WHITE PAPER ON FUNDING COMPREHENSIVE SERVICES FOR FAMILIES WITH SUBSTANCE USE DISORDERS IN CHILD WELFARE AND DEPENDENCY COURTS

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Draft Document

Introduction – Why Multiple Funding Streams Matter

Connecting separate agencies that serve children and families at the intersection of child welfare, substance abuse services and dependency courts[*] involves connecting the multiple funding streams that flow into child welfare, substance abuse and other health and human service agencies serving families. The more comprehensively a continuum of care is defined in children and family services, the wider an array of funding streams are needed. The more committed an agency is to "family-centered services," the more mastery is needed of all the different funding streams that can support families. No single agency has adequate funding sources by itself to achieve comprehensive outcomes; interagency funding streams are therefore critical to converting hopes for new linkages into reality.

Fiscal context always matters, and in tight fiscal climates tapping new sources of funding is both desired and resisted. It is desired for the obvious reason that hard-pressed agencies are anxious to find alternative funding streams to support their programs; it is resisted for the equally obvious reason that agencies seek to protect "their own" funding streams even more when funding is tight. The descriptions of funding and suggestions that follow are made in full awareness that in most States, fiscal constraints are very significant factors at present.

Defining the Issues

Several issues affect the ability of programs to provide the comprehensive services needed by children and families affected by substance abuse. Some of these issues are based on the nature of the collaborative relationship between the agencies, some flow from categorical funding constraints, and some are based on other Federal or State policies. Understanding which of these barriers are affecting a State's or community's ability to provide comprehensive services is a critical first step in developing their response.

► The Nature of the Collaborative Relationship

For substance abuse agencies in a partnership with child welfare agencies, there is a sometimes unspoken concern about what will happen if CWS agencies improve their ability to identify substance abuse among CWS clients: a fear that CWS agencies will "come after our money." Some substance abuse agencies have seen the problem differently, however, recognizing that better-documented needs among an under-served population may succeed in achieving either of two positive outcomes: getting an increase in substance abuse funding to meet those better-documented needs or getting an allocation of CWS funding to pay for treatment for CWS clients already in the treatment system. Since some CWS agencies have chosen to "buy their own," i.e. fund substance abuse treatment programs under their control rather than under the supervision of substance abuse agencies, it is possible to get a net increase in total substance abuse funding—but achieving coordinated and effective programs requires further discussions.

► Other Funding and Policy Concerns

- Existing categorical definitions of funding streams and eligibility restrictions create barriers to interagency efforts, with agency officials sometimes resistant to what seems like "one more earmark" on behalf of families with children

[*] We use the term Dependency courts to refer to the judicial system responsible for ensuring the legal rights of individuals and protection of children named in court petitions involving allegations of child abuse/neglect and specifies protective custody issues. Many jurisdictions also refer to these courts as Juvenile or Family Courts.

- Decisions by agencies to provide services directly or to negotiate for services with outside agencies are critical choices, but at times they may be made based on limited understanding of other agencies' funding streams
- Each system sees the other's funding streams as mysterious and difficult to access, and each sees its own as over-committed and possibly threatened, leading to a debate over "your money, our money, or their money?"
- A sustained, time-consuming effort is required to achieve new Federal, State and local collaboration, which is needed to create financing responsive to the multiple needs of children and families
- As the majority of funding flows through State-level government, State systems may need specific legislation to overcome categorical requirements
- There are significant financial incentives to maintain the status quo in fragmented funding streams
- Categorically funded programs that do not apply adequate "dosage" to ensure treatment effectiveness may require additional layers of funding from additional sources to get to scale and provide an adequate dosage of services. For example, programs that do not provide after-care services to parents may be unable to respond to relapse issues, resulting in re-admission to treatment that was under-funded but ends up with a higher overall cost due to clients' readmission.

Unified Fiscal Planning

Recently the concept of unified fiscal planning has been introduced. This approach includes a variety of strategies used by States and communities to create and sustain an integrated and flexible continuum of care for children and families.[1] Some of the more commonly used strategies include decategorization, pooled funding, blended funding, braided funding, wraparound, and refinancing to name a few of the more common names given to such efforts. Often the terms are used interchangeably or without clear definition. For the purposes of the paper we mean:

- *Decategorization* refers to State-level efforts to reduce or eliminate categorical requirements on how funds are spent. This reduction in requirements is often created in exchange for greater accountability for a set of negotiated outcomes.
- *Pooled or blended funding* is generally a local-level effort that is implemented among a group of agencies that formally integrates a set of funding streams into a single source of dollars. A new funding structure is often developed that administers and allocates the funds to the participating agencies based on negotiated contracts.
- *Braided funding* is generally implemented by an individual agency or program and refers to administrative effort to obtain multiple funding sources to create more comprehensive services. This strategy typically works within the categorical system and administrative responsibilities for maintaining the various categorical requirements remain.
- *Wraparound services* The term "wraparound" came into use in 1986, in an article by Lenore Behar, who defined "wraparound" as a way to "surround multi-problem youngsters and families with services rather than with institutional walls, and to customize these services."[2] The "wraparound" approach is more a process than a service, in which a child's or family's individual needs are addressed by the full range of services they need, with maximum flexibility in funding.

- *Refinancing* "Refinancing entails aggressively pursuing monies from uncapped Federal appropriations such as entitlement funds, using these new Federal funds to pay for standard services, and then applying the freed-up local and State funds to pay for alternative programs, including…comprehensive service initiatives."[3] This strategy will not be discussed in this paper, due to pending changes in Federal entitlements programs and uncertainty about how programs might be changed.

► Clarifying the Goal: Multiple Funding for What?

The purpose of multiple funding in the context of families with substance use disorders in child welfare must be clarified by State agencies. For the purposes of this paper, a proposed goal is:

> To expand the availability of prevention and pre-treatment services and family supports, treatment and interventions which are effective for families and their children, and post-treatment services and supports that contribute to family and child well-being and family recovery.

Understanding Available Funding

Creating better tools to work across systems and expanding current resources requires an inventory of existing resources from the two primary sources of funding—substance abuse treatment and child welfare services—as well as the range of supports that are needed to create a comprehensive continuum of care. This section will list and briefly describe the Federal sources of funding for each of the two systems. This section is not an exhaustive description of these programs, but rather an effort to explain to each of the two major parties the other funding system, which they typically do not understand in any detail.

This section is excerpted from a recent monograph developed by 11 national associations which details the goals, funding sources and collaborative efforts underway in many health and human services systems. The reader is referred to that document for further clarification about these programs.[4]

► Child Welfare Services

Approximately half of the funding for child welfare services comes from the Federal government in over 30 program areas. The Urban Institute reports that Federal sources are primarily focused in three programs: Title IV-E at 48% of Federal funds; the Social Services Block Grant at 17%; and, Temporary Assistance to Needy Families at 15%. Other Federal sources include Medicaid (10%), Title IV-B (5%) and other (5%).[5]

- Title IV-E of the Social Security Act is the major Federal funding stream for child welfare services and was established in 1980. Title IV-E Foster Care and Adoption Assistance provides funds to States to reimburse a portion of the cost of room and board for foster care, subsidize adoptions of children with special needs; train public agency staff and foster and adoptive parents; administer the program; and provide the statutory protections assured for children (case planning and permanency hearings). These funds are available only for the cost of care for low-income children (based on the former AFDC eligibility standard in effect on July 16, 1996). The State is responsible for the remaining costs for eligible children and 100 percent of costs for children who are not Title IV-E eligible. Proposed funding for Title IV-E for FY03 is $4.85 billion, based on an estimate of approximately 250,000 eligible children.

Comparatively smaller but programmatically important Federal funding sources are also used to finance child welfare:

- Title IV-B, Subpart 1, is a formula grant program with allocations to each State providing Federal support for a variety of child welfare services. There are no Federal income eligibility requirements for this program. Child welfare services are provided for the following purposes:
  - Protecting and promoting the welfare and safety of all children, including individuals with disabilities; homeless, dependent, or neglected children;
  - Preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;
  - Preventing the unnecessary separation of children from their families by identifying family problems and assisting families in resolving their problems and preventing the breakup of the family where the prevention of child removal is desirable and possible;
  - Restoring to their families children who have been removed and may be safely returned, by the provision of services to the child and the family;
  - Assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption; and,
  - Placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate.
- Title IV-B, Subpart 2 (Promoting Safe and Stable Families) provides funding for family preservation, family support, reunification and adoption promotion and support. Funds are allocated to States according to their relative share of children receiving food stamps. However, there are no Federal income eligibility requirements for this program. Services are to protect children from harm and help families (including foster, adoptive, and extended families) at risk or in crisis by providing family preservation services including:

  Preplacement preventive services programs, such as intensive family preservation programs, designed to help children at risk of foster care placement remain with their families, where possible;

  Service programs designed to help children, where appropriate, return to families from which they have been removed; or be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be appropriate for a child, in some other planned, permanent living arrangement;

  Service programs designed to provide follow-up care to families to whom a child has been returned after a foster care placement;

  Respite care of children to provide temporary relief for parents and other caregivers (including foster parents);

  Services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition; and,

Case management services designed to stabilize families in crisis such as transportation, assistance with housing and utility payments, and access to adequate health care.

Family support services are also funded by Subpart 2 and are to promote the well-being of children and families and are designed to increase their strength and stability. The purpose of these services are to increase parents' confidence and competence in their parenting abilities, to provide children a stable and supportive family environment and to enhance child development. Again, these services include adoptive, foster and extended families. Family support may include:

- Services, including in-home visits, parent support groups, and other programs designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition;
- Respite care of children to provide temporary relief for parents and other caregivers;
- Structured activities involving parents and children to strengthen the parent-child relationship;
- Drop-in centers to give families opportunities for informal interaction with other families and with program staff;
- Transportation, information and referral services to other community services, including child care, health care, nutrition programs, adult education literacy programs, legal services, and counseling and mentoring services; and,
- Early developmental screening of children to assess the needs of such children, and assistance to families in securing specific services to meet these needs.

- The Child Abuse Prevention and Treatment Act (CAPTA) State Grant Program provides funding to assist State agencies in improving: prevention, intake, screening, assessment and investigation of child abuse and neglect reports; training for child protective services workers and mandated reporters; risk and safety assessment protocols; and programs and procedures for the identification, prevention, and treatment of child abuse and neglect. In FY 2003 the Federal government provided $22 million for this program.

  Community Based Child Abuse Prevention grants are provided to States under Title II of CAPTA to develop, operate, expand and enhance Statewide systems of community-based, prevention-focused, family resource and support programs; foster the development of a continuum of preventive services through State and community-based public and private partnerships; and finance public information activities focusing on the healthy and positive development of families and child abuse and neglect prevention activities. In FY 2003 the Federal government provided approximately $33 million for this program.

  CAPTA Discretionary Grants fund a range of projects focused on research into the causes, prevention, and treatment of child abuse and neglect; demonstration programs to identify the best means of preventing maltreatment and treating troubled families; and the development and implementation of training programs. Grants for these projects are provided nationwide on a competitive basis to State and local agencies and community and faith based organizations. In FY 2003, approximately $18 million in discretionary

funds were awarded to support new and continuing research and demonstration grants, as well as evaluation, technical assistance and information dissemination activities.

The Chaffee Foster Care Independence and the Educational and Training Voucher Programs provides funding for support services, job training, housing, educational assistance and other services and skills needed for older youth (mostly ages 16-21) moving from foster care. In FY 2003, the Federal government provided $182 million for this program.

► Alcohol and Drug Services

- The Substance Abuse Prevention and Treatment (SAPT) Block Grant

The SAPT Block Grant program is the cornerstone of States' substance abuse programs. Based on a recent review of State data from the 2002 block grant applications, it has been determined that for 1999, the SAPT Block Grant accounted for approximately 40% of public funds expended for prevention and treatment. Twenty-two States reported that greater than 50% of their total funding for substance abuse prevention and treatment programs came from the Federal block grant. Eleven States reported block grant funding at greater than 60% of the total spent, while seven States reported over 70%. In 2004, SAPT Block Grant will provide approximately $1.8 billion to States and territories for distribution by formula.

Block Grant funds are to be used only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities including requirements regarding tuberculosis and human immunodeficiency. In addition, States are required to expend amounts from each SAPT Block Grant award for the following set asides.

- Primary Prevention - At least 20% must be set-aside for programs for individuals who do not require treatment for substance abuse
- HIV Early Intervention Services – 5% must be set-aside and expended for services for HIV Early Intervention
- Services to Pregnant Women and Women with Dependent Children – States may not expend less than the total they expended in Fiscal Year 1994 on programs for women who are pregnant or parenting children

In addition to the above set-asides, other requirements include:

- Notification of capacity for programs for the treatment of intravenous drug abuse
- Specific services for HIV and Tuberculosis for persons already receiving treatment for alcohol and drug abuse
- Admission preference for treatment services for pregnant women and women with dependent children

SAPT Block Grant funds may NOT be expended for:

- Inpatient hospital substance abuse programs, except when such treatment is a medical necessity and the individual cannot be treated in a community-based, non-hospital, residential treatment program.
- To make cash payments to recipients
- To purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.
- To provide financial assistance to any entity other than a public or non-profit private entity.
- To provide individuals with hypodermic needles or syringes.

- Programs of Regional and National Significance

Programs of Regional and National Significance include SAMHSA/CSAT's entire discretionary budget. These resources are CSAT's primary tools to focus Federal funding on particular service improvements and priority needs. These programs help to build, maintain, and enhance substance abuse treatment infrastructure and capacity by providing funding to States, communities, and service systems to increase the availability of services and meet urgent and emerging community needs. Included in these programs are treatment services programs targeting women with children, adolescents, and the funding of family drug treatment courts. In future years, SAMHSA's discretionary grant program will include Services Grants, Infrastructure Grants, Best Practices Planning and Implementation Grants, and Service to Science Grants.

In FY 2004, SAMHSA will initiate a $100 million drug and alcohol treatment voucher program entitled, "Access to Recovery," which will be targeted to States. States participating in the program may use a range of models for implementing treatment vouchers, including full implementation by a State or sub-State agency or implementation of all or part of the program through partnership with a private entity. Within a State, the program may be targeted to areas of greatest need or areas where there is a high degree of readiness to implement the program. Together with this program, the entire budget for Programs of Regional and National Significance is $419 million for FY 2004.

- Medicaid

Title XIX of the Social Security Act provides health care to qualifying beneficiaries through the Medicaid program administered by the Centers for Medicare and Medicaid Services (CMS). Within broad national guidelines, each of the States establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Thus, Medicaid varies considerably from State to State.

In general, all covered individuals must fall into certain categories -- children, the parent(s) or caregivers who live with them, persons age 65 or over, or persons with permanent disabilities. States can, however, apply to the Federal Department of Health and Human Services for a waiver to cover other population groups, such as single males at risk of becoming permanently disabled. A number of States have received waivers to cover such "expansion" populations. Eligibility for Medicaid coverage is means-tested, i.e., the applicant's income must be below a certain ceiling. For children and pregnant women, Federal law requires that the minimum income ceiling be 133 percent of the Federal poverty level (FPL) for pregnant women and children under six; for children ages 6 through 18, the minimum is 100 percent of the FPL. States must also, with certain exceptions, cover seniors and persons with disabilities who are receiving cash assistance under the Federal Supplemental Security Income program, children in foster care or placed in subsidized adoption, and those who would have been eligible for cash assistance under the old AFDC program as it was configured in July 1996. For other population groups, the income standards are established by the States.

Federal law also mandates all State Medicaid programs offer a certain package of "core" benefits, including inpatient hospital care, outpatient hospital, physician, lab and x-ray, nursing facility care, home health, health screening and treatment for children (the Early Prevention and Screening, Diagnosis and Treatment [EPSDT] component, which is further explained below) and family planning.

A broad range of optional services may also be covered for which States will receive Federal matching funds; the most significant of these options is prescription drugs and for the population considered in this white paper, substance abuse treatment services. Since 1981, States have

also been able to apply for a Federal waiver to offer home and community-based services to seniors and persons with disabilities in lieu of placement in a nursing home. Every State now has at least one of those waivers.

Medicaid programs are funded jointly by the State and Federal governments. In some States counties share in a portion of the State's cost. The Federal matching percentage (FFP) varies from State to State and from year to year, according to the State's per capita income compared to the national figure. Nationally, the State share is around 43 percent.

Medicaid has increasingly become an important source of funding for child welfare services, particularly under the targeted case management and the "rehab option." which allows home- and community-based service delivery. Services are delivered by community-based professionals and include a wide range of rehabilitative services including life skills, in-home supports, pre-employment services, employment follow along services, assistance obtaining housing and employment, peer counseling and peer supports, medication self- management, symptom self-management, accessing community supports and services, family and caregiver supports and crisis response.

Some drug and alcohol treatment is provided under Medicaid, but it is a State discretionary program and not all States include substance abuse services in their programs. According to the 1996 Uniform Facility Data Set (UFDS), in 13 States Medicaid made up less than 5% of total treatment funding. In 14 States it made up between 5% and 9%, in 15 States between 10% and 19%, and in 8 States, Medicaid made up more than 20% of total treatment funding.[6]

States determine the types of services (e.g., opiate medications), duration and scope of services in their State plans. Without a specific substance abuse State plan, some services can be provided under a Medicaid service category that qualifies for Federal matching funds. For example, if detoxification is provided as a part of a general inpatient hospital treatment, in most States it is reimbursable under Medicaid.[7]

- Private Insurance

Private insurance plans, out-of-pocket expenditures, and charity groups pay about 35 percent of substance abuse treatment costs, while the public pays approximately 65 percent. In contrast, the public funds only 46 percent of all other health care costs, with private payers covering the majority of the costs. States and localities have negotiated contracts with managed care organizations (MCO's) to provide substance abuse services to State-referred clients. States have also negotiated coverage for adolescents under Federal expansions of children's health coverage, as mentioned below in discussing the State SCHIP programs.

- Temporary Assistance for Needy Families Block Grant (TANF)

The TANF block grant is administered Federally, through the Office of Family Assistance at the Department of Health and Human Services, Administration for Children and Families (ACF).

The block grant is presently funded at $16.5 billion annually and is categorized as mandatory funding and is therefore, not subject to the yearly appropriations process. Funding for both the high performance and out-of-wedlock bonus and supplemental grants to States are not included in the base funding. To receive Federal block grant funds, States are required to maintain funding for qualified program expenditures at a level equivalent to at least 80 percent of the State share of AFDC expenditures in Federal FY94—when welfare caseloads were at their highest levels in recent history. If the State meets the work participation rate requirement, the MOE requirement drops to 75 percent.

TANF funds programs in most States that support families so that children may be cared for in their own homes or in the homes of relatives. Some of these supports include Family Resource Centers that bring together a range of health and human service providers into a community-based mutli-service center.

In addition, TANF is currently used in a number of States to fund substance abuse services. In the current bills in Congress to re-authorize TANF, substance abuse treatment is proposed to be an allowable activity to fulfill the parents' work requirement. Proposals vary in the length of treatment to be allowed from three to six months.

States may also use TANF funds for child care and social services. States may transfer TANF funds into the Child Care and Development Block Grant (now the Child Care and Development Fund (CCDF) explained below). States can also directly spend TANF funds on child care without transferring them to the CCDF. In addition, a State may transfer TANF funds to the Social Services Block Grant (SSBG). A State may transfer up 10 percent of TANF grant funds for a fiscal year to the SSBG, and a maximum of 30 percent to SSBG and CCDF combined. Once funds are transferred, they become subject to the rules of the receiving program.

- **Social Services Block Grant (SSBG)**

The Social Services Block Grant (Title XX) provides funding used by many States to support child welfare. In 2001, across all States, the highest proportion of SSBG expenditures was for child protective services; the second highest was for child foster care services. Forty-three States collectively reported $314 million of SSBG expenditures for child protective services (12%) and 35 States reported $270 million of SSBG expenditures for child foster care services (10%). The next largest expenditures, each more than $200 million, were for special services for individuals with disabilities (8%), prevention and intervention (8%), home-based services (8%), and child day care (8%). Administrative costs, which include staff training and licensing, were $270 million and accounted for 10 percent of SSBG expenditures.

Twelve States reported SSBG expenditures for substance abuse services; 39 States did not report any SSBG expenditures for this service.

- No more than 6 percent of a State's SSBG expenditures were used for substance abuse services.
- SSBG expenditures for substance abuse services were $16 million; New Jersey's SSBG expenditures for substance abuse services accounted for 31 percent of that amount.
- Compared with funding from other Federal, State, and local sources, two States funded substance abuse services primarily with the SSBG -- Nevada (100%) and North Carolina (75%).

- **Community Services Block Grant (CSBG)**

The Community Services Block Grant (CSBG) is a Federal, anti-poverty block grant, which funds the operations of a State-administered network of local agencies. The Federal agency, which oversees the block grant (the CSBG and the SSBG), is the Office of Community Services within the Administration for Children and Families at the U.S. Department of Health and Human Services.

State CSBG administrators must pass through 90 percent of the monies to local agencies. Up to five percent is deemed a State administration allotment that can be used to cover the administration of the program. The last five percent is deemed discretionary dollars and can be used to build the capacity of the network, demonstrate new initiatives and/or provide training and technical assistance.

The CSBG network consists of more than 1,100 agencies that create, coordinate and deliver programs and services to low income groups in 96 percent of the nation's counties. Most agencies in the CSBG network are Community Action Agencies (CAAs) created through the Economic Opportunity Act, a predecessor of the CSBG. Community representation and accountability are hallmarks of the CSBG network, where agencies are governed by tri-partite boards, consisting of elected public officials, representatives of the low- income community, and appointed leaders from the private sector.

As outlined in the CSBG legislation, the network operates programs in, but not limited to, the following areas: housing, nutrition, healthcare, alcohol/substance abuse, employment, income management, education, transportation, childcare, and family relationships.

► Other Sources of Funds for Services for Children and Adolescents

■ Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental, and hearing services. In addition, the Social Security Act requires that any medically necessary health care service be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Certain activities are required by the State Medicaid agencies including: States must inform all Medicaid-eligible persons under age 21 that EPSDT services are available; they must set specific periodicity schedules for screening, dental, vision, and hearing services; and, they must annually report EPSDT performance information.

The EPSDT program consists of two components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources.

The EPSDT benefit must include: screening, health education, vision services, dental services, hearing services and other necessary care to treat physical and mental illnesses and conditions found in screening services. The purpose of EPSDT is to diagnose health conditions early, before they become complex and their treatment more costly. Under EPSDT, children and adolescents are to be screened for developmental delays, mental health conditions, and substance use disorders. Unfortunately, States vary considerably in their mental health and substance abuse policies and practices. Training among health care practitioners regarding EPSDT screening is needed to improve screening practices for these concerns.[8]

■ State Children’s Health Insurance Program (SCHIP)

The Balanced Budget Act of 1997 created a new children's health insurance program called the State Children's Health Insurance Program (SCHIP). This program gave each State permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a State administered program and each State sets its own guidelines regarding eligibility and services. Families that do not currently have health insurance are likely to be eligible, even if they are working. The States have different eligibility rules, but in most States, uninsured children under the age of 19, whose families earn up to $36,200 a year (for a family of four) are eligible. For little or no cost, this insurance pays for: doctor visits, hospitalizations, immunizations and emergency room visits. States were given the option of expanding their existing Medicaid coverage to incorporate the goals of this program, or to establish separate SCHIP programs.

- **Child Care**

The Child Care and Development Block Grant (CCDBG) was first authorized as an amendment to the Omnibus Budget Reconciliation Act of 1990 and was reauthorized by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193). Its intent is to assist low-income families, families receiving temporary assistance, and those transitioning from public assistance in obtaining child care, so they can work or attend educational and training programs. The Department of Health and Human Services selected the name Child Care and Development Fund (CCDF) to signify the unification of the CCDBG with the new child care subsidy funding available under the Social Security Act. The CCDF program is administered by States, territories and tribes by the Child Care Bureau in the Administration on Children, Youth and Families.

The CCDF is a consolidation of three Federal funding sources (discretionary, mandatory and matching) and two State funds (maintenance of effort and matching).

- *Discretionary funding* is authorized by the CCDBG and appropriated by Congress annually. States are not required to match discretionary funds. Discretionary funds must be obligated in the year they are received or in the subsequent fiscal year. All discretionary funds must be liquidated within three years of award.
- *Mandatory funds* were pre-appropriated for a multi-year period. No matching funds are required. A State must obligate mandatory funds within one year in order to request matching funds. If a State does not request matching funds, there is no fiscal year limitation on the expenditure of mandatory funds, and they can be carried over from year to year.
- *Matching funds* were created under PRWORA and are remainder funds (the difference between the amount appropriated by Congress for a given year and the amount of mandatory funds distributed to States). To be eligible to receive matching funds, States must provide matching funds at the current Medicaid match rate; obligate the Federal and State share of matching funds in the year in which the matching funds are awarded; obligate all of its mandatory funds in the fiscal year in which the mandatory funds are awarded; and obligate and expend its Maintenance of Effort (MOE) funds in the year in which the matching funds are awarded.

States must set aside a minimum of 4 percent of their overall Federal funding for child care to be used for activities that improve the quality of child care. Administrative costs under the CCDF are capped at 5 percent. Other set asides include funding for Infant and Toddler programs, Child Care Resource and Referral Services, and School age programs.

- **Developmental Services**

State governments provide a wide range of residential and daytime services for individuals with developmental disabilities. These disabling conditions result from mental retardation and a wide-range of other disabilities that occur during the developmental period between ages 0 and 21 and include conditions such as cerebral palsy, epilepsy, autism and many other related neurological disorders. Some of these disabilities may be related to prenatal exposure to alcohol or other substances. Developmental disabilities programs must address a broad spectrum of medical, social, psychological, and educational needs throughout an individual's lifespan, and, in recent years, have been characterized by: an emphasis on the most *integrated community-based* setting; increased reliance on *private providers* of services; a growing emphasis on *self-directed, individually tailored services* and supports; and, *decentralization* of decision-making authority

Over the past two decades, the Federal-State Medicaid program has emerged as the principal source of funding for long-term services to individuals with developmental disabilities. The two primary Medicaid funding avenues available to the States are: (a) payments on behalf of residents of public and private intermediate care facilities for persons with mental retardation (ICFs/MR); and (b) payments on behalf of participants in home and community-based services (HCBS) waiver programs. Another significant source of Federal revenue includes Title XX, Social Services Block Grant Program, Supplemental Security Income (SSI) and Social Security Old Age, Survivors and Disability Insurance (OASDI) benefits are individual entitlements.

- **Special Education**

The Individual with Disabilities Education Act (IDEA) is the Federal law that mandates special education supports and services to the nation's infants and toddlers, preschoolers, children and young adults. Originally passed by Congress in 1975 as the Education for All Handicapped Children Act of 1975 (P.L. 94-142), the law has been amended several times, most recently in 1997. Special education services are funded through a combination of Federal, State and local funding. There are three large formula grant programs as well as numerous Federal-level programs.

- *Part B* – is considered the cornerstone of the program providing grants to States that assist States in providing a free appropriate public education to school-age children with disabilities
- *Part C* – the Infants and Toddlers Program, assists in providing early intervention services to infants and toddlers under the age of three.
- *Section 619* – of Part B provides funding for services to children with disabilities ages three to five
- *Part D* of the program provides funding for research, personnel preparation and in-service training.

For parents and caretakers of substance-exposed children, these funds are critical and can provide strong legal authorization for services.

- **State Mental Health Authorities (SMHAs)**

In general, the focus of SMHAs is to serve adults and children with the most serious psychiatric disorders. Most are unemployed, poor, and uninsured. They are frequently homeless and are significantly over-represented among the segment of the population in contact with the criminal and juvenile justice systems. Most adults served by SMHAs suffer from mental disorders including schizophrenia, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. The children served are generally those with diagnosable mental health problems that severely disrupt their ability to function socially, academically, and emotionally.

Funding for SMHAs is derived from a variety of sources, including State appropriations and Federal funds in the form of block grants, Medicaid, Medicare, and other miscellaneous sources. As with all State government offices, the governor is ultimately the supervisor of each SMHA. In some States, an appointed board of directors guides the development and progress of each SMHA. An SMHA could be located in a State's health or human services department, or it could be an independent State agency. Many SMHAs include the State's offices of substance abuse, trauma/domestic violence, and mental retardation services.

■ SAMHSA Discretionary Grants Serving Children and Adolescents

While discretionary grants do not offer the amount or continuity of other Federal programs, SAMHSA has several discretionary grant programs serving children and adolescents. Since 1998, CSAT has been making awards through local and State units of government to enhance and expand the drug and alcohol treatment services for community providers, targeting adolescent populations.

SAMHSA's Center for Mental Health Services (CMHS) supports the National Child Traumatic Stress Initiative cooperative agreements to improve the quality of treatment and services received by children and adolescents who have experienced traumatic events. These awards are also designed to increase access to treatment and services throughout the country.

In 2004, SAMHSA will be awarding Children's State Incentive Grants to enable States to develop and enhance their children's service system infrastructure in order to increase their capacity to serve children and adolescents with serious emotional disturbance, substance abuse disorders, and co-occurring disorders, and their families. Infrastructure enhancement activities may include, for example, policy development, network building and development of cross-system partnerships and structures, coordinated funding planning, development of integrated data and accounting systems, workforce development, planning for implementation of evidence-based practices, training and technical assistance. While the Children's State Incentive Grants may not support direct service delivery, increased service capacity and increased access to services are expected outcomes of the program.

► Other Sources of Funding for Serving Parents and Families

■ Workforce Development

In 1998, Congress passed the Workforce Investment Act (WIA), the first major reform of the nation's job training system in over 15 years. It was designed to replace the patchwork Federal system that developed over the last sixty years with a locally designed and driven system to improve the quality of the workforce, enhance the productivity and competitiveness of the nation and reduce welfare dependency. The Workforce Investment Act took effect on July 1, 2000. It was designed to permit communities and States to build a workforce investment system that respects individual choices, reflects local conditions, and results in increased employment, retention, and earnings of participants, and increases occupational skills attained by participants.

The major public funding sources for the employment and training services provided under the WIA are Federal general revenue funds that are appropriated to the U.S. Department of Labor. The funds are allocated by formula to States and further distributed by formula to local workforce investment areas. In most cases, the State grantee is the State workforce agency, sometimes also referred to as the State Labor Department or State Employment Security Agency.

Each State and local area has a workforce investment board (WIB), appointed by the local elected official, to assist in the development of the State plan and set policy for the local area. Each State and local board must develop and submit to the governor or local-elected official a comprehensive five-year local plan.

■ Housing

Because of the importance of providing housing for persons in both inpatient and outpatient programs, some substance abuse providers have become skilled at working with housing funding sources. Some programs have used clients' TANF funding for a portion of the room and

board costs of treatment; others have tapped Federal housing and social services programs that support homeless persons and families for temporary housing. Housing is also a critical aftercare expense, and some programs have mastered the complexities of Section 8 and other Federal housing support programs as a means of providing aftercare services to meet a critical need for children and families affected by substance abuse.

► Courts

States and localities fund courts in many different ways—most typically through State general funds. There are also Federal programs that provide funding for innovative court programs, including efforts by dependency courts to improve substance abuse services. At times, those special funds may include funding for services; typically, however, courts are not a funder of direct services.

■ Court Improvement Program

The State Court Improvement Program (CIP) was created as part of the Omnibus Budget Reconciliation Act (OBRA) of 1993, Public Law 103-66, which among other things, provided Federal funds to State child welfare agencies and Tribes for preventive services and services to families at risk or in crisis. OBRA designated a portion of these funds ($5 million in fiscal year 1995 and $10 million in each of FYs 1996 through 1998) for grants to State court systems to conduct assessments of their foster care and adoption laws and judicial processes, and to develop and implement a plan for system improvement. Awards are made to the highest State courts in States participating in the IV-E program. The Adoption and Safe Families Act of 1997 (ASFA), Public Law 105-89, reauthorized the CIP through 2001, which Congress funded at $10 million annually. There were no substantive changes made to the CIP in the 1997 reauthorization.

The Promoting Safe and Stable Families Amendments of 2001, Public Law 107-133, reauthorized the Court Improvement Program through FY 2006. The law also expands the scope of the program to: (1) include improvements that the highest courts deem necessary to provide for the safety, well-being, and permanence of children in foster care, as set forth in ASFA; and (2) implement a corrective action plan, as necessary, in response to findings identified in a child and family services review of the State's child welfare system. Public Law 107-133 authorizes a mandatory funding level of $10 million for CIP and new discretionary funding for FYs 2002 through 2006. From any discretionary funding appropriated annually for the Promoting Safe and Stable Families Program, the law authorizes a 3.3 percent set-aside for the CIP. Finally, the Court Improvement Program authority was transferred to a new section 438 of the Social Security Act.

As of FY 2001 all eligible States (50 States, the District of Columbia, and Puerto Rico) are receiving annual Court Improvement Program grants. Typical activities include development of mediation programs, joint agency-court training, automated docketing and case tracking, linked agency-court data systems, one judge / one family models, time-specific docketing, formalized relationships with the child welfare agency, improvement of representation for children and families, CSFR program improvement plan (PIP) development and implementation, and legislative changes. For further information, call the Children's Bureau at (202) 205-8709.

Options in Child Welfare Funding

There are several options which States could use to explore uses of Title IV-B funding to purchase substance abuse services if the family is receiving in-home services. Either IV-B Part 1 (child welfare services) or IV-B Part 2 (Promoting Safe and Stable Families) may be used for either parent treatment that is needed to resolve child welfare problems or for related services

such as child care, transportation, and case management. These funds are flexible for "time limited reunification services," so that both parents whose children are in care and parents whose children are still at home can be included.

In addition, with a correctly written State plan, agencies could use IV-E administration money with local (or State funds) for the 50% match to pay for case management of recovery services delivered by a substance abuse counselor and agency if they are contracted to provide services to families in child welfare—just as these services are contracted to child-serving agencies. In some cases, a treatment agency can be funded as a foster/group home placement if they have fewer than 25 children in care, and if the parent is in treatment and supervised by staff. States may also be able to use foster homes as "family care," with Title IV-E funding used for the child's care and parents' room and board paid by the substance abuse agency (or, as described above in the housing section, by TANF resources). Detailed discussions with the Federal regional offices are essential in exploring these options. State licensing standards may vary, so this approach needs to be reviewed by State licensing staff early in the process.

Finally, the Children's Bureau currently has authority to grant waivers of Title IV-B and IV-E requirements, providing States with an opportunity to use Federal funds more flexibly in order to test innovative approaches to child welfare service delivery and financing. Four States have operated waivers specifically addressing substance use disorders—Delaware, Maryland, New Hampshire, and Illinois. As of November 2003, twelve States are operating seventeen different waiver projects, and two States (Illinois and New Hampshire) are continuing to operate waiver programs that cover substance abuse services.[9] This authority is available at present through 2004, and is expected to be renewed.

Options in Alcohol and Drug Services Funding

In working to develop multiple funding streams for parents with substance use disorders in the child welfare system, several steps can be helpful:

- Look at the percentage of total substance abuse funds utilized by women and women with children, to determine whether their share is proportionate to their needs in the State
- Look at the available information on the short-term effectiveness of programs for child welfare families (even if focused only on retention measures) for decisions about redirection
- Look at in-prison and post-release substance abuse treatment programs that target parents, who may include parents whose children have been taken into custody
- Explore mental health funding options, including Medicaid, in light of the substantial portion of parents with co-occurring mental health problems
- Review the availability of tobacco settlement funding, which in some States has been available for funding treatment programs that aim at reducing prenatal use of alcohol, tobacco, and illicit drugs
- States also control excise taxes on alcohol and tobacco products that have been used in some States to expand resources for this population

The Lessons of Prior Efforts

Agencies working in a coalition that is addressing funding issues for families affected by substance use disorders can take advantage of several lessons from prior efforts. These include:

- ► Take inventory—it is easier to connect resources already in place if they are well-inventoried, and very difficult to link programs that have never been identified as part of the available resources.

A frequent concern expressed by child welfare staff is that "there are no treatment slots." Yet it is very rare that child welfare staff (or their substance abuse counterparts, in fact) have ongoing access to a current list of all the funding streams for treatment and the slots that are currently supported by those funding streams. As a result, the generalization that there are no slots may not be well-founded, and may be based only on anecdotes.

The development of "children and family budgets" in some States and localities have helped those jurisdictions identify multiple funding sources. Other States, notably Arizona, have developed inventories of funding with geographic identifiers that enable an annual assessment of what funding streams are used for which programs. Many States, however still have no comprehensive inventories of all funding streams that are being used to support ADS programs in that State; a recent effort in California identified more than $1 billion in funding flows for substance abuse treatment and prevention programs from fifteen different sources.

Once identified, the inventory must be updated routinely because of the changes over time in funding streams; a directory must be kept current, which requires the knowledge base and staffing to keep abreast of changes. Arizona has revised and annually updated its inventory for twelve years, and uses it to review the extent to which best practices programs are being funded by State agencies.

States and localities may also wish to develop a "two-generation" project overview that addresses funding streams and programmatic activities aimed at supporting women and their children under TANF, child welfare, substance abuse funding sources, and State-specific programs that may be based on tobacco taxes or tobacco settlement funding. Once these funding streams have been identified in a single site, it becomes easier to review how these funds are used and the extent to which current best practices are being used and for which populations.

- ► Remember both parties must gain from negotiations over funding

Reciprocity must be the watchword; a meeting about "re-allocating *your* funding" is not an invitation to collaboration that most agencies will welcome. The tone of interagency efforts must be that all funding is "on the table," not a single funding source.

- ► Both budget and program people must be part of sustained discussions

A single meeting of either budget or program staff is unlikely to produce results. Both kinds of expertise are needed, along with feedback from staff most familiar with the auditors (State and Federal).

- ► Assemble relevant background materials so that participants in the discussion can see that other States and national organizations have addressed the issues of multiple funding streams and made some progress.[10]

Some of the most innovative of these efforts have been made by women's treatment providers, some of which have described their successes in combining more than forty different funding streams to achieve diversified funding for their programs.

► Pick the best bets

Realistically, once a State or locality has a first-approximation of an inventory, it would not be a good use of resources to devote equal attention to what may prove to be as many as two dozen or more funding sources, once Federal, State, and local funding streams are all identified. Each jurisdiction will need to pick a few "best bets" to pursue, based on several criteria:

- Where resources are most significant
- Where new flexibility may be available
- Where champions of a linked funding approach may exist within the leadership of another agency

► Don't forget that the cheapest money can be redirected funds that are already in the State or locality

At times, States and localities can find themselves caught up in an ongoing effort to pursue the latest grant, in ways that ignore resources already in the community. In scarce budget climates, fiscal conservatives sometimes point out, it becomes all the more important to ensure that current spending is used effectively, rather than being allocated to outdated programs that may no longer be successful in attracting clients or serving them well. A redirected dollar requires no grant application, no grant renewal process, nor any skewing of agendas to meet what the funder wants to do rather than what the local agency wants to do. It is money that is already in the State or community, and thus it is an appropriate target for questions of effectiveness when that community finds itself in fiscal hard times.

Both prevention and treatment programs that have been assessed to be ineffective—or that have no capacity or willingness to measure their outcomes—are appropriate targets in tight budget times. A redirection agenda that annually reviews a small number of programs that are less able to document effectiveness can create a very different climate from the entitlement attitude that sometimes prevails when the same agencies have received funding year after year. As the Federal government moves to emphasize performance-based and evidence-based funding in its support for both child welfare and substance abuse outcomes at the State and local level, a greater emphasis is expected on redirection of programs toward those best able to demonstrate effectiveness on these criteria. A 10% shift in current funding from ineffective to effective programs may represent far more "new" funding than may be available from external sources.

Conclusion

Combining different funding streams is likely to remain a necessary task for agencies and communities that seek better programs for parents and children in the child welfare system who are affected by substance abuse. Categorical funding streams are not likely to disappear, nor are the complex needs of the families we serve. The hopeful news is that States and communities have shown that they can respond to Federal flexibility with their own ingenuity in linking funding with families. The challenge, however, will remain doing so at scale with programs that are effective because they aim at multiple problems.

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[9] These projects are summarized by the Administration for Children and Families at http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2007/summary_demo2007.htm

[10] In addition to the APHSA report already mentioned, *Opportunities for Collaboration Across Human Services Programs,* these sources include an earlier APHSA report: *Connecting CPS and SA Treatment in Communities: A Resource Guide*, published in 2001; APHSA's *Federal Funding for Substance Abuse Treatment and Support Services: Sources and Uses,* published in January 1999; in CSAT's TIP #38, *Integrating Substance Abuse Treatment and Vocational Issues*, a chapter (Chapter 6) was included on funding and policy issues, including discussion of flexible funding options and the need to develop family-centered funding strategies in contrast to categorical funding streams.