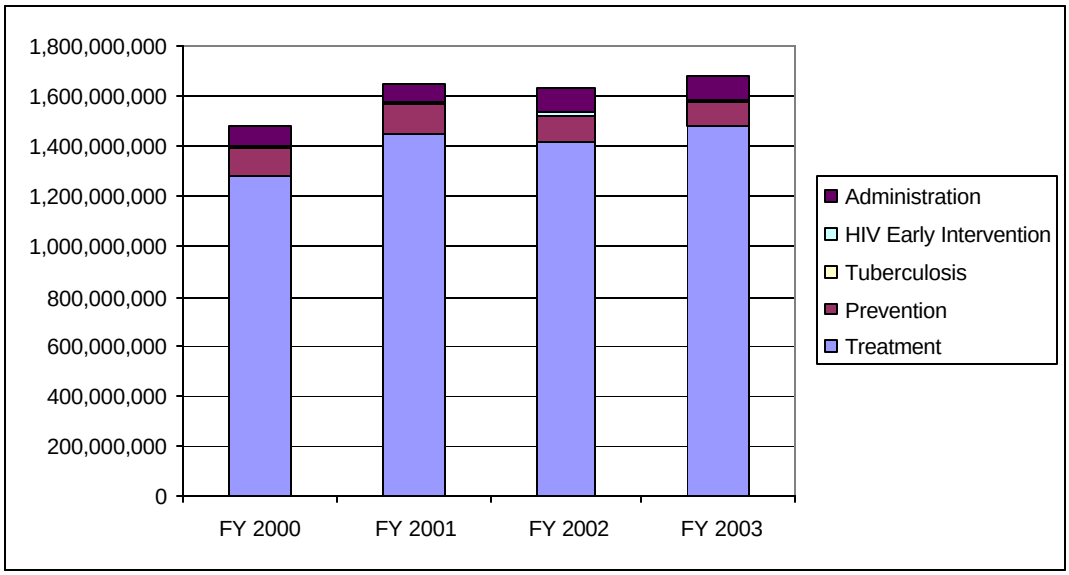


Table 2.7. Expenditures of State Funds for All Single State Agencies by Activity, FYs 2000–2003 (n=51)

Activity	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Treatment	1,284,639,457	86	1,449,613,033	88	1,420,400,518	87	1,479,740,375	88
Prevention	112,766,350	8	115,746,768	7	103,749,822	6	98,543,763	6
Tuberculosis	453,050	0	578,437	0	532,669	0	564,241	0
HIV Early Intervention	7,449,812	1	8,657,897	1	12,632,048	1	9,913,994	1
Administration	78,907,558	5	76,536,176	5	93,457,117	6	90,326,183	5
TOTAL*	**1,484,216,227**	**100**	**1,651,132,311**	**100**	**1,630,772,174**	**100**	**1,679,088,556**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
* Totals may not equal 100 percent due to rounding.

Examination of individual State data shows greater variation in the distribution of expenditures from State sources than from the Block Grant. In FY 2003, SSAs spent an average of 88 percent of State funds on treatment and rehabilitation services (range 37 to 100 percent), 6 percent on prevention services (range 0 to 25 percent), and 6 percent on other services including administrative costs, HIV early intervention, and tuberculosis services (table 2.8). Specific findings include:

- Only three SSAs spent 20 percent or more of State funds on prevention services. These States included Wisconsin (25 percent), Tennessee (23 percent), and Rhode Island (20 percent). Other SSAs spending a larger proportion of State funds on prevention activities included Michigan (19 percent), Delaware, New Hampshire, and New Mexico (at 17 percent each).

- Seventeen SSAs spent 0 percent of State funds on prevention services (including three SSAs that expended so little, it accounted for 0 percent). States spending 0 percent of State funds on prevention services are indicated in bold on table 2.8.

- The majority of SSAs (43 of the 50 States and the District of Columbia) spent 75 percent or more of State funds on treatment and rehabilitation services, of which 7 SSAs spent all (100 percent) of their State funds on treatment. The seven States spending 100 percent were Georgia, Idaho, Louisiana, Massachusetts, North Dakota, South Carolina, and Virginia. Other SSAs spending a large proportion of State funds on treatment included Arizona, California, Nevada, and West Virginia (at 99 percent each). States spending the smallest proportions included Alaska (37 percent), Michigan (52 percent), and Pennsylvania and New Mexico (at 63 percent each).

- Most States spent less than 20 percent of State funds on other activities. SSAs indicating spending the greatest proportions of State funds on other activities included Alaska (which spent 47 percent on administration), Michigan (which spent 20 percent on administration and 10 percent on HIV early intervention), Pennsylvania (which spent 24 percent on administration), New Mexico (which spent 20 percent on administration), Maine (which spent 15 percent on administration and 3 percent on HIV early intervention), and Arkansas (which spent 17 percent on administration). Ten SSAs did not spend State funds on other activities.

Table 2.8. Single State Agency Expenditures of State Funds by Activity, FY 2003*

State	Treatment		Prevention		Other**		Total
	$	%	$	%	$	%	$
Alabama	**4,518,640**	**96**	**0**	**0**	**207,615**	**4**	**4,726,255**
Alaska	8,691,771	37	3,670,956	16	11,113,354	47	23,476,081
Arizona	14,604,477	99	146,401	1	0	0	14,750,878
Arkansas	**4,641,505**	**83**	**0**	**0**	**919,844**	**17**	**5,561,349**
California	**189,402,376**	**99**	**274,836**	**0**	**2,181,705**	**1**	**191,858,917**
Colorado	10,340,271	94	698,938	6	0	0	11,039,209
Connecticut	49,250,158	93	3,056,000	6	466,846	1	52,773,004
Delaware	10,061,665	83	2,102,110	17	0	0	12,163,775
District of Columbia	21,262,226	88	1,607,513	7	1,307,476	5	24,177,215
Florida	64,407,293	94	1,588,762	2	2,186,781	3	68,182,836
Georgia	**46,378,871**	**100**	**0**	**0**	**0**	**0**	**46,378,871**
Hawaii	**7,959,833**	**88**	**25,000**	**0**	**1,060,810**	**12**	**9,045,643**
Idaho	**3,819,401**	**100**	**0**	**0**	**0**	**0**	**3,819,401**
Illinois	110,833,082	92	6,234,718	5	4,015,394	3	121,083,194
Indiana	**9,590,831**	**91**	**35,838**	**0**	**967,449**	**9**	**10,594,118**
Iowa	14,173,390	91	945,924	6	432,760	3	15,552,074
Kansas	6,408,370	83	864,529	11	469,416	6	7,742,315
Kentucky	10,892,858	78	1,776,995	13	1,321,306	9	13,991,159
Louisiana	**22,605,911**	**100**	**0**	**0**	**0**	**0**	**22,605,911**
Maine	7,756,371	71	1,183,963	11	1,917,556	18	10,857,890
Maryland	60,455,542	93	1,462,839	2	3,323,134	5	65,241,515
Massachusetts	**45,562,409**	**100**	**0**	**0**	**75,000**	**0**	**45,637,409**
Michigan	11,334,531	52	4,115,363	19	6,473,217	30	21,923,111
Minnesota	56,866,067	98	854,163	1	368,656	1	58,088,886
Mississippi	**4,088,372**	**98**	**0**	**0**	**96,176**	**2**	**4,184,548**
Missouri	24,292,141	87	773,017	3	2,981,634	11	28,046,792
Montana	**3,541,745**	**92**	**0**	**0**	**289,203**	**8**	**3,830,948**
Nebraska	9,969,310	97	89,411	1	255,380	2	10,314,101
Nevada	3,609,093	99	42,000	1	0	0	3,651,093
New Hampshire	4,186,535	69	998,975	17	852,993	14	6,038,503
New Jersey	55,445,770	98	652,405	1	454,825	1	56,553,000
New Mexico	14,074,316	63	3,677,961	17	4,491,090	20	22,243,367
New York	253,564,695	80	42,507,362	13	22,667,402	7	318,739,459
North Carolina	**48,371,348**	**95**	**0**	**0**	**2,513,559**	**5**	**50,884,907**
North Dakota	**6,690,061**	**100**	**0**	**0**	**31,394**	**0**	**6,721,455**
Ohio	47,325,308	81	3,263,239	6	7,697,617	13	58,286,164
Oklahoma	19,786,536	88	860,302	4	1,918,084	9	22,564,922
Oregon	10,375,167	91	985,390	9	0	0	11,360,557
Pennsylvania	26,653,952	63	5,057,069	12	10,264,979	24	41,976,000
Rhode Island	8,400,066	67	2,473,724	20	1,578,084	13	12,451,874
South Carolina	**7,123,678**	**100**	**0**	**0**	**4,366**	**0**	**7,128,044**
South Dakota	**3,056,701**	**93**	**0**	**0**	**245,308**	**7**	**3,302,009**
Tennessee	5,536,445	69	1,843,963	23	586,166	7	7,966,574
Texas	16,934,997	92	673,295	4	859,240	5	18,467,532
Utah	10,059,708	88	941,092	8	487,652	4	11,488,452
Vermont	4,332,636	82	741,493	14	185,553	4	5,259,682
Virginia	**39,859,035**	**100**	**0**	**0**	**0**	**0**	**39,859,035**
Washington	44,325,677	92	976,673	2	2,951,484	6	48,253,834
West Virginia	**7,532,320**	**99**	**0**	**0**	**46,743**	**1**	**7,577,063**
Wisconsin	2,934,552	75	962,771	25	0	0	3,897,323
Wyoming	5,854,362	86	378,773	6	537,167	8	6,770,302

SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

*States spending 0 percent of State funds on prevention services are indicated in bold.

**Other activities include HIV early intervention, TB services, and administrative costs.

Prevention Services

The SSA is responsible for administering prevention programs across the State. Most States have systems in place to select or develop, implement, monitor, and evaluate prevention programs that address ATOD issues. Most States also have a theoretical framework that focuses on risk and protective factors with the aim of reducing risk factors and increasing protective factors related to substance abuse among individuals and their peers, families, schools, and communities. Some States also mention using other theoretical frameworks, most notably, those focusing on assets and resiliency. Generally, States indicate wanting to help their residents build healthy lifestyles and acquire skills that reduce their risk of later developing alcohol or drug dependence. States indicate implementing programs to develop strong, positive self-images among their residents and to educate residents about the dangers of alcohol and drugs among children, adolescents, and adults.

Arizona - Over the past decade, Arizona's prevention system has evolved into a research-based, comprehensive system based on a risk and protective factor framework. Arizona employs a logic model to identify appropriate targets for prevention, select strategies, and evaluate outcomes. The State has integrated prevention services into the treatment and rehabilitation continuum; this integration stretches resources to serve more people with appropriate services.

Many States mention using the Institute of Medicine classification system for selecting and implementing strategies and ensuring that they address "universal," "selective," and "indicated" populations. States also mention making sure that prevention is integrated into the treatment and rehabilitation continuum and support early intervention strategies for those who have participated in illegal use of ATOD to determine whether behavior can be reversed through education. Most SSAs partner and/or collaborate with other State agencies such as departments of police, education, justice, highway safety, health, and transportation; the National Guard; and Safe and Drug-Free Schools to deliver prevention services.

Virginia - The Prevention Service Unit Manager is part of the Governor's Office for Substance Abuse Prevention Collaborative, which is developing and maintaining a statewide, cross-system social data indicator and youth survey database and developing a statewide prevention plan. The collaborative includes the State prevention directors in the departments of education, social services, juvenile justice, criminal justice, motor vehicles, and health; the Alcohol Beverage Control Board; the Virginia Tobacco Settlement Foundation; and the National Guard.

States are recognizing the Center for Substance Abuse Prevention (CSAP) shift to using the Srategic Prevention Framework (SPF) as a tool to strengthen prevention systems and are becoming more actively engaged in implementing the steps of the SPF, which include (1) conducting a comprehensive needs assessment to assess population needs and to measure resources and readiness to meet those needs; (2) building capacity among the prevention workforce to deliver prevention services and strategies; (3) planning a comprehensive approach to prevention programs, policies, and strategies to have the most impact; (4) implementing programs that have proved to be effective; and (5) evaluating the chosen policies, strategies, and programs and their impact on program recipients and communities. CSAP has awarded SPF State Incentive Grants (SIGs) to 17 States to help States strengthen their prevention infrastructure to deliver prevention services.

New Mexico - New Mexico maintains the philosophy that prevention strategies and programs are best formulated at the local level. Therefore, the system is designed to empower local communities and prevention providers. Programs located throughout New Mexico provide a wide variety of prevention services, and are required to submit a community needs assessment, a community plan, an implementation plan, and an outcome evaluation plan.

Single State Agency Responsibilities

The SSA responsibilities for prevention activities generally involve one or more of the following:

- Conducting statewide needs assessment and planning or assisting substate entities in conducting needs assessment and planning for prevention services
- Marketing prevention to policymakers and State leaders; developing and implementing a policy that addresses ATOD prevention
- Procuring and managing funding, including the SAPT Block Grant, the SIG/SPF SIG, SAMHSA discretionary grants, State monies, and other funds
- Procuring, contracting for, and managing substance abuse prevention contracts
- Selecting, implementing, monitoring, and evaluating prevention programs and strategies
- Fostering networks and/or collaboration with other State agencies and among substate entities
- Selecting and supporting strategies to train and maintain an effective prevention workforce
- Meeting Synar requirements related to youth access to tobacco

Wisconsin - The Brighter Futures Initiative (BFI) is a legislatively created initiative that funds 10 youth development programs, with the goal to assist youth and families in becoming safe, healthy, self-sufficient members of their community. BFI grantees receive enhanced technical assistance and access to current research on best practices in community, youth, and family development strategies to achieve their stated goals and benchmarks.

System Configuration

The configuration of State prevention services delivery systems varies. States administer programs at the State level or contract with other entities at the regional, county, or local level. States may select public, private, for-profit, not-for-profit, or a mix of such agencies to deliver services. As such, States or substate entities are responsible for an array of activities, including one or more of the following:

- Sponsoring/providing conferences, training, and/or technical assistance to providers and others; workforce development training for providers, State and substate staff, and others involved in prevention efforts; workplace development; community coalition building; and youth mentoring
- Providing technical assistance to contractors on evidence-based programs, building infrastructure, conducting needs assessment, and/or developing coalitions
- Selecting and implementing evidence- and research-based programs targeting outcomes and/or intervening variables such as risk and protective factors
- Partnering and/or collaborating with community coalitions, community task forces and policy boards, universities and colleges, and school districts
- Implementing nonscience-based strategies such as information dissemination and participating at health fairs, community festivals, conferences, and other large public gatherings

Rhode Island - Key to the State's prevention strategy and infrastructure is the Student Assistance Plan (SAP), which operates in 21 high schools and 25 junior and middle schools throughout the State. SAP places student assistance counselors in every secondary school to assess and educate students. SAP's design is built on a research foundation, has been a core component of Rhode Island's prevention system for more than two decades, and is nationally recognized for its effectiveness.

Most States indicate that their primary target population is youth. Others mention targeting children of people who abuse substances, parents, school personnel, housing authority staff and residents, senior citizens, college or university students, employees, participants in juvenile and adult probation programs, and the disabled community. Some States mention targeting specific ethnic minorities, including Native Americans, African Americans, and/or Hispanics/Latinos.

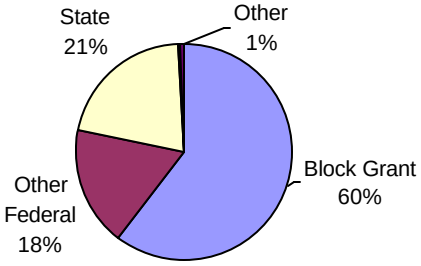
> ***South Dakota*** - The two-tiered Diversion Program refers juveniles entering the court system for alcohol- or drug-related offenses to either the Primary Prevention Program (10 hours) or the Intensive Prevention Program (30 hours). Each includes a family component and an early intervention strategy.

Prevention Funding and Expenditures

SSA expenditures on prevention activities remained fairly stable from FY 2000 through FY 2003 and increased slightly over time from $538 million in FY 2000 to $560 million in FY 2003 (figure 2.15, table 2.9). The majority of prevention expenditures derived from the Block Grant, which accounted for 60 to 67 percent of total prevention expenditures (increasing from $324 million in FY 2000 to $372 million in FY 2003)(figures 2.13–2.14). Expenditures from State funds accounted for 18 to 21 percent of total prevention expenditures, and other Federal funds accounted for 14 to 18 percent.

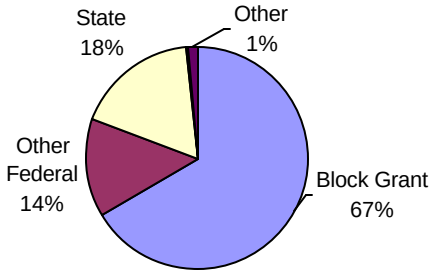
Some States were awarded a Program of Regional and National Significance (PRNS) grant through CSAP, including the SPF SIG. Expenditures from these sources are generally reported by States as other Federal expenditures. Additional information on PRNS and the SPF SIG is found in the Discretionary Funding portion of the Aggregate Findings.

Figure 2.13. Expenditures on Prevention Services by Funding Source, FY 2000



***N*=$538 million**

Figure 2.14. Expenditures on Prevention Services by Funding Source, FY 2003



***N*=$560 million**

Figure 2.15. National Expenditures for Prevention Services by Funding Source, FYs 2000–2003 (n=51)

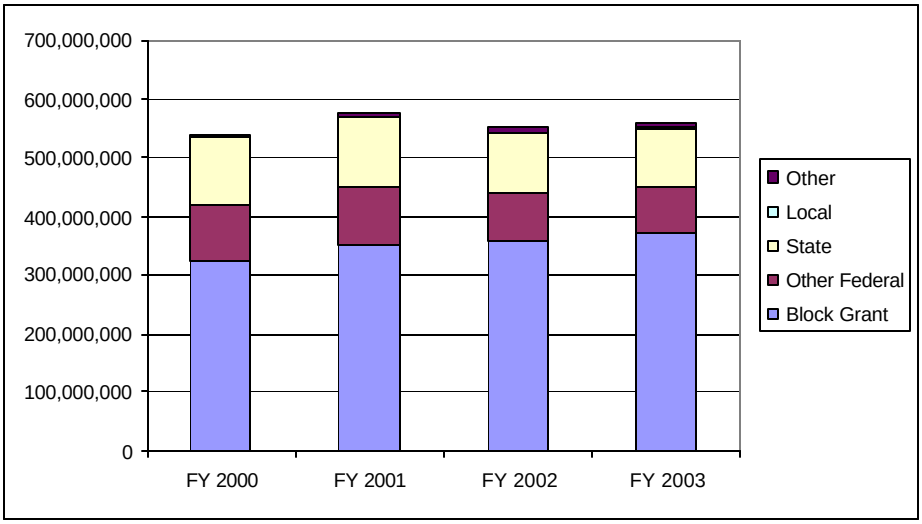


Table 2.9. Single State Agency Expenditures for Prevention Services From All Funding Sources, FYs 2000–2003

Funding Source	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Block Grant	324,333,222	60	351,498,950	61	357,719,619	65	371,997,015	67
Other Federal	96,615,991	18	100,978,133	18	80,817,742	15	80,170,874	14
State	112,766,350	21	115,746,768	20	103,749,822	19	98,543,763	18
Local	880,632	0	1,000,170	0	965,623	0	1,026,142	0
Other	3,567,459	1	6,527,754	1	9,110,009	2	8,229,307	1
TOTAL*	**538,163,654**	**100**	**575,751,775**	**100**	**552,362,815**	**100**	**559,967,101**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
* Totals may not equal 100 percent due to rounding.

In 2003, 67 percent of national expenditures on prevention services came from Block Grant funds (range 9 to 100 percent), 18 percent came from the State (range 0 to 57 percent), 14 percent came from other Federal sources (range 0 to 69 percent), and 1 percent came from local and other sources (range 0 to 30 percent) (table 2.10). Specific highlights include the following:

- Seven SSAs received all (100 percent) of their prevention funds from the Block Grant. These States included Alabama, Arkansas, Louisiana, Massachusetts, Mississippi, Virginia, and West Virginia. Other States spending a higher proportion Block Grant funds on prevention services, when compared with other States, included Arizona (98 percent), New Jersey (94 percent), and California and Texas (93 percent each). SSAs for which Block Grant funds constituted the smallest proportions included Wyoming and Alaska (at 9 percent), Maine (16 percent), and Rhode Island (23 percent).

- Seventeen SSAs spent 0 percent of State funds on prevention services (including three SSAs that expended so little, it accounted for 0 percent). States spending 0 percent of State funds on prevention services are indicated in bold on table 2.8.

- States spending the largest proportion of State funds on prevention services, when compared with other States, included New York (57 percent), Delaware (52 percent), New Mexico (48 percent), and Vermont (43 percent).

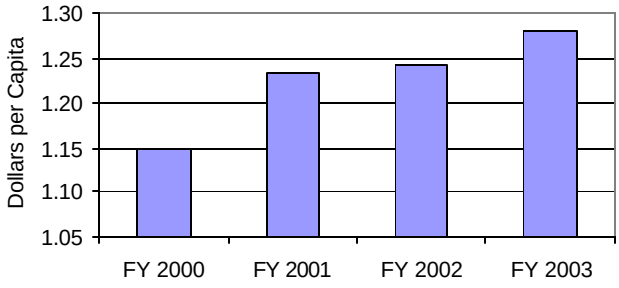
- States spending the largest proportion of funds from other Federal sources, when compared with other States, included Maine (69 percent), Wyoming (56 percent), Alaska (52 percent), and North Dakota (50 percent). Fifteen States received no prevention funding from other Federal sources.

- Eight States spent local and other funds for prevention activities in FY 2003. These States included Connecticut (30 percent), Wyoming (30 percent), and Pennsylvania (5 percent).

Per Capita Expenditures of Block Grant Funds for Prevention Services

On average, per capita Block Grant funding for primary prevention activities increased steadily for the United States as a whole, from $1.15 in FY 2000 to $1.28 in FY 2003 (figure 2.16). Examination of individual State-level data show that States varied somewhat in their Block Grant expenditures per capita on prevention services (range $0.88 to $2.39 for FY 2003). Specific findings for FY 2003 include the following:

Figure 2.16. Block Grant Expenditures on Prevention Services Per Capita, FYs 2001–2003 (n=51)



- States spending the greatest amount of Block Grant funds per capita on prevention activities included the District of Columbia ($2.39 per capita), Delaware ($1.85), Hawaii ($1.67) and Texas ($1.62).

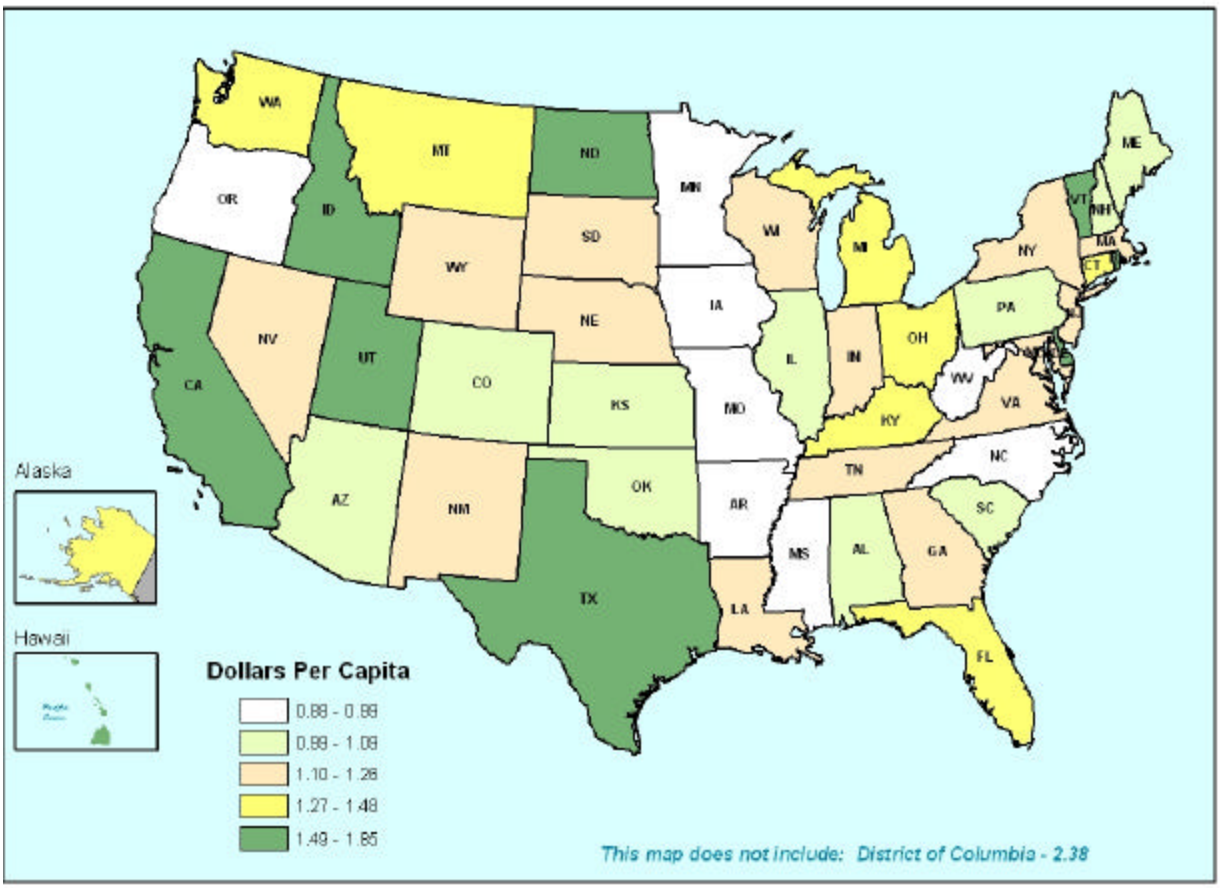
- States with the lowest rate of Block Grant funding per capita were Arkansas ($0.88 per capita), Oregon ($0.90), Minnesota ($0.91), and Missouri ($0.92). See figure 2.17 and Appendix A for details.

Table 2.10. Expenditures for Prevention Services by From All Funding Sources, FY 2003

State	Block Grant		Other Federal		State		Local and Other		Total
	$	%	$	%	$	%	$	%	$
Alabama	4,930,210	100	0	0	0	0	0	0	4,930,210
Alaska	899,135	9	4,939,973	52	3,670,956	39	0	0	9,510,064
Arizona	6,115,130	98	0	0	146,401	2	0	0	6,261,531
Arkansas	2,406,920	100	0	0	0	0	0	0	2,406,920
California	57,199,375	93	4,317,489	7	274,836	0	0	0	61,791,700
Colorado	4,916,473	80	565,836	9	698,938	11	0	0	6,181,247
Connecticut	4,617,482	30	2,993,489	20	3,056,000	20	4,487,993	30	15,154,964
Delaware	1,514,936	37	458,511	11	2,102,110	52	0	0	4,075,557
District of Columbia	1,330,593	28	1,742,903	37	1,607,513	34	0	0	4,681,009
Florida	24,719,689	90	0	0	1,588,762	6	1,184,678	4	27,493,129
Georgia	10,836,486	82	2,407,940	18	0	0	0	0	13,244,426
Hawaii	2,080,096	51	2,012,169	49	25,000	1	0	0	4,117,265
Idaho	2,087,456	86	325,849	14	0	0	0	0	2,413,305
Illinois	13,768,851	63	1,730,932	8	6,234,718	29	0	0	21,734,501
Indiana	7,185,330	83	1,446,363	17	35,838	0	0	0	8,667,531
Iowa	2,726,377	39	3,276,141	47	945,924	14	0	0	6,948,442
Kansas	2,852,110	76	16,046	0	864,529	23	0	0	3,732,685
Kentucky	5,550,682	62	1,639,849	18	1,776,995	20	0	0	8,967,526
Louisiana	5,191,933	100	0	0	0	0	0	0	5,191,933
Maine	1,363,847	16	5,775,391	69	1,183,963	14	0	0	8,323,201
Maryland	6,422,948	81	0	0	1,462,839	19	0	0	7,885,787
Massachusetts	7,825,701	100	0	0	0	0	0	0	7,825,701
Michigan	13,249,022	74	589,378	3	4,115,363	23	0	0	17,953,763
Minnesota	4,610,981	84	0	0	854,163	16	0	0	5,465,144
Mississippi	2,827,985	100	0	0	0	0	0	0	2,827,985
Missouri	5,253,735	63	2,284,869	27	773,017	9	0	0	8,311,621
Montana	1,316,159	66	664,663	34	0	0	0	0	1,980,822
Nebraska	2,134,625	77	494,934	18	89,411	3	36,925	1	2,755,895
Nevada	2,573,503	52	2,299,133	47	42,000	1	3,760	0	4,918,396
New Hampshire	1,352,668	50	377,640	14	998,975	37	0	0	2,729,283
New Jersey	10,679,913	94	0	0	652,405	6	0	0	11,332,318
New Mexico	2,343,564	31	1,566,618	21	3,677,961	48	0	0	7,588,143
New York	23,845,680	32	8,569,756	11	42,507,362	57	0	0	74,922,798
North Carolina	7,954,361	80	1,993,324	20	0	0	0	0	9,947,685
North Dakota	1,013,452	50	1,031,462	50	0	0	0	0	2,044,914
Ohio	16,270,812	66	5,272,948	21	3,263,239	13	0	0	24,806,999
Oklahoma	3,557,768	65	1,092,879	20	860,302	16	0	0	5,510,949
Oregon	3,219,634	62	961,834	19	985,390	19	0	0	5,166,858
Pennsylvania	12,627,524	59	2,549,326	12	5,057,069	24	989,217	5	21,223,136
Rhode Island	1,727,982	23	3,202,232	43	2,473,724	33	0	0	7,403,938
South Carolina	4,136,827	52	3,801,608	48	0	0	15,419	0	7,953,854
South Dakota	927,941	62	567,764	38	0	0	0	0	1,495,705
Tennessee	6,973,848	76	411,079	4	1,843,963	20	0	0	9,228,890
Texas	35,844,543	93	1,587,694	4	673,295	2	458,854	1	38,564,386
Utah	3,693,865	46	3,320,604	42	941,092	12	0	0	7,955,561
Vermont	985,578	57	0	0	741,493	43	0	0	1,727,071
Virginia	8,511,634	100	0	0	0	0	0	0	8,511,634
Washington	9,118,562	90	0	0	976,673	10	0	0	10,095,235
West Virginia	1,784,561	100	0	0	0	0	0	0	1,784,561
Wisconsin	6,281,389	87	0	0	962,771	13	0	0	7,244,160
Wyoming	637,139	9	3,882,248	56	378,773	5	2,078,603	30	6,976,763

SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

Figure 2.17. Block Grant Expenditures Per Capita on Prevention Services, FY 2003



SOURCE: FY 2006 SAPT Block Grant applications and U.S. Census estimates

Core Strategies

SAMHSA requires States to submit information about their activities related to CSAP's six core prevention strategies in their Block Grant application which include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environmental strategies[4]. SAMHSA also requests that States document their reported and intended expenditures in the same six areas in the SAPT Block Grant application. A description of the strategies is provided below. To see highlights from States and the District of Columbia, see Appendix B.

Information Dissemination activities provide awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. These activities also provide knowledge and awareness of available prevention resources, programs, and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of information activities include clearinghouses/ information resource centers, media campaigns, brochures, resource directories, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

[4] DHHS Block Grant 45 CFR Section 96.124 (2005)

Education activities affect critical life and social skills, including decisionmaking, refusal skills, and critical analysis of media messages. These activities involve two-way communication, with the interaction between the educator/facilitator and the participant being the basis of the activity. Activities under this strategy include classroom and/or small group sessions for youth or other groups, parenting and family management classes, peer leader/helper programs, and groups for children with parents who abuse substances.

Alternative activities provide opportunities for persons from target populations to participate in activities that exclude ATOD use. The underlying assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and drugs. Examples of activities under this strategy include drug-free dances and parties, youth and/or adult leadership activities, community drop-in centers, and community service activities.

Problem identification and referral activities identify persons who have participated in illegal use of tobacco or alcohol and those who have experimented in the first use of illicit drugs to assess whether their behavior can be reversed through education. They do not include any activities to determine whether a person is in need of treatment. Examples of such activities include employee assistance programs, student assistance programs, and driving under the influence (DUI)/driving while intoxicated education programs.

Community-based process strategies enhance the ability and capacity of the community to effectively provide ATOD prevention and treatment services. Activities in this strategy include organizing, conducting needs assessments, planning, enhancing efficiency and effectiveness of service implementation, evaluation, interagency collaboration, coalition building, and networking. Examples of activities used for this strategy include fostering sustainable community coalitions, engaging local stakeholders (government officials, schools, law enforcement, and others), conducting community and volunteer training, systematic planning, procuring funding, and community teambuilding.

Environmental strategies establish or change written and unwritten community standards, codes, attitudes, and norms, thereby influencing incidence and prevalence of ATOD use and abuse in the general population. This strategy is divided into two subcategories to distinguish between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives. Examples of activities used for this strategy include promoting the establishment and review of ATOD use policies in schools, review and advocacy of laws that limit ATOD use in public places, technical assistance to communities to maximize local enforcement efforts governing availability and distribution of alcohol and tobacco, modifying alcohol and tobacco advertising practices, and product pricing strategies.

While not an original CSAP core strategy, activities that fall under the ***Section 1926*** category are of interest to and monitored by CSAP. Activities in this category are generally designed to facilitate State compliance of the Synar amendment regulation with the aim of reducing youth access to tobacco products[5]. Activities in Section 1926 may include merchant or community education, or conducting the Synar compliance inspection survey and analyzing the results.

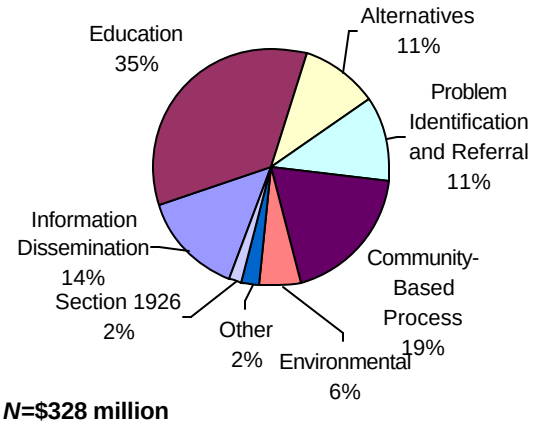
The ***other*** category that States complete as part of the Block Grant application is designed to capture spending outside the core prevention strategies. Expenditures in this category may include the hiring of contractors to provide specific technical assistance and/or resource development activities, such as quality assurance, research/evaluation, and information systems (this is described in greater detail later in the Aggregate Findings); and other prevention activities that cannot be classified under the six prevention strategies.

[5] DHHS Block Grant 45 CFR Section 96.130 (2005)

Expenditures of Block Grant Funds for Core Strategies

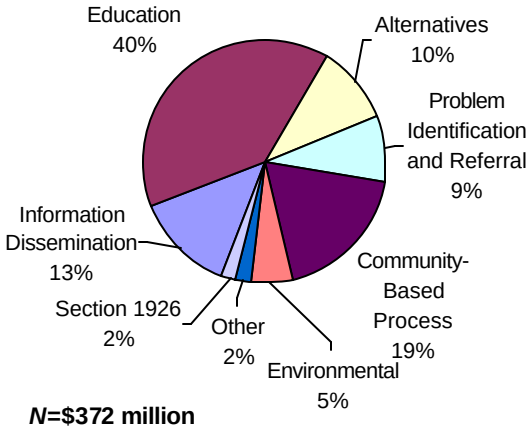
Nationally, Block Grant expenditures for CSAP prevention core strategies increased steadily from $328 million in FY 2000 to $372 million in FY 2003 (figure 2.20, table 2.11). The distribution of expenditures remained relatively stable during this period. Expenditures on education activities accounted for 35 to 40 percent of total expenditures during this period, and community-based process accounted for 17 to 19 percent of funding (figure 2.18–2.19). Problem identification and referral and alternatives each accounted for approximately 10 percent of total funding on core strategies.

Figure 2.18. Expenditures of Block Grant Funds by Core Strategy, FY 2000



***N*=$328 million**

Figure 2.19. Expenditures of Block Grant Funds by Core Strategy, FY 2003



***N*=$372 million**

Figure 2.20. National Expenditures of Block Grant Funds by Core Strategies, FYs 2000–2003

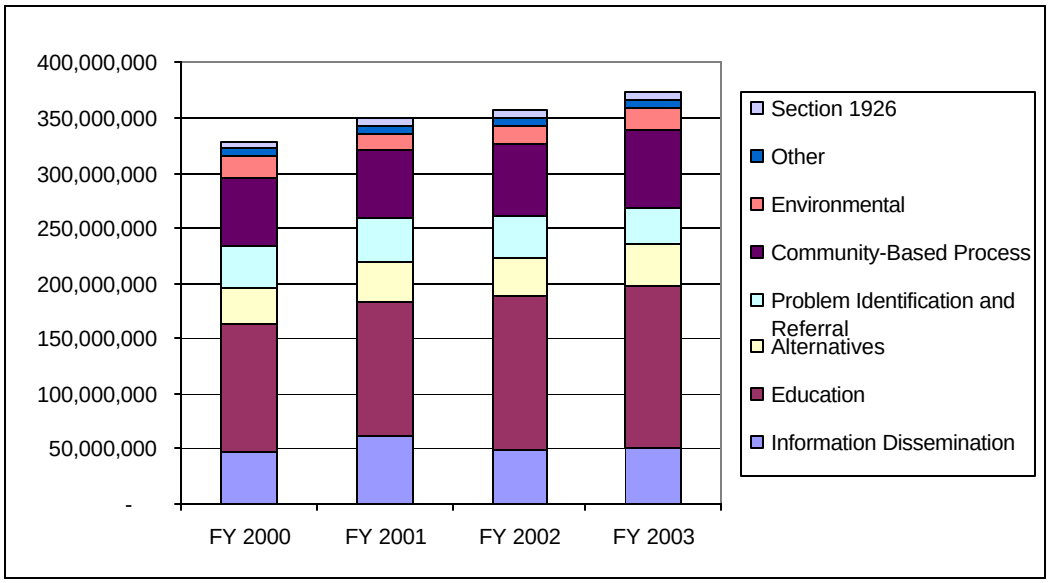


Table 2.11. Single State Agency Expenditures of Block Grant Funds by Core Strategy, FYs 2000–2003

Strategy	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Information Dissemination	46,648,589	14	61,915,036	18	48,985,997	14	50,079,526	13
Education	115,580,653	35	121,616,501	35	140,048,930	39	147,465,094	40
Alternatives	34,603,930	11	36,503,534	10	33,982,248	10	38,653,401	10
Problem Identification and Referral	37,035,536	11	40,184,461	12	37,499,214	11	31,987,165	9
Community-Based Process	62,213,085	19	60,577,797	17	64,809,135	18	70,306,824	19
Environmental	19,210,089	6	15,109,477	4	17,674,906	5	20,332,166	5
Other	6,816,289	2	7,153,152	2	7,269,615	2	6,543,726	2
Section 1926	5,608,827	2	5,819,171	2	5,983,249	2	6,929,228	2
TOTAL*	**327,716,998**	**100**	**348,879,129**	**100**	**356,253,294**	**100**	**372,297,130**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4a

* Totals may not equal 100 percent due to rounding. Dollars spent may not be consistent from table to table due to State reporting discrepancies in the Block Grant applications.

Treatment and Rehabilitation Services

Single State Agency Responsibilities

The primary SSA responsibilities for treatment activities generally involve one or more of the following:

- Conducting statewide needs assessment and planning of treatment services
- Administration of State and Federal funds and compliance with funding requirements
- Development of programs to address the needs of special populations
- Delivery of technical assistance, training, and other workforce development activities for contracted service providers and affiliate agencies
- Quality assurance of contracted services
- Financial support to providers through a competitive bid, grants program, or contracts
- Participation in planning groups and committees concerned with substance abuse, co-occurring substance use and mental disorders, and the treatment system
- Review of provider licensing, including fiscal and data systems reviews

***California*-**. Previously the SSA's role in planning and implementing treatment services was largely fiduciary. However, the SSA has revised its role to one in which the State takes the lead in planning, focuses on actual program performance in its monitoring activities, emphasizes evidence-based practices in its technical assistance, and continually improves all the systems that support treatment services.

System Configuration

Most States use a regional configuration to provide substance abuse treatment services. States administer services themselves, contract with regional or local entities to provide services, or contract with other entities to plan for, manage, and implement services. Most States have both publicly and privately funded treatment programs, and some States contract out all or most of their treatment services. Typically, the types of agencies that SSA contract with include the following:

***Kansas* –** The Kansas treatment system has one point of entry for clients in the four Regional Alcohol and Drug Assessment Centers (RADACs). RADACs provide assessments, outreach, and clinical utilization reviews for persons and families needing substance abuse treatment services in their identified regions, among other things.

- County governments, which may provide direct services or contract out for services
- Community-based programs
- Hospitals
- Not-for-profit organizations
- For-profit organizations
- Managed care organizations
- Correctional programs
- Operating while intoxicated programs

***Iowa* –** Iowa has operated under a managed care system since FY 1996. Providers are reimbursed using the SAPT Block Grant, and State appropriations are contracted to deliver substance abuse treatment services to an agreed-on minimum number of clients or covered lives.

Generally, State-funded services are available to individuals who have low incomes, are indigent, or cannot afford treatment for alcohol or drug addiction. All States are required to provide a continuum

of care that includes outreach, early identification and intervention, assessment, placement, and movement within appropriate levels of treatment, as well as continuing care and support services during the recovery phase.

Treatment services are designed to maintain a cost-effective, high-quality continuum of care for rehabilitating individuals who abuse alcohol and drugs. Most States support basic services that include diagnostic evaluation, client motivational counseling, primary treatment, and followup counseling. Substance abuse treatment services generally include opioid substitution, intensive inpatient, long-term residential, outpatient, recovery house, involuntary, youth residential, and youth outpatient services. In addition, States support and promote peer-based programs, such as Alcoholics Anonymous and Narcotics Anonymous to provide support during and after the primary treatment phase.

> ***Virginia –*** Virginia's SSA does not provide direct alcohol and drug treatment services. Rather, services are contracted to 40 community services boards (CSBs) located throughout the State, which provide direct substance abuse treatment services or contract for services through local providers. The CSBs vary in their composition, organizational structures, and array of services.

Crisis services are typically short in duration and provided in inpatient or outpatient settings. Inpatient rehabilitation services include intensive evaluation and services in a medically supervised setting. Residential services offer intensive treatment and rehabilitation, community residential services, and supportive living services. Outpatient services are delivered at different levels of intensity based on the severity of problems presented and include medically supervised services, outpatient rehabilitation services, and nonmedically supervised outpatient services. Methadone treatment programs administer methadone by prescription in conjunction with a variety of other rehabilitative assistance.

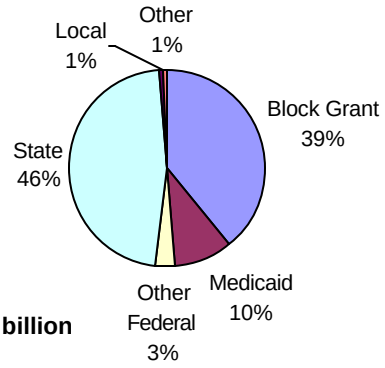
States' target populations for services generally include those who are poor, underinsured, or uninsured. As stipulated in SAPT Block Grant requirements, individuals who are a high priority for admission to treatment services are pregnant women and people who inject drugs. Other populations targeted for treatment services include youth and adults with substance use problems in the criminal justice system, individuals with dual diagnoses, children at risk of substance abuse or with substance use problems, children under the supervision of the State, and older adults with substance use problems. Additionally, some States specify giving priorities to women on welfare, persons with communicable diseases, deaf and hard-of-hearing persons, homeless persons, and social services-involved parents.

Treatment Funding and Expenditures

Nationally, expenditures on treatment and rehabilitation activities increased from $2.7 billion in FY 2000 to $3.2 billion in FY 2003 (figure 2.23, table 2.12)[6]. The proportion of expenditures from the different funding sources remained stable during this time (figures 2.21–2.22). State funds consistently accounted for 46 to 48 percent of total expenditures on treatment (ranging from $1.3 billion in FY 2000 to $1.5 billion in FY 2003). Block Grant funds accounted for 37 to 39 percent of total expenditures on treatment services, and Medicaid accounted for 10 to 12 percent of expenditures.

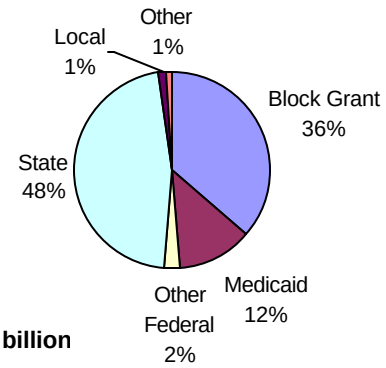
Some States were awarded a Program of Regional and National Significance (PRNS) grant through CSAT, including Access to Recovery (ATR) and Screening, Brief Intervention, Referral and Treatment (SBIRT). Expenditures from these sources are generally reported by States as other Federal expenditures. Information about PRNS, ATR, and SBIRT are found in the Discretionary Funding section of the Aggregate Findings.

Figure 2.21. Expenditures on Treatment Services by Funding Source, FY 2000



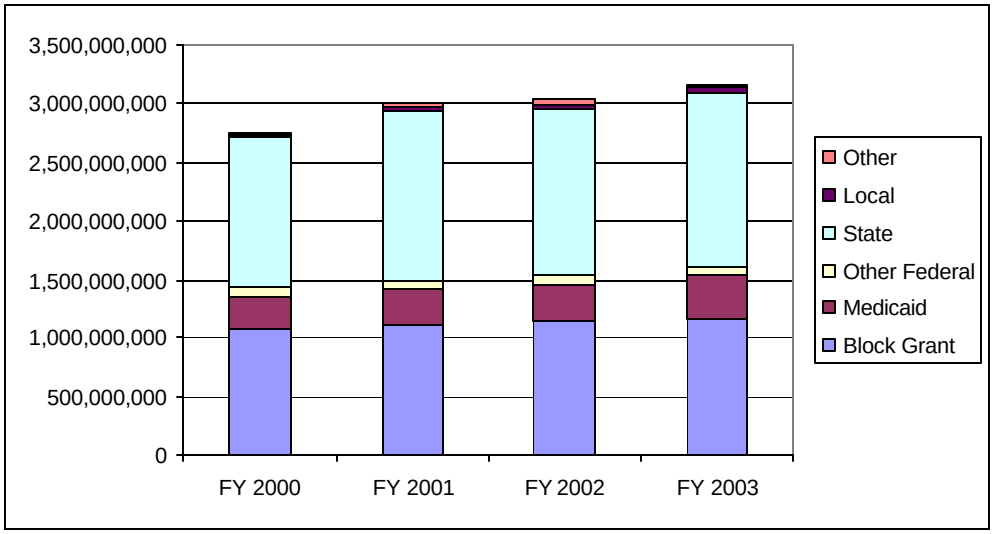
***N*=$2.7 billion**

Figure 2.22. Expenditures on Treatment Services by Funding Source, FY 2003



***N*=$3.2 billion**

Figure 2.23. National Expenditures for Treatment Services by Funding Source, FYs 2000–2003 (n=51)



[6] The Inventory does not include expenditure or financial information from private third-party payers such as commercial health insurers.

Table 2.12. Single State Agency Expenditures for Treatment Services From All Funding Sources, FYs 2000–2003 (n=51)

Funding Source	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Block Grant	1,077,449,834	39	1,096,467,378	37	1,140,561,755	38	1,154,602,763	36
Medicaid	262,729,447	10	306,360,660	10	322,250,498	11	387,480,029	12
Other Federal	86,737,787	3	88,890,282	3	77,230,820	3	77,523,265	2
State	1,284,639,457	46	1,449,613,033	48	1,420,400,518	47	1,479,740,375	48
Local	23,674,923	1	31,198,832	1	35,668,926	1	35,783,850	1
Other	18,172,925	1	31,024,658	1	38,780,304	1	33,300,449	1
TOTAL*	**2,753,404,373**	**100**	**3,003,554,843**	**100**	**3,034,892,821**	**100**	**3,168,430,731**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4
* Totals may not equal 100 percent due to rounding.

Most (48 percent) of the expenditures for treatment and rehabilitation services came from State funds in FY 2003 (range 13 percent to 75 percent), followed by the Block Grant, which accounted for 36 percent of all treatment expenditures (range 15 to 87 percent). For some States, funds from Medicaid contributed to overall treatment expenditures (range 0 to 47 percent)(table 2.13). Specific findings include the following:

- SSAs spending the highest proportions of State funds for treatment services, when compared with other States, included Connecticut (75 percent), the District of Columbia (75 percent), New York (71 percent), and Delaware (69 percent). SSAs spending a smaller proportion of State funds on treatment included Wisconsin and Michigan (13 percent each), Texas (16 percent), and Tennessee and Alabama (19 percent each).

- States spending the highest proportions of Block Grant funds on treatment services, when compared with other States, included Wisconsin (87 percent), Texas (83 percent), and Indiana (72 percent). States spending the smallest proportions of Block Grant funds on treatment included Wyoming (15 percent), District of Columbia (16 percent), and Connecticut (17 percent).

- Half of the SSAs indicated spending Medicaid funds for treatment services. The SSAs spending a higher proportion of Medicaid funds for treatment services included Vermont (47 percent), Oregon (43 percent), and Arizona (40 percent). Half of the SSAs did not indicate using Medicaid funds for treatment services.

Table 2.13. Single State Agency Expenditures for Treatment Services From All Funding Sources, FY 2003

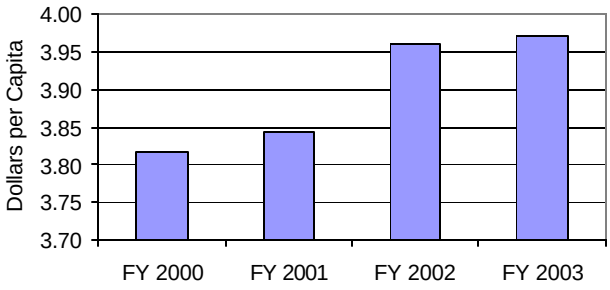
State	Block Grant		Medicaid		State		All Other*		Total
	$	%	$	%	$	%	$	%	$
Alabama	17,152,741	71	2,458,051	10	4,518,640	19	0	0	24,129,432
Alaska	3,408,015	26	181,547	1	8,691,771	66	876,321	7	13,157,654
Arizona	22,343,290	32	28,092,326	40	14,604,477	21	5,056,209	7	70,096,302
Arkansas	9,192,448	60	0	0	4,641,505	30	1,446,874	9	15,280,827
California	176,162,084	37	115,743,764	24	189,402,376	39	324,523	0	481,632,747
Colorado	18,280,906	63	341,854	1	10,340,271	36	0	0	28,963,031
Connecticut	11,418,255	17	0	0	49,250,158	75	4,593,164	7	65,261,577
Delaware	4,469,272	31	0	0	10,061,665	69	0	0	14,530,937
Dist. of Columbia	4,398,806	16	0	0	21,262,226	75	2,607,861	9	28,268,893
Florida	63,319,338	41	7,490,671	5	64,407,293	42	18,642,148	12	153,859,450
Georgia	33,490,123	42	0	0	46,378,871	58	0	0	79,868,994
Hawaii	4,341,242	35	0	0	7,959,833	65	0	0	12,301,075
Idaho	4,484,320	54	0	0	3,819,401	46	53,627	1	8,357,348
Illinois	47,434,191	23	45,445,971	22	110,833,082	53	4,293,321	2	208,006,565
Indiana	24,620,121	72	0	0	9,590,831	28	0	0	34,210,952
Iowa	9,543,565	26	12,459,958	34	14,173,390	38	984,787	3	37,161,700
Kansas	8,973,931	33	10,265,226	38	6,408,370	24	1,373,325	5	27,020,852
Kentucky	15,197,700	58	0	0	10,892,858	42	77,509	0	26,168,067
Louisiana	18,171,765	36	0	0	22,605,911	45	9,176,686	18	49,954,362
Maine	4,870,969	24	7,535,560	37	7,756,371	38	181,991	1	20,344,891
Maryland	22,480,317	23	1,509,383	2	60,455,542	63	11,785,235	12	96,230,477
Massachusetts	23,660,678	33	0	0	45,562,409	63	3,047,432	4	72,270,519
Michigan	42,021,077	49	28,144,755	33	11,334,531	13	4,380,189	5	85,880,552
Minnesota	16,324,664	18	2,014,998	2	56,866,067	61	17,582,485	19	92,788,214
Mississippi	9,897,947	69	0	0	4,088,372	28	373,178	3	14,359,497
Missouri	19,841,893	29	22,202,423	33	24,292,141	36	1,098,112	2	67,434,569
Montana	4,913,384	45	1,200,971	11	3,541,745	32	1,257,400	12	10,913,500
Nebraska	5,545,248	31	2,109,870	12	9,969,310	55	426,453	2	18,050,881
Nevada	8,999,740	71	0	0	3,609,093	28	121,573	1	12,730,406
New Hampshire	4,895,715	54	0	0	4,186,535	46	63,332	1	9,145,582
New Jersey	32,660,983	36	0	0	55,445,770	61	2,602,358	3	90,709,111
New Mexico	5,882,851	26	0	0	14,074,316	63	2,246,215	10	22,203,382
New York	83,470,927	23	0	0	253,564,695	71	20,739,569	6	357,775,191
North Carolina	25,017,161	33	0	0	48,371,348	64	2,133,607	3	75,522,116
North Dakota	3,970,641	27	3,313,330	22	6,690,061	45	900,072	6	14,874,104
Ohio	47,461,285	36	34,174,236	26	47,325,308	36	1,248,436	1	130,209,265
Oklahoma	13,341,630	37	189,727	1	19,786,536	56	2,309,640	6	35,627,533
Oregon	12,073,630	30	17,236,406	43	10,375,167	26	714,660	2	40,399,863
Pennsylvania	41,341,898	56	0	0	26,653,952	36	5,287,552	7	73,283,402
Rhode Island	4,738,905	26	5,099,558	28	8,400,066	46	23,367	0	18,261,896
South Carolina	15,429,544	57	875,635	3	7,123,678	26	3,520,034	13	26,948,891
South Dakota	3,450,509	46	0	0	3,056,701	40	1,047,428	14	7,554,638
Tennessee	19,452,248	67	0	0	5,536,445	19	4,073,317	14	29,062,010
Texas	87,289,044	83	0	0	16,934,997	16	1,145,926	1	105,369,967
Utah	12,690,265	56	0	0	10,059,708	44	0	0	22,749,973
Vermont	3,695,916	23	7,368,676	47	4,332,636	27	433,312	3	15,830,540
Virginia	29,852,916	43	0	0	39,859,035	57	0	0	69,711,951
Washington	24,587,971	24	31,346,544	31	44,325,677	43	1,916,490	2	102,176,682
West Virginia	6,468,098	46	0	0	7,532,320	54	0	0	14,000,418
Wisconsin	19,496,217	87	0	0	2,934,552	13	0	0	22,430,769
Wyoming	2,376,379	15	678,589	4	5,854,362	38	6,442,119	42	15,351,449

SOURCE: FY 2006 SAPT Block Grant Applications, Form 4

Per Capita Expenditures of Block Grant Funds for Treatment Services

On average, Block Grant funding for treatment and rehabilitation activities increased steadily for the United States as a whole, from $3.82 per capita in FY 2000 to $3.97 per capita in FY 2003 (figure 2.24). Examination of individual State-level data show that States varied greatly in their Block Grant expenditures per capita on treatment services (range $2.97 to $ 7.89 for FY 2003). Specific findings for FY 2003 include the following:

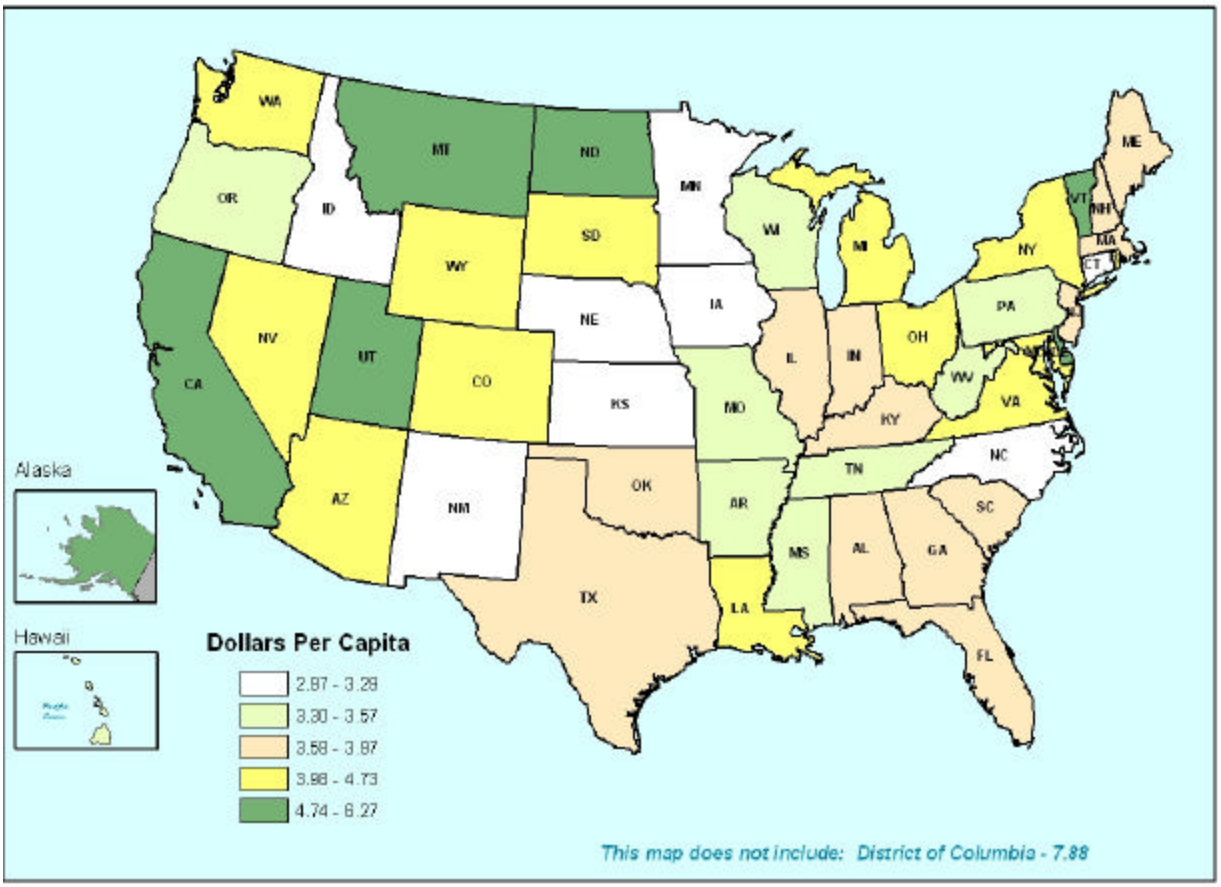
Figure 2.24. Block Grant Expenditures on Treatment Services Per Capita, FYs 2001–2003



- States with the highest rates of Block Grant funding per capita on treatment services were the District of Columbia ($7.89 per capita), North Dakota ($6.27), Vermont ($5.97), and Delaware ($5.46).

- States with the lowest rates of Block Grant funding per capita were North Carolina ($2.97 per capita), New Mexico ($3.13), Nebraska ($3.19), and Minnesota ($3.23). See figure 2.25 and Appendix C for details.

Figure 2.25. Block Grant Expenditures Per Capita on Treatment Services, FY 2003

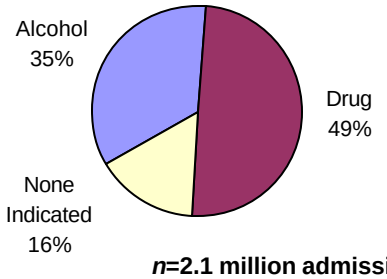


SOURCE: FY 2006 SAPT Block Grant applications and U.S. Census estimates

Admissions

States are requested to complete Form 7a, Treatment Utilization Matrix, as part of their Block Grant application. This form instructs States to indicate the number of clients admitted with a primary diagnosis of alcohol or drug use by type of treatment modality. Of the 50 States and the District of Columbia, 48 submitted this form in their 2005 SAPT Block Grant indication[7].

Figure 2.26. Percentage of Admissions by Primary Diagnosis, FY 2002



***n*=2.1 million admissions**

SOURCE: FY 2005 SAPT Block Grant Application, Form 7a; reported data from State FY 2002

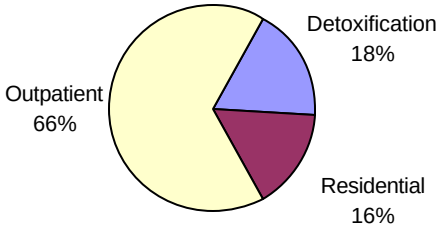
Treatment programs in the 47 responding States totaled more than 2 million admissions. Of these, half were reported as having a primary diagnosis of drug problems and more than a third were reported as having an alcohol problem for their primary diagnosis (figure 2.26).

The majority of admissions (66 percent) were for ambulatory (outpatient) treatment and included methadone and non-methadone outpatient, intensive outpatient, and detoxification treatment services (figures 2.27–2.28, table 2.14). Of these admissions, the largest number (nearly 1.1 million) were for outpatient (non-methadone) treatment.

Eighteen percent of admissions nationwide were for detoxification treatment services (24-hour care) and included hospital inpatient and free-standing residential treatment. Among the detoxification services, most (nearly 350,000 admissions) were admitted for free-standing residential care.

Sixteen percent of admissions were for residential treatment services and included hospital inpatient and short- and long-term residential treatment services. Of these, most admissions were for short-term residential treatment (176,000 admissions), followed by long-term residential treatment (156,000 admissions).

Figure 2.27. Percentage of Admissions by Primary Diagnosis, FY 2002

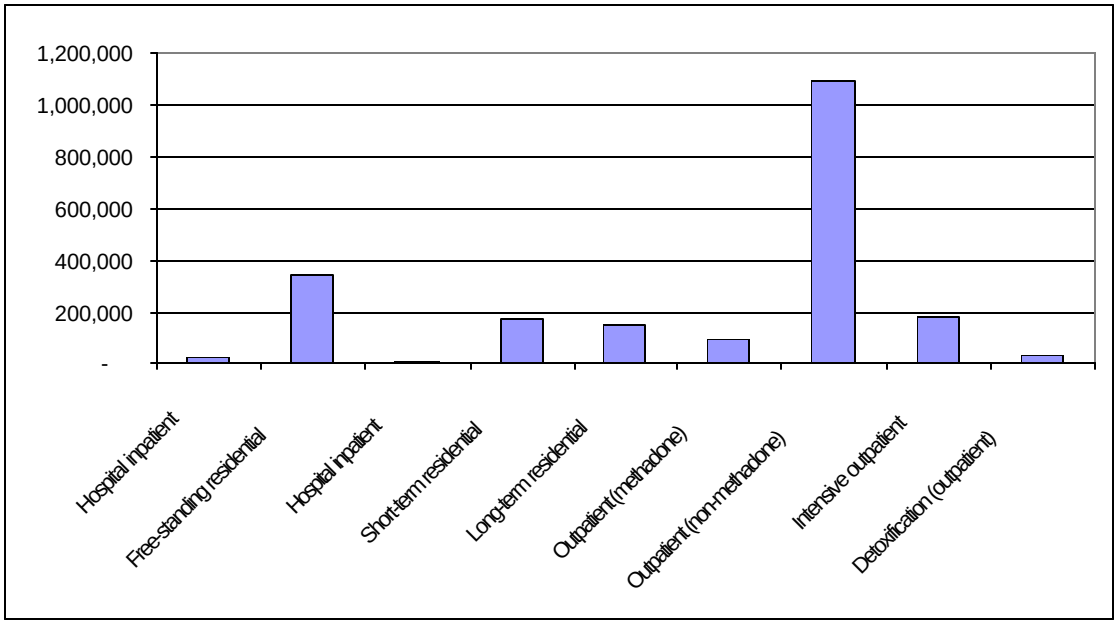


***n*=2.1 million admissions**

SOURCE: FY 2005 SAPT Block Grant Application, Form 7a; reported data from State FY 2002

[7] States not submitting information included Alaska, Virginia, and West Virginia.

Figure 2.28. National Number of Admissions by Type of Care* (*N*=21 million), FY 2002



SOURCE: FY 2005 SAPT Block Grant Application, Form 7a; reported data for State FY 2002
*47 States completed Form 7a in the FY 2005 Block Grant application and are included in this table. States not included were Alaska, the District of Columbia, Virginia, and West Virginia.

Table 2.14. Total Number of Persons Admitted by Type of Treatment Care, FY 2002 (*n*=48 States)

Type of Care	Total Admissions by Primary Diagnosis			Total
	Alcohol Problems	Drug Problems	Not Indicated	
Detoxification (24-hour care)				
Hospital inpatient	10,138	11,672	1,156	22,966
Free-standing residential	159,640	140,733	48,188	348,561
Rehabilitation/Residential				
Hospital inpatient (rehabilitation)	2,655	2,869	742	6,266
Short-term residential	52,101	90,893	33,234	176,228
Long-term residential	36,910	85,486	33,758	156,154
Ambulatory (Outpatient)				
Outpatient (methadone)	1,278	73,561	17,789	92,628
Outpatient (non-methadone)	409,327	517,720	164,154	1,091,201
Intensive outpatient	57,264	97,826	30,766	185,856
Detoxification (outpatient)	1,588	28,477	26	30,091
TOTAL	730,901	1,049,237	329,813	2,109,951

SOURCE: FY 2005 SAPT Block Grant Application, Form 7a; reported data for State FY 2002

Co-Occurring Disorders

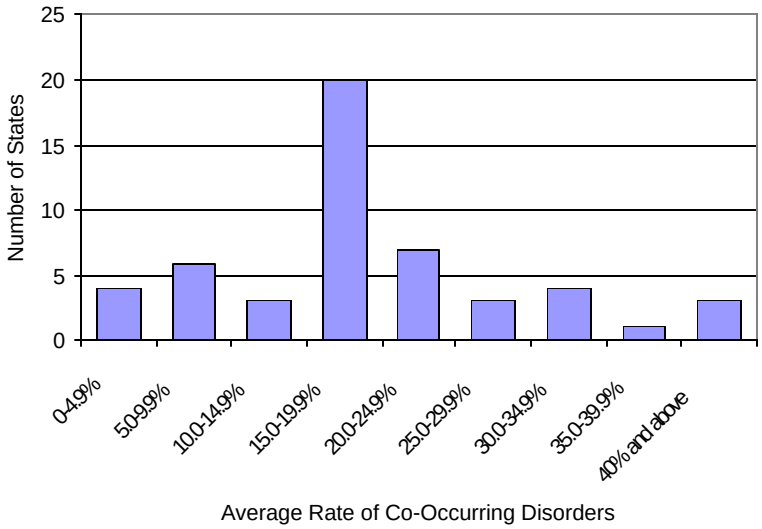
The Treatment Episode Data Set (TEDS) provides information on the demographic and substance abuse characteristics of the Nation's substance abuse treatment facility admissions, as reported through individual State administrative data systems. All 50 States and the District of Columbia submitted data for 2002. Thirty-seven States reported whether clients admitted for substance abuse treatment also had a presenting psychiatric problem. Using data from the 37 States, calculations (with imputation) were conducted to estimate the rates of persons admitted with co-occurring psychiatric problems and substance abuse issues for all States. (See Appendix D for details of the methods used to calculate the rates of co-occurring disorders).

When grouping the States by their average rate of co-occurring disorder (in 5 percent increments), calculations showed that one-quarter of the States had average rates of co-occurring disorders between 15 and 20 percent and nearly one-fifth of States had average rates of co-occurring disorders between 20 and 25 percent (range 0 to 68 percent)(figure 2.29).

The State rates of co-occurring disorders varied only slightly when separating out clients with a primary diagnosis of alcohol abuse from those with a primary diagnosis of drug abuse in combination with alcohol. Appendix E provides State details.

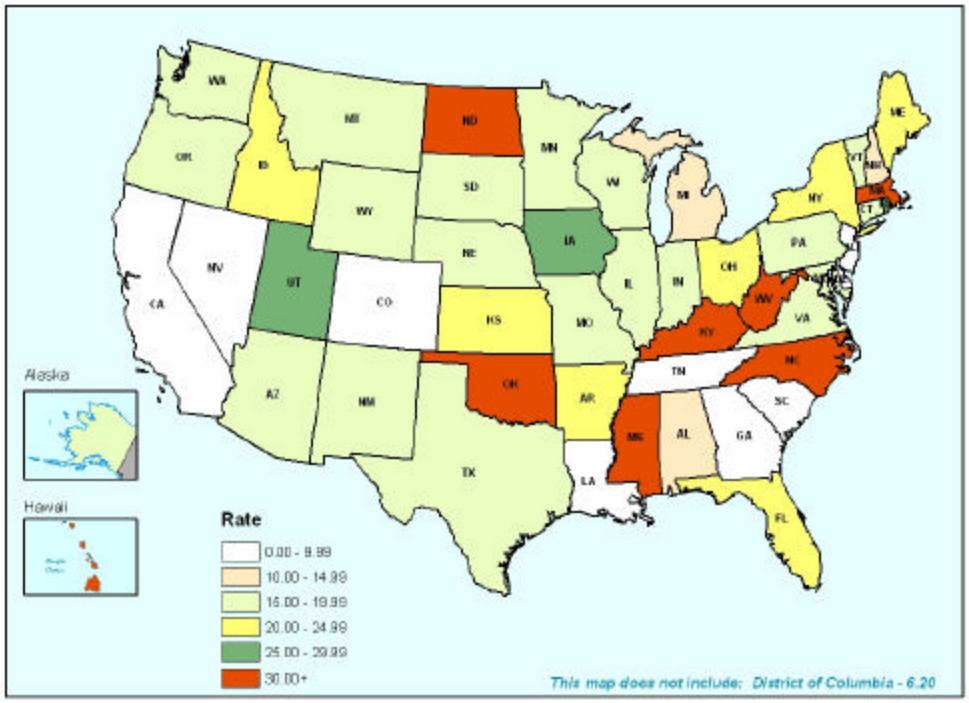
Figures 2.30–2.31 show the average rate of co-occurring disorder among treatment clients by State for clients admitted as using alcohol only and for those admitted for using alcohol in combination with other drugs.

Figure 2.29. Number of States by Rate of Co-Occurring Disorders Among Treatment Clients, FY 2002



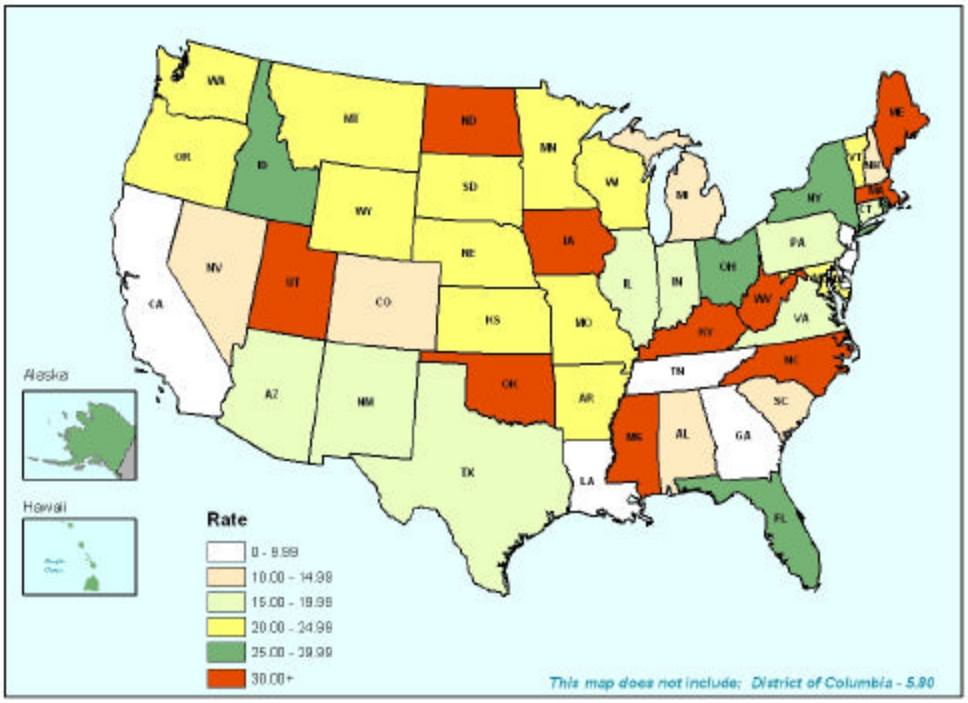
SOURCE: Treatment Episode Data Set, 2002

Figure 2.30. Rate of Co-Occurring Disorders Among Persons Admitted for Alcohol Abuse, 2002



SOURCE: Treatment Episode Data Set, 2002

Figure 2.31. Rate of Co-Occurring Disorders Among Persons Admitted for Illicit Drug Abuse, 2002



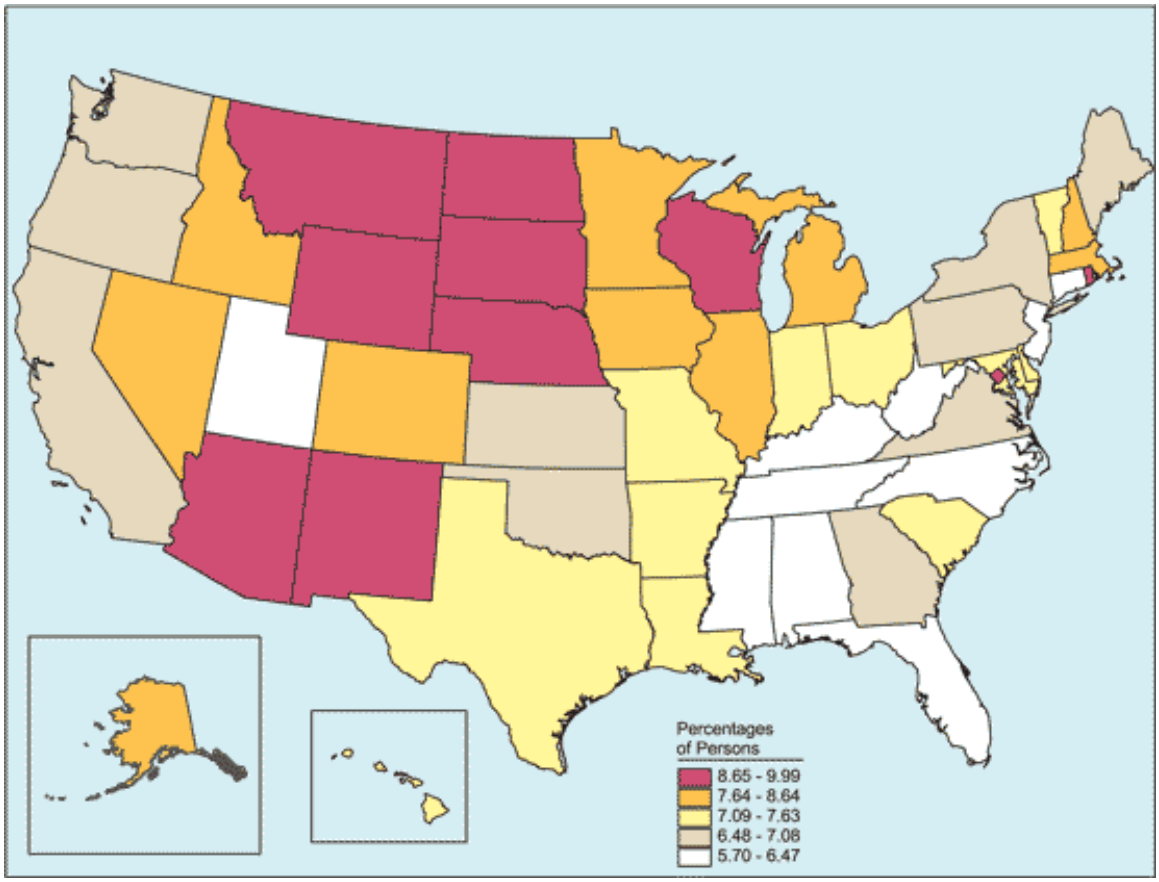
SOURCE: Treatment Episode Data Set, 2002

Treatment Gap

Alcohol: The definition of a person needing, but not receiving, treatment for an alcohol problem is that he or she meets the criteria for abuse of or dependence on alcohol according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (*DSM-IV TR*), but has not received specialty treatment for an alcohol problem in the past year.

The percentage of persons aged 12 or older needing, but not receiving, treatment for alcohol problems was 7.2 percent in 2002–2003[8]. Persons aged 18 to 25 had the highest rate of needing, but not receiving, treatment (16.9 percent). When examining State averages for persons aged 12 or older, the States with the lowest rates of persons needing, but not receiving, treatment for alcohol abuse or dependence were Tennessee (5.7 percent), Alabama (5.8 percent), and New Jersey (5.8 percent). The States with the highest rates were Montana (10.0 percent), South Dakota (9.6 percent), and Nebraska (9.5 percent). Figure 2.32 and Appendix F provide details by State.

Figure 2.32. Percentages of Persons Needing, but Not Receiving, Treatment for Alcohol Use in Past Year Among Persons Aged 12 or Older, by State, 2002–2003



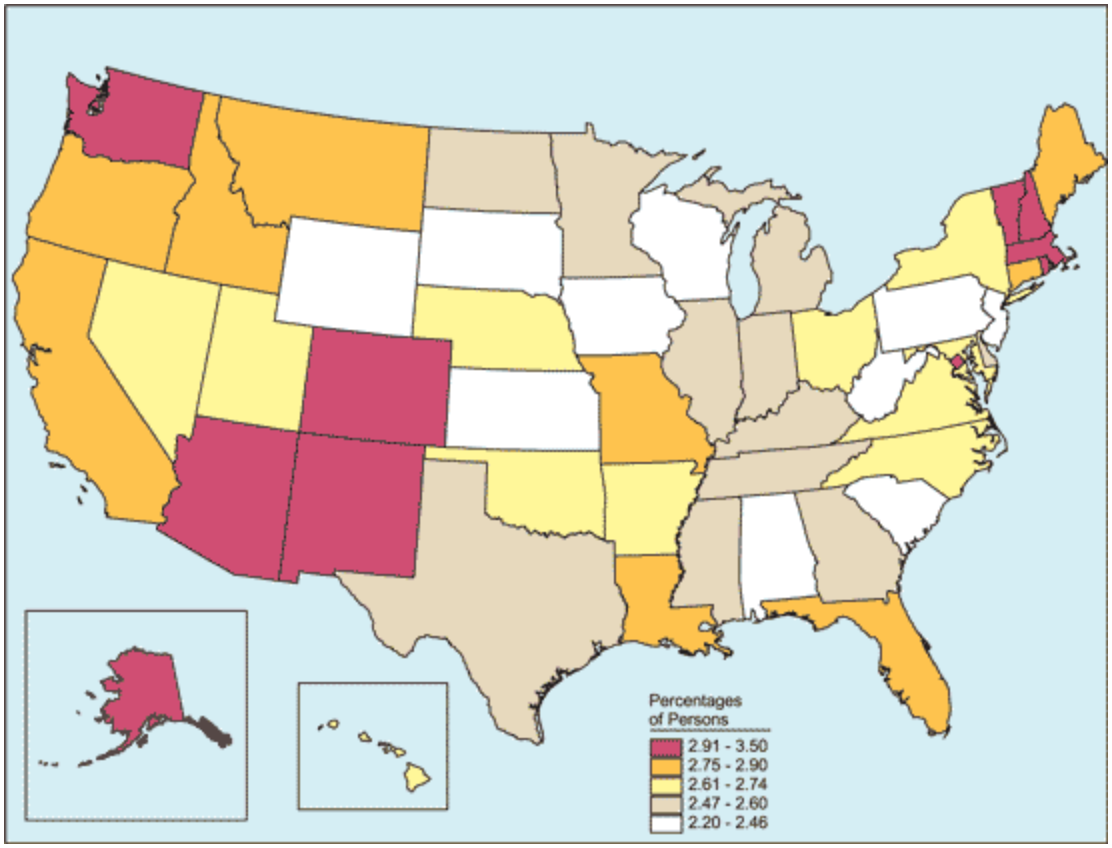
SOURCE: National Survey on Drug Use and Health; data are combined for 2002 and 2003

[8] www.drugabusestatistics.samhsa.gov/2k3State/ch5.htm

Illicit Drugs: The definition of a person needing, but not receiving, treatment for an illicit drug problem is that he or she meets the criteria for abuse of or dependence on illicit drugs according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* [9] but has not received specialty treatment for an illicit drug problem in the past year. Specialty treatment is treatment received at a drug and alcohol rehabilitation facility (inpatient or outpatient), hospital (inpatient only), or mental health center[10].

The percentage of persons aged 12 or older needing, but not receiving, treatment for illicit drug use problems was 2.7 percent in 2002–2003. Persons aged 18 to 25 had the highest rate of needing, but not receiving, treatment (7.5 percent). When examining State averages for persons aged 12 or older, the States with the lowest rates of persons needing, but not receiving, treatment for illicit drug abuse or dependence were Alabama, Kansas, and Pennsylvania (at 2.2 percent each). The States with the highest rates were New Mexico (3.5 percent), Vermont (3.4 percent), and Rhode Island (3.2 percent). Figure 2.33 and Appendix G provide details by State.

Figure 2.33. Percentages of Person Needing, but Not Receiving, Treatment for Illicit Drug Use in Past Year Among Persons Aged 12 or Older, by State, 2002–2003



SOURCE: National Survey on Drug Use and Health; data are combined for 2002 and 2003

[9] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington DC, 2000

[10] SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, combined data for 2002 and 2003

Resource Development Activities

Planning and Needs Assessment Activities

States are moving toward conducting comprehensive needs assessments that use a variety of primary and secondary data sources to determine their populations' need for services, identify resources and gaps in services, and gauge provider and community readiness and capacity to deliver services. States are also becoming more sophisticated in prioritizing their needs and developing plans on how to best meet them. Brief descriptions about how States conduct needs assessments and plan for services are below. To see examples of such activities and State highlights see Appendix H.

Conducting Needs Assessments

Most States use national standardized instruments to assess ATOD prevention and treatment needs that include questions about ATOD use, risk and protective factors, and consequences related to ATOD use[11]. For most States, these data provide a statewide estimate of need at the State level only. Some States have enhanced the survey methodology and/or developed their own instruments so that they also provide estimates at a regional, county, or local level to facilitate regional or local planning.

States also appear to make good use of information from other sources including archival and social indicator data from other State and local agencies, program monitoring information, and both formal and informal input from community members, providers, local officials, and members from target populations.

States generally make the needs assessment findings available to their substate entities, local providers, and the general public. Methods used to disseminate findings include posting them on State Web sites, creating detailed printed reports, and distributing them via CD-ROM.

Developing Alcohol, Tobacco, and Other Drug Prevention and Treatment Plans

All States conduct ATOD prevention and treatment planning at some level, yet the planning processes and resulting plans vary considerably in scope and content. For some States, planning for prevention and treatment services is a combined process within the SSA resulting in an integrated ATOD prevention and treatment plan. For some States, plans are the result of active collaboration with other State agencies and address a variety of public health issues and health promotion concerns, in addition to ATOD prevention and treatment. Some States may have a stand-alone strategic plan for prevention and another one for treatment. Some States have the active involvement of the Governor's office in their ATOD planning, and in others a structured planning process is mandated by the State legislature to meet a need and/or achieve a desired outcome. Some States require planning by their substate entities, and others require comprehensive planning from their providers.

[11] The national instruments and/or data sources most cited include the Youth Risk Behavior Survey, National Survey on Drug Use and Health, Behavior Risk Factor Surveillance Survey, Pregnancy Risk Assessment Monitoring System, Youth Tobacco Survey, Kids Count Survey, and State Treatment Needs Assessment Project data.

Evaluation Activities

States use a variety of methods to monitor and evaluate their ATOD prevention and treatment policies, programs, and strategies, and they assess their providers at a variety of levels including programmatic, fiscal, and compliance and for achievement of goals, objectives, and client outcomes. States are primarily interested in determining whether programs are doing what they said they would do, serving the numbers of persons in the anticipated strategies, and having an intermediate or long-term impact. Brief descriptions about how States monitor and evaluate services are below. To see examples of such activities and State highlights, see Appendix H.

Evaluating Outcomes

States are moving increasingly toward evaluating the outcomes of their services, strategies, programs, and policies. Although most States have a formal process for monitoring their substance abuse prevention and treatment services, not as many are evaluating the long-term results, or outcomes, of their funded programs and strategies. While some States are adept at measuring program-specific outcomes, others are not. The capacity to measure outcomes is becoming more of an issue as States are increasingly being required to collect and analyze population or community-level outcome data. As States move toward collecting and analyzing population-level data, States will increasingly be able to link needs assessment and evaluation activities.

Computerized Management Information Systems

Many States have developed and/or use administrative databases to collect information about the persons served, strategies employed, and other characteristics of their ATOD prevention and treatment systems. Such systems allow States to describe the population served, treatment or prevention strategies delivered, length of delivery, and, depending on the sophistication of the evaluation methodology, performance outcomes.

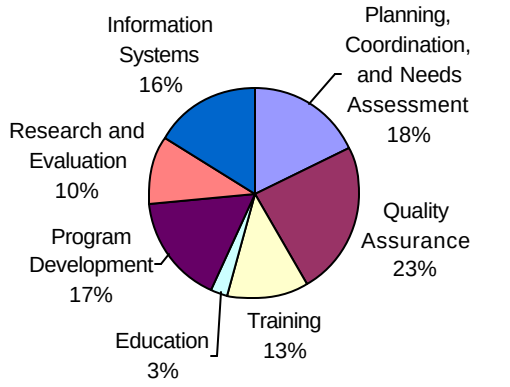
Training and Technical Assistance Activities

All States indicated wanting to maintain a well-qualified and trained workforce to deliver prevention and treatment services. Most States do not have a written and formal workforce development plan, but many SSAs will only contract with provider agencies that have staff development requirements, require certification or credentialing of provider staff, and offer or support a variety of trainings, workshops, conferences, and institutes. In addition, SSAs collaborate with other agencies such as the Center for the Application of Prevention Technologies (CAPTs), the Addiction Technology Transfer Centers (ATTCs), colleges, universities, and other training entities to strengthen their workforce. SSAs also provide technical assistance to substate entities and providers to enhance skills in delivering effective prevention and treatment services and offer Web-based resources. States also strengthen the prevention and treatment workforces through other methods such as by maintaining a resource clearinghouse or library, working with the college and/or university system to develop the workforce, and using designated Regional Alcohol and Drug Awareness Resources (RADAR) Network Centers to disseminate information and provide assistance. To see examples of training and technical assistance activities and State highlights see Appendix H.

Expenditures of Block Grant Funds for Resource Development Activities

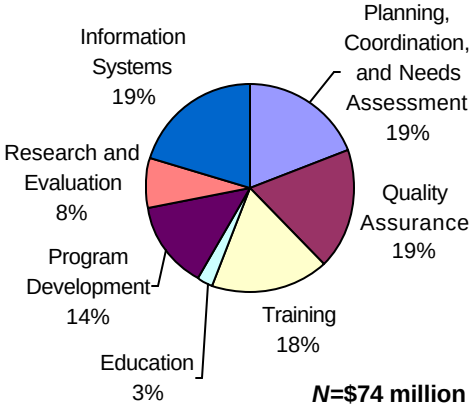
Nationally, Block Grant funding for resource development activities increased from $64 million in FY 2000 to $74 million in FY 2003 (figure 2.36, table 2.15). There were slight changes in the distribution of funds: expenditures on quality assurance and program development decreased slightly during this period, from 23 to 19 percent and from 17 to 14 percent respectively, and expenditures on training and information systems increased from 13 to 18 percent and from 16 to 19 percent, respectively (figures 2.34–2.35).

Figure 2.34. Expenditures of Block Grant Funds by Resource Development Activity, FY 2000



***N*=$64 million**

Figure 2.35. Expenditures of Block Grant Funds by Resource Development Activity, FY 2003



***N*=$74 million**

Figure 2.36. Expenditures of Block Grant Funds by Resource Development Activity, FYs 2000–2003

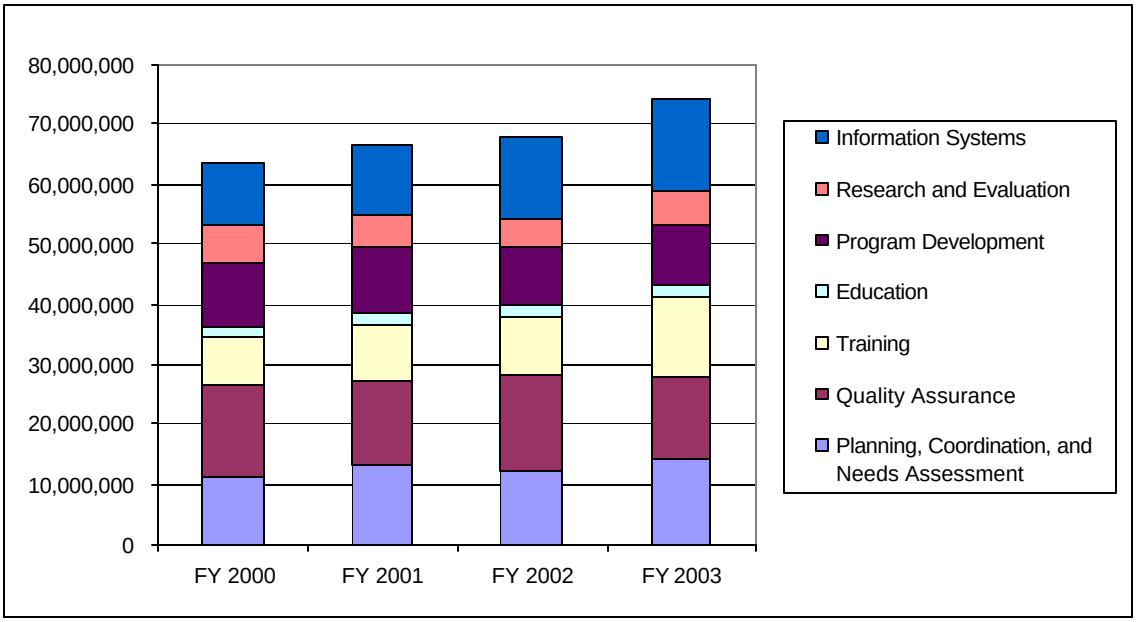


Table 2.15. Single State Agency Expenditures of Block Grant Funds by Resource Development Activity, FYs 2000–2003

Activity	FY 2000		FY 2001		FY 2002		FY 2003	
	$ Spent	%	$ Spent	%	$ Spent	%	$ Spent	%
Planning, Coordination, and Needs Assessment	11,302,508	18	13,041,761	20	12,300,231	18	14,248,411	19
Quality Assurance	15,249,896	23	14,400,483	22	16,065,296	24	13,701,459	19
Training	8,008,501	13	9,045,182	14	9,624,839	14	13,152,565	18
Education	1,593,711	3	2,060,864	3	1,952,244	3	1,877,090	3
Program Development	10,711,161	17	10,897,592	16	9,370,367	14	10,273,517	14
Research and Evaluation	6,547,267	10	5,617,797	8	4,922,473	7	5,706,620	8
Information Systems	10,284,749	16	11,541,230	17	13,731,384	20	14,986,691	19
TOTAL*	**63,697,793**	**100**	**66,604,909**	**100**	**67,966,834**	**100**	**73,946,353**	**100**

SOURCE: FYs 2003–2006 SAPT Block Grant Applications, Form 4b

* Totals may not equal 100 percent due to rounding. Dollars spent may not be consistent from table to table due to State reporting discrepancies in the Block Grant applications.

Discretionary Funding

In addition to dispersing Block Grant funds to States and territories, SAMHSA supports substance abuse prevention and treatment efforts through a broad range of the competitive discretionary grants awards. Discretionary grants permit the Federal Government, according to specific authorizing legislation, to exercise judgment (discretion) in selecting the applicant/recipient organization through a competitive grant process. Several of the grants awarded through CSAP or Center for Substance Abuse Treatment (CSAT) support the National Drug Control Strategy and are designated as PRNS. These programs include the SPF SIG, ATR, and SBIRT, which are described later in this report.

During the grants re-engineering process in 2003, all of SAMHSA's discretionary grant programs were reviewed and most were placed in one of the following four broad categories for funding[12].

- **Services Grants** address gaps in services and/or increase the applicant's ability to meet the needs of specific populations and/or specific geographical areas with serious, emerging problems.

- **Infrastructure Grants** increase the capacity of the mental health and/or substance abuse service systems through needs assessments, the coordination of funding streams, and/or the development of provider networks, workforces, data infrastructure, and so on.

- **Best-Practices Planning and Implementation Grants** help grantees identify substance abuse treatment and prevention and mental health practices that could effectively meet local needs, develop plans for implementation of these practices, and pilot-test practices before full-scale implementation.

- **Service-to-Science Grants** support and evaluate innovative practices that are already in place.

The eligible recipients vary by grant award. Some grants are eligible to specific entities, such as the Governor's office or community coalitions, and others are available to a variety or wider range of entities. Most discretionary grant programs are for multiyear projects, but some may be for 1 year only.

Center for Substance Abuse Prevention

In FY 2004 CSAP dispersed monies through 23 discretionary grants programs. These programs addressed a variety of prevention areas, including enhancing an agency's infrastructure to deliver prevention services, prevention of specific drugs such as methamphetamine and ecstasy, trainings, conferences and resource-related grants, and combined substance abuse and HIV prevention. Overall, CSAP awarded 994 awards to the 50 States and the District of Columbia in FY 2004, totaling nearly $193 million (table 2.16).

[12] http://alt.samhsa.gov/samhsa_news/VolumeXII_1/article4_1.htm

Table 2.16. Center for Substance Abuse Prevention Discretionary Grants Awarded to States, FY 2004

CSAP Discretionary Grants	Number of Awards	Total $ Amount	Average $ Amount per Award
American Indian/Alaska Native National Resource Center	1	1,047,050	1,047,050
Anti-Drug Coalition	1	994,100	994,100
Centers for Application of Prevention Technology	1	337,588	337,588
Cooperative Agreement for Ecstasy & Other Club Drugs Prevention Services	17	4,970,052	292,356
CSAP 2004 Earmarks	15	3,588,703	239,247
Drug Free Communities	717	63,448,406	88,492
Drug Free Communities Mentoring	23	1,519,505	66,065
Emergency Response	1	50,000	50,000
Family Strengthening	4	1,657,521	414,380
Fetal Alcohol Syndrome / Effects	1	5,777,580	5,777,580
HIV/AIDS Cohort 2 Expansion Cooperative Agreements	17	1,081,812	63,636
HIV/AIDS Cohort 2 Youth Services Cooperative Agreements	15	954,540	63,636
HIV/AIDS Cohort 3 Services	50	16,600,860	332,017
HIV/AIDS Cohort 4 Services	21	7,151,074	340,527
HIV/AIDS Cohort 5 Services	45	11,250,000	250,000
Iowa Methamphetamine Prevention Sole Source	1	399,949	399,949
Prevention of Methamphetamine and Inhalant Use	14	4,720,079	337,149
SAMHSA Conference Grants	6	150,000	25,000
SE Center for the Application of Prevention Technologies	1	481,920	481,920
Single Sole Source Grant to the Iowa Department of Public Health 2004	1	200,000	200,000
State Incentive Cooperative Agreements*	13	24,767,318	1,905,178
Strategic Prevention Framework State Incentive Grants*	17	39,966,405	2,350,965
Youth Transition into the Workplace	12	1,799,771	149,981
TOTAL	**994**	192,914,233	

SOURCE: www.shamhsa.gov

*Grants were open only to Governors' offices of SSAs.

Examples of Discretionary Awards for Prevention

Cooperative Agreement for Ecstasy and Other Club Drugs Prevention Services

The Cooperative Agreement for Ecstasy and Other Club Drugs Prevention Services grants are intended to expand and strengthen effective, culturally appropriate ecstasy and other club drugs prevention services at the State and local levels. Grant recipients were SSAs or equivalent agencies of tribal governments. Although eligibility is limited to governmental entities, these governmental entities are required to partner with local community organizations (public or private) in developing and implementing the grant project.

CSAP granted 17 awards for a total of nearly $5 million to 11 State and Native American tribal governments to prevent ecstasy and other club drug use (table 2.17). The dollar amount awarded to the State/entity was a standard amount of $292,356 per award, although some States received more than one award.

Table 2.17. Number of Awards and Amount Awarded for the Cooperative Agreement for Ecstasy and Other Club Drugs Prevention Services Grant by State, FY 2004

State	Number of Awards	Total $ Amount
Arizona	1	292,356
California*	2	584,712
Connecticut	1	292,356
Florida	2	584,712
Hawaii	1	292,356
Maryland	1	292,356
Massachusetts	1	292,356
Mississippi	1	292,356
Oregon	2	584,712
Pennsylvania	1	292,356
Texas	4	1,169,424
TOTAL	**17**	**4,970,052**

SOURCE: www.samhsa.gov
*Of the two awards to California, one went to the California Department of Alcohol and Drug Programs and one went to the Jamul Indian Village.

State Incentive Cooperative Agreement for Community-Based Action

The SIGs call for Governors to develop and implement a comprehensive statewide substance abuse prevention strategy to optimize the use of State and Federal substance abuse prevention funding streams and resources including the 20-percent primary prevention set-aside from the SAPT Block Grant, the funds from this SIG program, and the additional financial support from Federal agencies, States, and communities. The SIG program has three goals: (1) coordination of funding, (2) development of a comprehensive State prevention system, and (3) assistance in measuring progress in reducing substance use by establishing targets for measures included in the NSDUH.

CSAP awarded 13 State Incentive Cooperative Agreements for Community-Based Action to 13 Governors' or District offices (figure 2.37). The grant amount ranged from $300,000 (to the District of Columbia) to $4 million (to California and Texas)(table 2.18).

Figure 2.37. State Incentive Cooperative Agreement for Community-Based Action, FY 2004

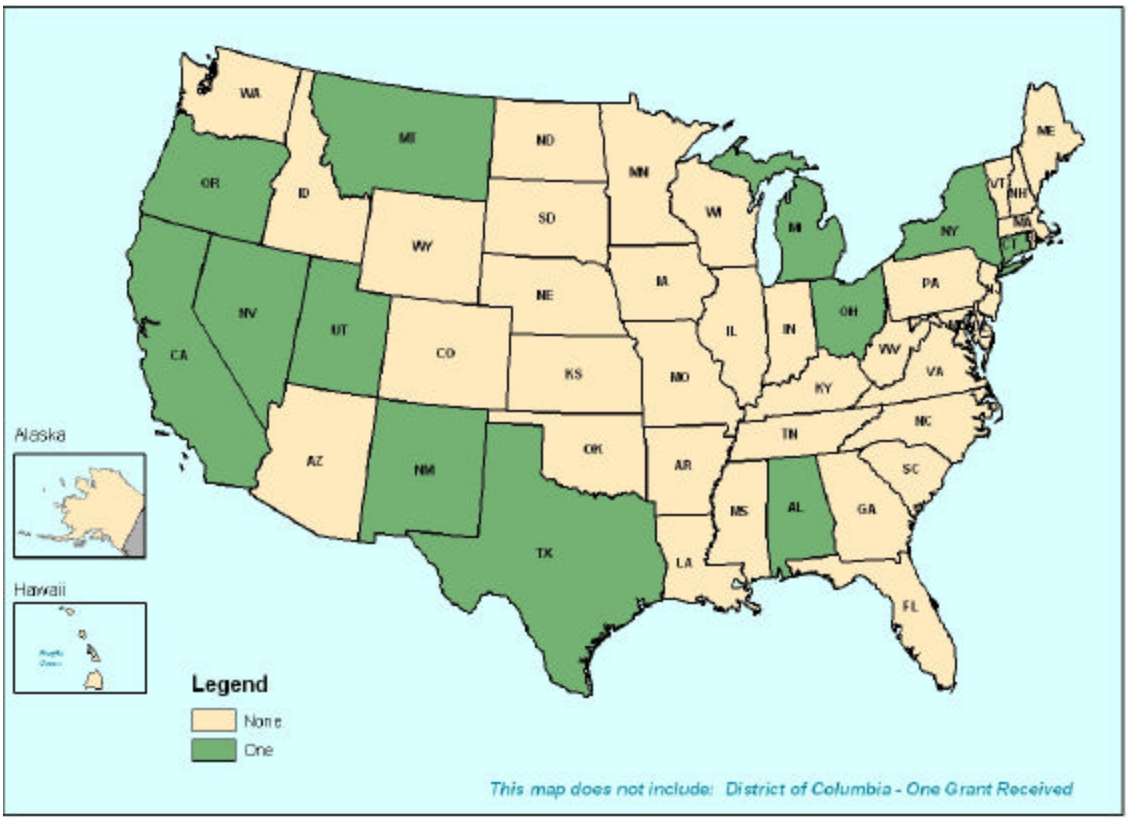


Table 2.18. State and Award Amounts for the State Incentive Cooperative Agreement for Community-Based Action Grant, FY 2004

State	Total $ Amount
Alabama	3,000,000
California	4,000,000
Connecticut	750,000
District of Columbia	300,000
Michigan	2,967,318
Montana	750,000
New Mexico	750,000
Nevada	3,000,000
New York	750,000
Ohio	3,000,000
Oregon	750,000
Texas	4,000,000
Utah	750,000
TOTAL	**24,767,318**

SOURCE: www.samhsa.gov

Strategic Prevention Framework State Incentive Grants (SPF SIGs)

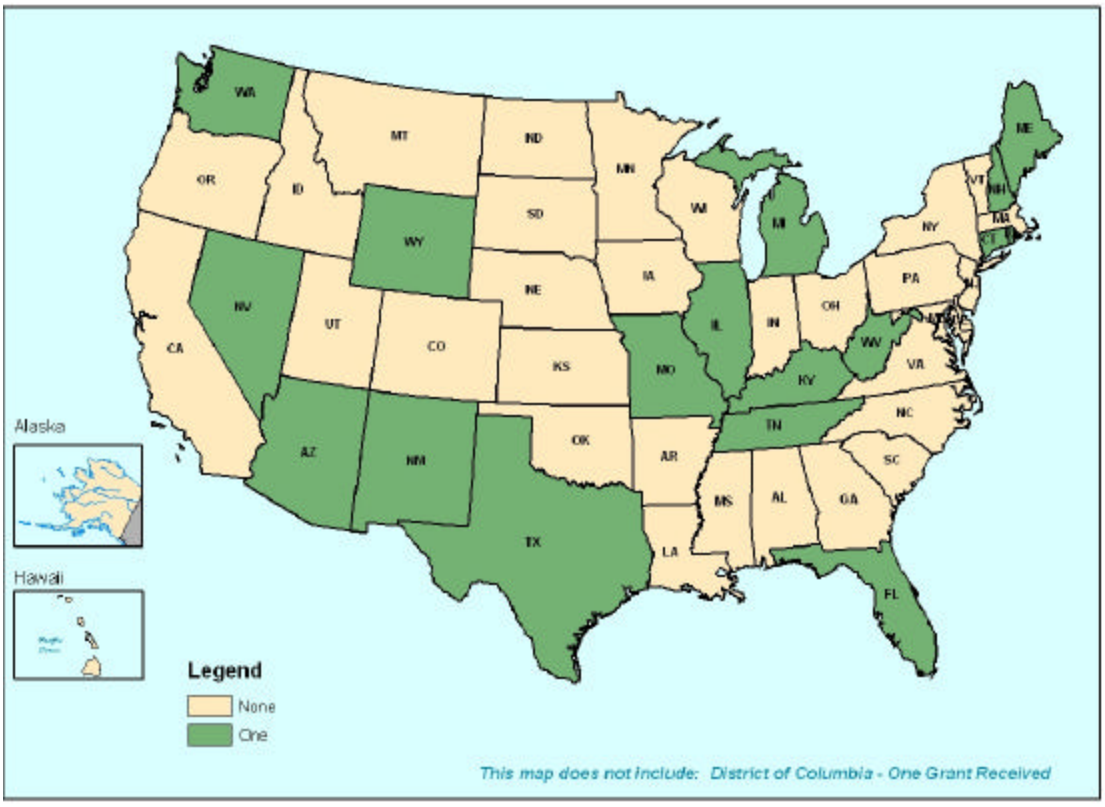
The SPF SIG program is one of SAMHSA's Infrastructure Grant programs. SAMHSA's Infrastructure Grant programs support an array of activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse and/or mental health services. The SPF SIGs, in particular, provide funding to States to implement SAMHSA's SPF to:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking
- Reduce substance abuse-related problems in communities
- Build prevention capacity and infrastructure at the State and community levels

This program helps States enhance the prevention infrastructure and service delivery system throughout the State. Eligibility for the SPF SIG is limited to the immediate office of the Governor in those States and territories that receive the SAPT Block Grant.

CSAP awarded 17 SPF SIGs to 17 Governors' offices (figure 2.38). Each award was in the amount of $2,350,965 (CSAP's total award for the 17 States was nearly $40 million).

Figure 2.38. Strategic Prevention Framework State Incentive Grants, FY 2004



Other Discretionary Awards to Single State Agencies

SSAs, in addition to other types of entities, were eligible to apply for other discretionary grant programs, may have received a sole source award, or were the sole recipient of a grant project. These awards could be awarded for a single year or multiple years. Highlights of these awards for FY 2004 include the following:

- ***Alaska*** received nearly $5.8 million for the Comprehensive, Integrated Approach to Fetal Alcohol Syndrome: Prevention, Intervention, and Service Delivery, a 5-year congressionally earmarked project that is jointly funded by CSAP and CSAT to provide prevention activities including education and training of service providers, public school students and their families, and the general public. Interventions will include family planning, alcohol treatment, and other services for women of childbearing age at high risk for having a child with Fetal Alcohol Syndrome/alcohol-related birth defects.

- The ***Iowa Department of Public Health*** was awarded the Iowa Methamphetamine Prevention Sole Source award for nearly $400,000 to develop a prevention initiative based on a CSAP model program. Schools and communities receiving funding will have a choice of three model programs: Reconnecting Youth, Strengthening Families, and Life Skills Training. This is part of a 3-year grant.

- The ***Iowa Department of Public Health*** was awarded the Single Sole Source Grant to the Iowa Department of Public Health for $200,000 for a 1-year award (no description available).

Center for Substance Abuse Treatment

In FY 2004 CSAT dispursed monies through 30 discretionary grants programs. These programs addressed a variety of areas, including enhancing an agency's capacity to deliver treatment services; providing treatment to specific populations such as homeless persons, pregnant/post-partum women, or persons with co-occurring disorders; and enhancing data systems and other infrastructure to improve delivery of treatment services. Overall, CSAT awarded 564 awards to the 50 States and the District of Columbia, totaling nearly $344 million (table 2.19).

Table 2.19. Center for Substance Abuse Treatment Discretionary Grants Awarded to States, FY 2004

CSAT Discretionary Grants	Number of Awards	Total $ Amount	Average $ Amount per Award
Access to Recovery*	15	99,410,000	6,627,333
Addiction Technology Transfer Center	14	9,111,338	650,810
Adult Juvenile and Family Drug Courts	41	15,490,218	377,810
CSAT 2004 Earmarks	24	6,292,653	262,194
DATA Physician Clinical Support System	1	499,681	499,681
Effective Adolescent Treatment	38	9,176,223	241,480
Grants for Accreditation of Opioid Treatment Providers	4	750,000	187,500
Homeless Addictions Treatment	68	32,427,885	476,881
Iowa Methamphetamine Treatment Sole Source, 2003	1	499,963	499,963
Methamphetamine Populations	6	2,965,536	494,256
NASADAD State Collaborative Activity	1	500,000	500,000
Pregnant/Post-Partum Women	20	9,848,190	492,410
Recovery Community Service	21	5,528,195	263,247
Recovery Community Support - Facilitating	3	1,050,000	350,000
Recovery Community Support - Recovery	5	1,747,559	349,512
Rehabilitation and Restitution	1	1,350,000	1,350,000
Residential Substance Abuse Treatment	17	7,829,723	460,572
SAMHSA Conference Grants	8	386,700	48,338
Sole Source for Hawaii	1	297,967	297,967
State Data Infrastructure*	32	3,199,960	99,999
State Targeted Capacity Expansion (TCE) Screening, Brief Intervention, Referral, and Treatment*	7	22,198,826	3,171,261
Strengthening Access and Retention*	13	2,528,580	194,506
Strengthening Communities , Youth	12	8,454,272	704,523
Targeted Capacity, HIV/AIDS	138	63,073,333	457,053
Targeted Capacity Expansion	36	16,803,029	466,751
TCE Innovative Treatment	6	2,940,703	490,117
TCE Minority Populations	6	2,999,755	499,959
TCE Rural Populations	6	2,994,695	499,116
Treatment of Persons With Co-Occurring Substance-Related and Mental Disorders*	7	7,404,167	1,057,738
Youth Offender Reentry Program 2004	12	5,821,671	485,139
TOTAL	**564**	**343,580,822**	

SOURCE: www.samhsa.gov
*Grants were open only to Governors' offices or SSAs.

Examples of Discretionary Awards for Treatment

Access to Recovery (ATR)

ATR is a Presidential initiative promoting the use of vouchers to provide client choice among substance abuse treatment and recovery support service providers. It is also intended to expand access to a comprehensive array of clinical treatment and recovery support options and increase substance abuse treatment capacity. Recipient organizations are limited to the chief executive officer (e.g., Governor) in the States, territories, and the District of Columbia or the head of a tribal organization.

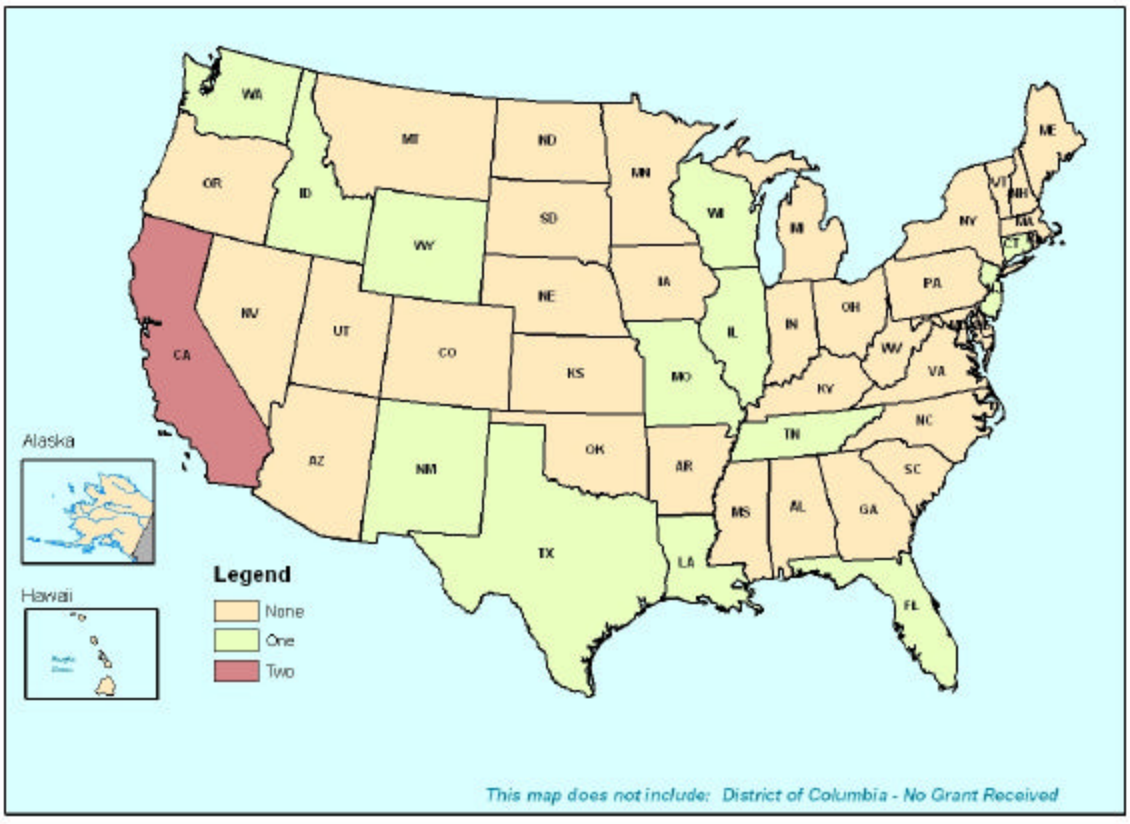
ATR's three key objectives are as follows:

1. Increase the Nation's treatment capacity—States are required to broaden their base of providers.
2. Expand consumer choice—Nonprofit, proprietary, community-based, and faith-based programs that are licensed/certified by the States are eligible providers.
3. Reward performance with financial incentives

The way it works: When a person seeks treatment, professionals assess the individual's needs, offer a voucher for the level of care required, and refer the person to a variety of providers who can offer such services. The individual then selects a provider and "pays" for the treatment with the voucher. The provider redeems the voucher through the organization administering the State's program.

CSAT awarded 15 ATR grants totaling more than $99 million to 15 entities (figure 2.39). The award amounts ranged from nearly $1 million (Wyoming) to $8 million (awarded to 10 States). California received two ATR awards; one was awarded to the governor's office and the other went to the California Rural Indian Health Board.

Figure 2.39. Access to Recovery Awards, FY 2004



SOURCE: www.samhsa.gov

Screening, Brief Intervention, Referral, and Treatment (SBIRT)

The purpose of the SBIRT grant program is to expand and enhance State substance abuse treatment service systems by expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment in general medical and other community settings.

All States, territories, and federally recognized Indian tribes were eligible to apply, but the applicant must be the immediate State Governor's office (for territories and Indian tribes, the office of the chief executive officer).

CSAT awarded seven SBIRT grants to States. Six of the seven awards were for approximately $3 million, and one was for $2 million (Alaska)(table 2.19).

Table 2.19. State and Award Amounts for the Screening, Brief Intervention, Referral, and Treatment Grant, FY 2004

State	Total $ Amount
Alaska	2,176,494
California	3,331,238
Illinois	3,346,000
New Mexico	3,346,000
Pennsylvania	3,307,430
Texas	3,346,000
Washington	3,345,664
TOTAL	**22,198,826**

SOURCE: www.samhsa.gov

State Data Infrastructure

The primary goal of this program is to help SSAs report performance measures for planned SAPT Block Grant/Performance Partnerships Grants (PPGs). Funds assist States, in collaboration with one another and with CSAT, to develop administrative data infrastructure for collecting and reporting PPG and related information. Funds can also be used to train State staff to collect and analyze performance data.

Applicants are limited to SSAs.

CSAT awarded more than $3 million to 32 SSAs (figure 2.40). Each award was for approximately $100,000.

State Incentive Grants (COSIG) for Treatment of Persons With Co-Occurring Substance-Related and Mental Disorders

SAMHSA's Center for Mental Health Services (CMHS) and CSAT jointly fund this program for States to develop and enhance the infrastructure of States and their treatment service systems to increase the capacity for accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance use and mental disorders and their families.

Only the immediate State Governors' offices were eligible for this grant because they have the greatest potential to provide the multiagency leadership to develop the State's infrastructure/treatment service systems.

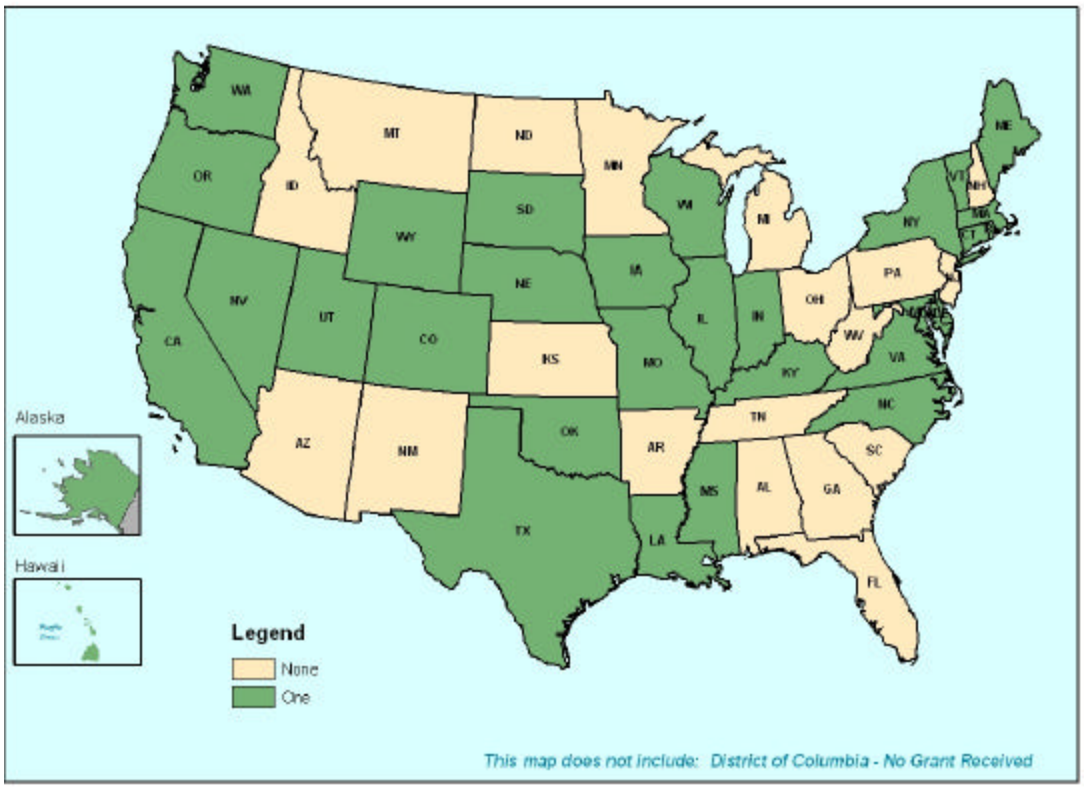
CSAT/CMHS awarded seven COSIG grants to seven States for a total of more than $7 million for FY 2004 as part of a 5-year grant. Awards ranged from more than $900,000 (Missouri) to approximately $1 million (five of seven States)(table 2.20).

Table 2.20. State and Award Amounts for the State Incentive Grant for Treatment of Persons with Co-Occurring Substance-Related and Mental Disorders, FY 2004

State	Total $ Amount
Alaska	1,071,750
Arkansas	1,100,000
Hawaii	1,009,743
Louisiana	1,095,298
Missouri	931,722
Pennsylvania	1,095,654
Texas	1,100,000
TOTAL	**7,404,167**

SOURCE: www.samhsa.gov

Figure 2.40. State Data Infrastructure Awards, FY 2004



SOURCE: www.samhsa.gov

Other Discretionary Awards to Single State Agencies

SSAs, in addition to other types of entities, were eligible to apply for other discretionary grant programs, may have received a sole source award, or were the sole recipient of a grant project. These awards could be awarded for a single year or multiple years. Highlights of these awards for FY 2004 included the following:

- The ***Iowa Department of Public Health*** was awarded the Iowa Methamphetamine Treatment Sole Source grant for nearly $500,000 to expand the service capacity for adults who abuse methamphetamine in the central Iowa area through targeted case management and to assist clients in accessing treatment and continuing care services.

- The ***Ohio Department of Alcohol and Drug Addiction Services*** was awarded $1.35 million for Rehabilitation and Restitution. Although awarded to the State, this program will operate in Cuyahoga County in collaboration with the county's Department of Justice Affairs. This program will provide substance abuse treatment and supportive services for more than 5 years to persons who are charged with certain first-time nonviolent felonies to improve treatment retention and outcome, reduce the stigma of past substance abuse and nonviolent criminal activity, and reduce criminal activity. The project promotes multisystem collaboration and provides linkages to substance treatment, educational and vocational services, restitution and community services, and gender-specific family support services.

- ***Nebraska*** was awarded a SAMHSA Conference Grant in the amount of $50,000 to provide the most current information on problem gambling and co-occurring substance abuse from the leading experts in the field.