

Building Community Solutions to Substance Abuse and Delinquency

Financing Collaborative Approaches and Challenges for Building Integrated Systems

Tom Gerstel
and
Patricia Shane, Ph.D., M.P.H.
for the
Robert Wood Johnson Foundation
Reclaiming Futures Initiative

March 29, 2001

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DELINQUENCY**

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I. INTRODUCTION

National expenditure data for mental health and substance abuse treatment services remain challenging to evaluate and forecast. Only recently, between 1987-1997, has the capacity been developed to estimate the overall mental health (MH) and substance abuse (SA) service expenditures in a manner consistent with overall national health care expenditures.

In the narrower framework of integrating juvenile justice services with substance abuse treatment, there are six relevant key national findings by Substance Abuse and Mental Health Services Administration (SAMHSA) and others that are notable. In addition to findings by SAMHSA the work of Coffey et al., Dennis & McGeary, Ford et al., the Hay Group, McKusick et al., and Tau et al. have contributed to a better understanding of the breadth of the challenges faced in the fields of delinquency and substance abuse treatment. Overall, MH/SA treatment accounts for less than 10 percent of all US health care expenditures, inclusive of all age groups, while trends indicate that the share is dwindling, relative to all health care. Within this category of funding, most of the money (86 %) is directed at mental health services. In combination with the nation's relatively small funding levels for substance abuse treatment, national trends suggest that cost containment measures are eroding access to treatment services through employee benefits.

- Children and youth constitute about 28 percent of the population, but only account for about 14 percent of total national health care expenditures.ⁱ
- McKusick et al. found the total national expenditures for MH/SA treatment for children, youth, and adults totaled \$79.3 billion in 1996 (*Ford, 2000, p48*).
- MH/SA expenditures represented 7.8 percent of the more than \$1 trillion in all U.S. health care expenditures in 1997, down from 8.8 percent in 1987.ⁱⁱ
- Combined child, youth, and adult national expenditures for MH/SA treatment services were reported by SAMHSA to total \$85.3 billion in 1997 (*Tau, 2000, pp65-92*). These data do not disaggregate information specific to youth/adolescents. Of this total:
 - \$73.4 billion (86 percent) was for mental health treatment.
 - \$11.9 billion (14 percent) was for substance abuse treatment (*Coffey, 2000, pii*).

- While MH/SA expenditures increased at an annual rate of 7.2 percent between 1986 and 1996, the rate of increase was only half that in general health care expenditures during the same period. [\$39.5 billion in 1986 to \$79.3 billion in 1996].ⁱⁱⁱ
- Between 1988 and 1997 the value of employer general health care benefits dropped 7.4 percent while the overall value of behavioral health care benefits dropped 54.1 percent.^{iv}

Estimates of spending on publicly financed treatment services range between 49 percent^v to 69 percent^{vi} of all substance abuse services. This 20 percent disparity appears to reflect whether Medicaid and Medicare expenditures are classified as public expended funds or assigned as third party insurance benefits. Privately financed services account for an estimated 31 percent of all remaining substance abuse treatment. These global numbers do not allow a consideration of costs and funding specific to adolescents, but they provide a broad introduction to the position of SA treatment within national funding priorities.

Adolescent substance abuse treatment financing occurs in a complex, bifurcated system with multiple and divergent mandates, underdeveloped case coordination capabilities, lack of integrated youth services, and levels of care that are too often missing within a community's treatment resources. Reliable information on costs and services for adolescents is lacking, in part, because there is no single "authority" to which all treatment providers must directly or indirectly report. Treatment providers today may report to the federal government, state agencies, or local entities in a variety of formats on an array of services that are often not well organized, integrated, or logical. We still have limited research and clinical clarity regarding the highly complex interplay between juvenile justice systems and adolescent substance abuse treatment. While there is significant information available on national trends, much remains to be developed in these evolving youth systems. A new budgetary paradigm, devised with active participation by all stakeholders, could play a pivotal role in the planning and implementation of system changes.

The 2001 Drug Abuse Education, Prevention, and Treatment Act, introduced by a bipartisan group of lawmakers in February 2001, calls for \$2.7 billion in spending over the next three years to increase drug treatment services. In its current form, the bill includes \$300 million in new spending for adolescent residential drug treatment programs and \$76 million in expanded funding for substance abuse research. The Substance Abuse and Mental Health Administration would receive \$100 million next year to expand its community and school-based drug education program for children (*Zwillich, 2001*). It truly is a time for planning and *Reclaiming Futures: Building Community Solutions to Substance Abuse and Delinquency*.

A. Hidden Costs of Substance Abuse to States

Many of the costs associated with substance abuse are embedded in state departments and activities that are not connected to prevention or treatment efforts. Most state budgets are organized by function: education, health, family assistance, mental health and disabilities programs, public safety, justice, and state workforce programs. State budget revenue and cost centers are typically categorical and most programs are separate budget line items based on the organizational structure of the state. While most states engage in annual budget processes, the cross system-impact of substance abuse problems is rarely assigned explicit costs, nor has it been the focus of actuarial studies or long-term policies for resource investment and allocation. Elected officials have political incentives that tend to encourage a focus on shorter-term results, while longer-term comprehensive infrastructure solutions to improve substance abuse and juvenile justice systems have been elusive.

In January 2001, The National Center on Addiction and Substance Abuse at Columbia University released a comprehensive 3-year study on the devastating societal costs attributed to substance abuse. The report, **Shoveling Up: The Impact of Substance Abuse on State Budgets**, conservatively estimates some of the hidden costs of substance abuse on state budgets. The findings demonstrate the tremendous havoc substance abuse has on education, health, child and family assistance, mental health and developmental disabilities, public safety, state workforces, and our justice systems.

- In 1998, the 50 states' annual spending budgets totaled \$620 billion; researchers estimate that \$81.3 billion (13.1 percent) was used to address costs and problems associated with substance abuse.
- For every dollar states spent on adults and children, only four cents was used to provide substance abuse education, prevention, treatment, and research activities.
- In 1998, states spent approximately \$2.2 million on prevention and treatment efforts with *children and youth*. In total, states spent \$24.7 billion on the *consequences* of substance abuse to children. This represents 113 times the spending on prevention or treatment.
- States spent another \$2.9 billion on substance-involved youth in the juvenile justice systems – again, 10 times more than the spending on prevention and treatment.^{vii}

B. Developing Capacity

The substance abuse service systems in the 50 states provide services for a little less than one million persons daily in approximately 9,600 substance abuse specialty programs (Ford, 2000, p18). Most are adults participating in outpatient services while adolescents have made up less than 10 percent of those in treatment since 1987. By 1992, the number of youth who were engaged in treatment on any given day had declined to 5 percent of the total treatment population. Since 1996, the trend has reversed and returned to 8 percent (Ford, 2000, p21).

There are gaps between utilization figures, which report the number of youths who receive SA treatment services, and published estimates about how many children and youths may need services but are not being identified nor referred for services. Dennis et al. concluded in recent work that fewer than ten percent of adolescents with past-year symptoms associated with alcohol and other drug use have ever received treatment.^{viii} During the past 10 years the complicated Medicaid reimbursement systems and shifts in managed care practices have contributed to some of the failures to adequately identify and address the needs of children and adolescents within primary care, school, and mental health systems. Almost 21 percent of children and adolescents (age 9 to 17) exhibit some distress or impairment associated with a specific mental health or substance abuse diagnosis during their adolescent years. Pediatricians, who deliver more than 150 million pediatric visits each year, are the providers most likely to encounter children/adolescents in a setting that might allow for assessment. However, the average visit lasts less than 15 minutes. Nonetheless, pediatricians estimate that 19 percent of all children they see have behavioral or emotional problems, while only 7 percent of parents report problems.^{ix}

At the same time, trends indicate a growing number of drug-related juvenile justice cases. A review of the literature suggests that notable increases in juvenile justice cases parallel a disproportionate decline in health care benefits. Furthermore the growing numbers of poor children, minority youth, and dual-diagnosed youth, all of whom are over-represented in many juvenile justice systems, may be linked to a loss of health care benefits and related barriers in access to care.

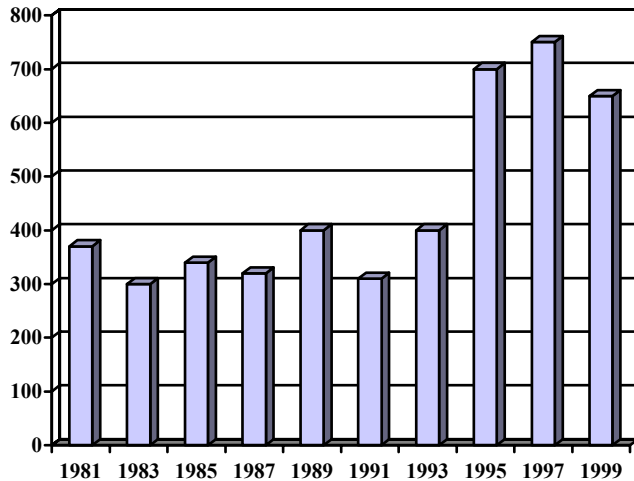
Between 1986 and 1995, the number of drug cases handled by the 3,000 juvenile courts in the United States increased nearly 145 percent.^x In 1995, the FBI reported 147,107 youth were arrested in the United States, for whom the most serious charge was a drug offense, representing 9 percent of juvenile court cases. Another 113,843 youth were arrested for liquor law violations, public drunkenness or driving while intoxicated. While these numbers are troublesome, upon closer review they become even more alarming. The data do not capture the higher number of youth involved in more serious crimes who were using/abusing substances prior to the time of their alleged offense, during the commission of the offense, or at the time of their arrest.

The 1999 national estimates for all juvenile arrests totaled 2.5 million, a decrease of 9 percent from 1995. Most of this decline involved drops in serious and violent offenses. From 1980 until 1994 the **rate for drug abuse related arrests** remained fairly constant at 300 to 400 youth per 100,000 population with the arrest rate soaring to nearly 800 by 1997. Arrest rates in this category then declined 13 percent to over 650 per 100,000 population in 1999. The increase in the number of drug abuse violation arrests between 1990 and 1999 was far greater for juveniles (132 %) than for adults (29 %) and greater for female juveniles than males.^{xi} Clearly spending for substance abuse screening, assessment and treatment has not kept pace with the heavy burden that has been absorbed by the juvenile justice systems throughout the United States. In the absence of an integrated system with the capacity to screen, assess and treat adolescents through a well considered partnership among agencies serving high risk youth, the juvenile justice

system becomes the de facto setting where adolescents with alcohol and other drug (AOD) problems are most likely to be seen.

Juvenile arrest rate for drug abuse violations

Arrests per 100,000 juveniles ages 10-17



- After staying relatively constant, the juvenile arrest rate for drug abuse violations broke out of the range in 1994, peaked in 1997, then dropped 13% by 1999.

- The Increase in the number of drug abuse violation overall arrests between 1990 and 1999 was far greater for juveniles (132%) than for adults (29%) and greater for female juveniles than males.

• *Data source:* Analysis of arrest data from the FBI and population data from the U.S. Bureau of the Census.

C. State Spending on Substance Abuse Treatment

By 1998, the 50 states reported spending \$2.5 billion on substance abuse treatment for *children, youth, and adults*.

- \$695 million spent by state departments of health.
- \$633 million spent by state substance abuse agencies.
- \$492 million spent on employee assistance programs.
- \$241 million spent by mental health institutions for dual diagnosed patients.
- \$433 million spent by state justice systems. Of this \$433 million:
 - \$149 million spent on state prison inmates.
 - \$103 million spent on adults on probation and parole.
 - ***\$133 million spent on juvenile offenders.***^{xii}

D. Barriers Across States and Systems

Juvenile laws and practices vary enormously across the 50 states. The adolescent substance abuse treatment system and juvenile justice systems are financed by a plethora of programs, laws, regulations, federal and state mandates, competing and conflicting policies, arbitrary eligibility requirements, and different definitions of similar service units that make up the framework for these widely varying service systems. Many public and non-profit agencies are funded from different and competing units of state and local government and engage in mandated, adversarial, due-process procedures with checks and balances that are often misunderstood by youth, family and community members. As these systems interact, conflicting missions, vocabularies, and responsibilities can be difficult to reconcile. Significant barriers and challenges are evident within juvenile systems and addressing them will be a necessary part of building more constructive paradigms (*Krisberg, 1998, p5*).

Historically, compartmentalized service systems each operate with their own long-standing mandates and philosophical underpinnings regarding confidentiality issues. Significant differences separate behavioral health care practitioners and juvenile justice professionals. As juvenile justice agencies and substance abuse treatment providers consider closer collaborative approaches and integrated services delivery systems, the challenge of complying with confidential and privileged information, laws, and policies is a critical issue requiring significant attention. Lawyers, mental health professionals, and members of the clergy have professional codes of ethics, which create additional imperatives to protect personal client information from being released to others.^{xiii} The potential for interagency strife on this and other points, such as drug testing, legal, clinical, and medical records, requires significant effort to overcome traditional barriers (*Krisberg, 1998, p9*).

II. SYSTEMS AND PARADIGMS

A. Seamless Systems - No Wrong Door

In November 2000, the U. S. Department of Health and Human Services released *Changing the Conversation: The National Treatment Plan (NTP) Initiative*. The Center for Substance Abuse Treatment (CSAT) began to develop the NTP in 1998 as a common starting point to engage people throughout the field in establishing priorities, guidelines, recommendations, and action plans that will increase treatment capacity and improve services. The NTP *Improving and Strengthening Treatment Systems* panel identified treatment planning, financing, reimbursement mechanisms and best business practices as areas vital to the framework necessary to improve treatment systems. The NTP Initiative details many of the relevant issues of financing, reimbursement, market forces and the impact of managed care.^{xiv} The recommended action steps and references in the NTP initiative merit review by individuals, community based organizations and government entities as they plan for and develop solutions to juvenile delinquency and community substance abuse problems.

B. Judicial and Educational Challenges

Judicial Leadership

The Juvenile Courts in the United States have grown to interact on a regular basis with various youth-serving and law enforcement agencies that have widely varying missions and priorities as well as complex agency specific languages. Juvenile jurisdictional systems, boundaries, philosophies, sentencing practices, and a number of other variables differ dramatically in a closed, decentralized, and often isolated fashion. Juvenile courts often struggle to address multiple service needs of court-involved families, when varying combinations of educational, mental health, substance abuse treatment, and welfare services are required. Yet, juvenile courts have little capacity to coordinate treatment plans or resources.

The juvenile court role is critical in forming collaborative approaches and the future building of integrated service systems. Within any system, there must also be the political support to finance infrastructure resources, services, and capacity building that will allow the judiciary the opportunity to advocate for the educational, social, mental health, and substance abuse treatment services of youth involved in all levels of delinquency.

Organizationally, a majority of the institutional correction systems for youth are independent bodies. They are rooted or continued to be embedded in adult correction systems and are constrained by regulatory practices, as well as service delivery guidelines.

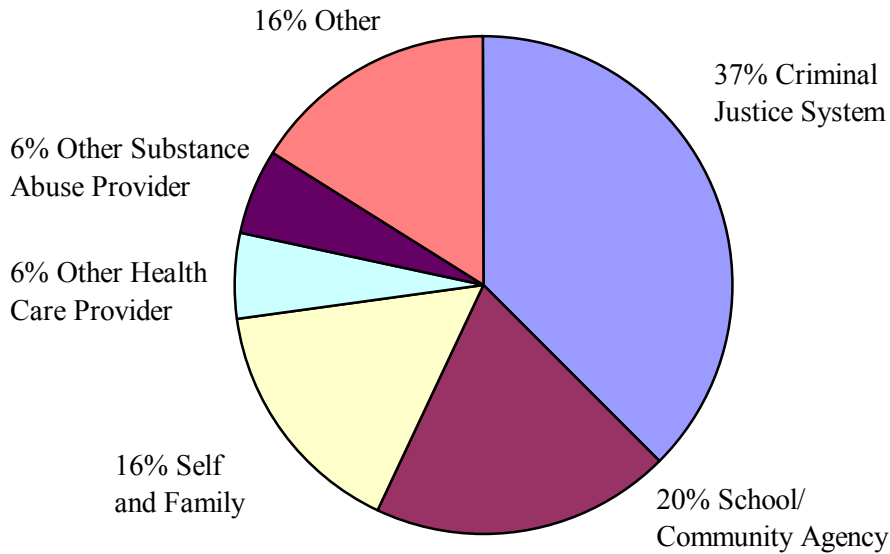
Educational Attention

Compliance with the federal special education law, the Individuals with Disabilities Education Act (IDEA) requires school districts to develop, follow up and periodically review Individual Education Plans (IEPs) for all children with disabilities. A majority of school districts and jurisdictions lack the infrastructure and prioritization to support the identification and delivery of services to youth involved in the juvenile justice systems and adolescent treatment systems.

C. Treatment Referral Sources and Levels of Care

Between 1992 and 1998 we have experienced an increase of 14 percent in the number of individuals referred from the criminal justice system for substance abuse treatment. The majority of youth involved in public treatment programs are now mandated by components of the juvenile justice system to participate in treatment. School and community agencies referred half as many youth to treatment while youth themselves or family members made up only 17% of the referrals to treatment in 1998. Alcohol continues to be a significant problem for adolescents while marijuana now, for the first time, is the leading substance mentioned in adolescent emergency room visits and autopsy reports.

Adolescent SA Treatment Admissions by Referral Source



Source:

1. Weighted based on total reported number of TEDS admissions under 18 divided by the sample (n=147,899) put in the public domain.
2. Office of Applied Studies 1998 TEDS public use data set
3. (Dennis, 2001, p19)

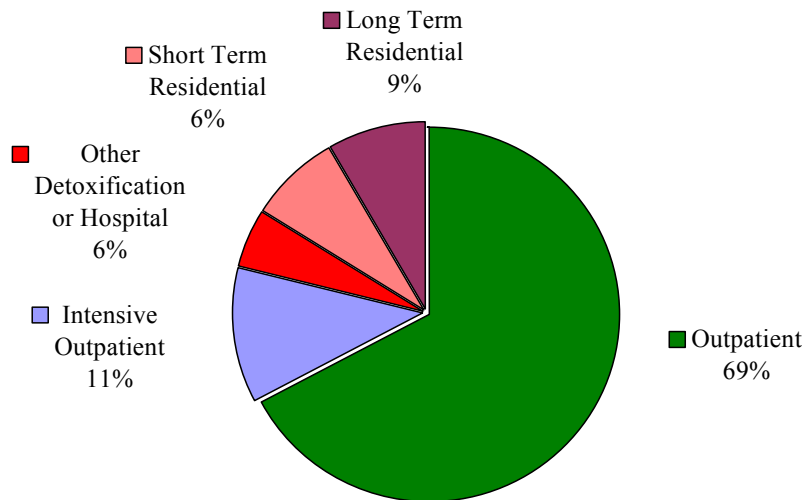
Continuum of Services

American Society of Addiction Medicine (ASAM) ASAM Patient Placement Criteria Levels of Care

The ASAM patient placement criteria is one of the primary industry tools in substance abuse treatment services for standardizing levels of care along a full continuum of services. There are clear advantages to matching individual clients to specific treatment modalities and levels of care. ASAM recognizes developmental and other specific life functioning domains as vital to engaging clients in meaningful and appropriate treatment services. Specifically for adolescents, treatment services along a continuum of care require an emphasis on program components to actively involve family members and to attend to academic needs. Flexible financing to provide for the integration of these two treatment service components should be a part of future capacity building endeavors for youth treatment and juvenile justice systems. ASAM standards are seen by many as paramount to developing funding mechanisms and strategies based on sound assessments and treatment outcome measurements that will satisfy clients as well as payors or service purchasers.^{xv}

The overwhelming majority of adolescents who participate in treatment services are receiving outpatient treatment, consisting of a variety of programming opportunities ideally designed to address major developmental, lifestyle, attitudinal and behavioral issues. Outpatient services typically include a defined program combining assessment, educational, therapeutic, and continuing care elements. Outpatient services usually involve fewer than nine contact hours per week.^{xvi}

Adolescent Levels of Care



Source:

1. Weighted based on total reported number of TEDS admissions under 18 divided by the sample (n=147,899) put in the public domain. (+ or - 3%)
2. Office of Applied Studies 1998 TEDS public use data set
3. (Dennis, 2001, p4)

These figures may reflect more about available treatment services and costs associated with accessing treatment services than about treatment matching based upon assessed needs or assignment to treatment based upon clinically determined appropriate levels of care.

III. FINANCING OF SERVICES

The primary focus of this section is the financing of substance abuse treatment delivery systems. Increased resource allocations in the area of prevention and earlier substance abuse treatment interventions hold the most promise to move more youth into healthy, productive, and honorable citizenship within our neighborhoods.

The success of Reclaiming Futures and other juvenile justice and substance abuse treatment initiatives are grounded in financial resource development and allocation.

Fundamentally sound yet flexible fiscal management and policies are necessary for long-term capacity building. It is critical that infrastructures within both juvenile justice and substance abuse treatment systems are adequate to support a full continuum of justice programs and treatment levels of care. Collaborative integrated systems that provide stable annual reimbursement mechanisms are better positioned to respond to the assuredly changing dynamics and behavioral patterns of youth involved in delinquency and substance abuse.

Establishing fair rate-setting methodologies, timely review, adjustments of rate structures, and the design of benefits are paramount as managed care principles continue to profoundly affect how alcohol and other drug treatment will be funded and delivered (*Kushner, 1995, Foreword*). As the overall health care system continues to experience rapid and profound changes the financing of substance abuse services must regain a level of parity in expenditures for services within the much larger public health area.

A. Public Sector

Public funds account for 69 percent of total treatment expenditures in the United States. Forty-eight percent of funds earmarked for prevention and treatment services are legislative appropriations from federal, state, and local governmental jurisdictions. Medicaid or Medicare programs finance the other 21 percent of public sector treatment funding. As of 1998 at least 40 state or partial state managed care plans and no less than 88 Medicaid managed care plans have become operational (*Ford, 2000, p81*). The responsible state agencies will need to assume a major role in framing their state's plans for substance abuse services. Attention to specific contractual stipulations between the States and managed care organizations will be essential and waivers with the federal government will need to be carefully crafted (*Kushner, 1995, Foreword*).

Medicaid

Created by the Social Security Act, Medicaid is a joint federal and state entitlement program administered by the states with partial federal funding for legislatively defined low-income individuals. Medicaid is the most widely utilized public third party reimbursement system that provides access to mental health and substance abuse treatment services. Federal law sets the broad guidelines for states in the financing of health care services for children and youth, including mental health and substance abuse services. States have significant and consequential flexibility in setting policies and requirements regarding the availability of Medicaid funding for specific categorical groups and services. Federal law also establishes mandatory and optional Medicaid services and states may decide to cover additional services and/or categorical groups.^{xvii}

Medicaid is substantially different from commercial insurance on several significant points. Medicaid covers many classes of benefits not common to private insurance such as long-term hospitalization for physical and mental health problems, nursing home care

or undefined conditions that do not stem from an acute illness or disability. Another important distinction lies in the mandate that Medicaid services are distinctly required to provide services to maintain a chronically ill individual while commercial coverage may exclude treatment for such conditions. Unlike Medicaid, commercial insurance has broad latitude in setting exclusions, limitations and the use of prior authorization programs (Ford, 2000, pp39-43).

Medicaid - Early, Periodic, Screening, Diagnosis, and Treatment Services (EPSDT)

This mandatory Medicaid health benefits and services program is designed for Medicaid eligible children and youth under age 21 to ensure access to early and comprehensive prevention, care, and treatment. This public health program is seriously underutilized in a number of states and could be part of a targeted service program in other states to interface with juvenile justice systems to:

- Reduce the number of youth in justice systems by earlier identification and service provision in other systems: primary care, education, and family assistance programs.
- Intervene with youth entering or exiting the juvenile justice systems with co-occurring substance abuse problems and identifiable mental health conditions.
- Implement services within the juvenile justice system to ameliorate disabilities and assist in acquisition of increasing functional abilities in major life domains with performance-based outcomes designed to move youthful offenders into less restrictive levels of care or to move them appropriately out of juvenile justice systems (Olin, 2001, p29).

State Medicaid agencies are mandated to reimburse providers for services and to confirm providers deliver EPSDT services. Expanded EPSDT financed services can provide opportunities for creative community solutions, integrated services and, most importantly, project and program sustainability.

Federal Grants – Substance Abuse and Delinquency

Forty percent of all revenues for facilities specializing in drug abuse treatment are made up from public subsidies consisting of financing from state, local, and federal block grants.^{xviii} The Catalog of Federal Domestic Assistance currently describes 1,381 federal domestic assistance programs, with over 300 administered by the Department of Health and Human Services. Twelve federal agencies with twenty-eight branches or divisions participate directly in mandated functions related to the broad mission to assist youth, parents, communities, and local government in prevention, early intervention, treatment, and juvenile delinquency control strategies.^{xix} Collectively, their mission is to provide integrated and comprehensive support to communities and local government entities as directed by Congress to address the prevailing problems and needs of youth.

Ten federal agencies administer forty-three federal grant programs that have specific congressional intent related directly to delinquency or youthful substance abuse services. Common among these programs is the strategic possibilities to develop, expand, or integrate services in combination with other entitlement programs, state, local, and/or private funding sources. These federal grant programs can form some of the foundation blocks to building community infrastructure solutions to delinquency and substance abuse.

The following list of federal agencies and forty-three grants have been identified and listed here as current programs that have the greatest likelihood of providing assistance to any substance abuse treatment providers or juvenile justice systems seeking to broaden or stabilize their funding base. These programs are listed by the primary federal agency with a more detailed listing of the division or branch that has primary responsibility for coordinating the program. For ease of reference the Catalog of Federal Domestic Assistance Number is also referenced.

Some of these listed federal programs are categorically restrictive and/or require coordination and application directly with state agencies. Others allow for and encourage a variety of applicants from private, non-profit, local and state entities. Demonstration and research grants are important in advancing innovative prevention and intervention methodologies that will often ultimately allow collaborating systems to strategically leverage additional funds based on implementation of “best practices” and improved outcomes.

Knowledge of these programs combined with advocacy at the state and local government level can result in new funding opportunities for increasing current program service volume or capacity building for new programs. It is strongly suggested that combinations of these funding resources be viewed as a parallel process at the state and local level with the overall Reclaiming Futures vision. Bringing service systems together for youth and families requires that we also bring blended and integrated funding streams and opportunities together.

Eight Grant Programs Administered by Health and Human Services

Community Services Block Grant

HHS/Administrative for Children and Families(ACF)/ Administration for Children (ACF)/Office of Community Services (OCS).

Catalog of Federal Domestic Assistance Number 93.570

Community Schools Youth Services and Supervision Program

HHS/Administrative for Children and Families(ACF)/ Administration for Children, Youth and Families (ACYF)/ Family Youth Services Branch(FYSB).

Catalog of Federal Domestic Assistance Number 93.588

Health Center Grants for Homeless Populations

HHS/Health Resources and Services Administration(HRSA)/ Bureau of Primary Health Care (BPHC)

Catalog of Federal Domestic Assistance Number 93.151

Special Project Grants to Schools of Public Health
HHS/Health Resources and Services Administration(HRSA)
Catalog of Federal Domestic Assistance Number 93.188

Community Health Centers
HHS/Health Resources and Services Administration(HRSA)/Bureau of Primary Health Care (BPHC)
Catalog of Federal Domestic Assistance Number 93.224

Urban Indian Health Services
HHS/Indian Health Services (IHS)
Catalog of Federal Domestic Assistance Number 93.19

Consolidated Knowledge Development and Application Program (KDAs)
HHS/Substance Abuse and Mental Health Services Administration (SAMHSA)
Catalog of Federal Domestic Assistance Number 93.230

Substance Abuse Prevention and Treatment (SAPT) Block Grants
HHS/Substance Abuse and Mental Health Services Administration (SAMHSA)
Catalog of Federal Domestic Assistance Number 93.959

(1998 SAPT Block Grants in fiscal year 1998 totaled \$1.36 billion.)

(AK \$2 million, AZ \$20 million, CA \$189 million, OR \$14 million, WA \$29 million, NY \$89 million, ID \$4 million)

Sixteen Programs Administered by the Department of Justice

Juvenile Accountability Incentive Block Grants (JAIBG)
DOJ/Office of Justice Programs (OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.523

Juvenile Justice and Delinquency Prevention: Allocation to States
DOJ/Office of Justice Programs (OJP)/Office of Juvenile Justice and Delinquency Prevention (OJJDP).
Catalog of Federal Domestic Assistance Number 16.540

Juvenile Justice and Delinquency Prevention: Special Emphasis
DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.541

National Institute for Juvenile Justice and Delinquency Prevention
DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.542

Gang-Free Schools and Communities: Community-Based Gang Intervention
DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.544

Title V: Delinquency Prevention Program
DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.548

Part E: State Challenge Activities (Challenge Grants)
DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.549

Justice Research, Development, and Evaluation Project Grants
DOJ/National Institute of Justice (NIJ).
Catalog of Federal Domestic Assistance Number 16.560

National Institute of Justice Visiting Fellowships

DOJ/National Institute of Justice(NIJ).
Catalog of Federal Domestic Assistance Number 16.561

Criminal Justice Research and Development: Graduate Research Fellowships

DOJ/National Institute of Justice(NIJ).
Catalog of Federal Domestic Assistance Number 16.562

Drug Courts Discretionary Grant Program

DOJ/Office of Justice Programs(OJP)/Drug Courts Program Office.
Catalog of Federal Domestic Assistance Number 16.585

Corrections: Training and Staff Development

DOJ/Federal Bureau of Prisons/National Institute of Corrections (NIC).
Catalog of Federal Domestic Assistance Number 16.601

Corrections: Technical Assistance/Clearinghouse

DOJ/National Institute of Corrections(NIC).
Catalog of Federal Domestic Assistance Number 16.603

Juvenile Mentoring Program (JUMP)

DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.726

Drug-Free Communities Support Program Grants

DOJ/Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention (OJJDP).
Catalog of Federal Domestic Assistance Number 16.429

Tribal Youth Program (TYP)

DOJ/ Office of Justice Programs(OJP)/Office of Juvenile Justice and Delinquency Prevention(OJJDP).
Catalog of Federal Domestic Assistance Number 16.731

Six Programs Administered by the Department of Education

Title 1 Program for Neglected and Delinquent Children

Department of Education/Office of Elementary and Secondary Education(OESE).
Catalog of Federal Domestic Assistance Number 84.013

Safe and Drug-Free Schools and Communities: National Programs

Department of Education/Office of Elementary and Secondary Education(OESE)/Safe and Drug-Free Schools (SDFS) Program.
Catalog of Federal Domestic Assistance Number 84.184

Safe and Drug-Free Schools and Communities: State Grants Program – State Education Agencies and Office of the Governor

Department of Education/Office of Elementary and Secondary Education(OESE)/Safe and Drug-Free Schools (SDFS) Program.
Catalog of Federal Domestic Assistance Number 84.186 A&B

Safe and Drug-Free Schools and Communities – Native Hawaiian Program

Department of Education/Office of Elementary and Secondary Education(OESE)/Safe and Drug-Free Schools (SDFS) Program.
Catalog of Federal Domestic Assistance Number 84.186 C

Native Hawaiian Curriculum Development, Teacher Training and Recruitment

Department of Education/Office of Elementary and Secondary Education(OESE)/Office of School Improvement Program (SIP).
Catalog of Federal Domestic Assistance Number 84.297 A

Center for Students With Disabilities Involved With At Risk of Involvement With the Juvenile Justice System

Department of Education/Office of Special Education and Rehabilitative Services(OSERS).
Catalog of Federal Domestic Assistance Number 84.324 J

**Three Programs Administered by the
Department of Housing and Urban Development**

Community Development Block Grants/Entitlement Grants

HUD/Community Planning and Development.
Catalog of Federal Domestic Assistance Number 14.218

Supportive Housing Program (SHP)

HUD/Community Planning and Development.
Catalog of Federal Domestic Assistance Number 14.235

Public Housing Drug Elimination Program (PHDEP)

HUD/Public and Indian Housing/Community Security and Conservation Division.
Catalog of Federal Domestic Assistance Number 14.854

Two Programs Administered by the Department of Labor

Welfare-to-Work Grants to States and Localities

DOL/Employment and Training Administration (ETA).
Catalog of Federal Domestic Assistance Number 17.253

Workforce Investment Act (WIA)

DOL/Employment and Training Administration (ETA).
Catalog of Federal Domestic Assistance Number 17.255

Four Programs Administered by the Corporation for National Service

Foster Grandparent Program

Corporation for National Service.
Catalog of Federal Domestic Assistance Number 94.001

Retired Senior Volunteer Program (RSVP)

Corporation for National Service.
Catalog of Federal Domestic Assistance Number 94.002

AmeriCorps

Corporation for National Service.
Catalog of Federal Domestic Assistance Number 94.006

Volunteers in Service to America (VISTA)

Corporation for National Service.
Catalog of Federal Domestic Assistance Number 94.013

Program Administered by the Department of the Interior

Services to Indian Children, Elderly and Families (Social Services)

DOI/Assistant Secretary, Indian Affairs/Bureau of Indian Affairs (BIA)
Catalog of Federal Domestic Assistance Number 15.025

Program Administered by the Department of Agriculture

Community Food Projects

USDA/Under Secretary for Research, Education, and Economics/Cooperative State Research, Education, and Extensive Service(CSREES).

Catalog of Federal Domestic Assistance Number 10.225

Program Administered by the Department of Transportation

Alcohol Traffic Safety and Drunk Driving Prevention Incentive

DOT/National Highway Traffic Safety Administration(NHTSA).

Catalog of Federal Domestic Assistance Number 20.601

Program Administered by the Department of Treasury

Gang Resistance Education and Training Program

Department of Treasury Forfeiture Fund

B. Private Sector

Third Party Reimbursement

Commercial employee-based insurance funds 26.3 percent of the national spending on substance abuse treatment. The changes, growth, and potential benefits of managed care will undeniably continue to have a significant impact on substance abuse services well into the next decade.

There have been four generally identifiable major phases of managed care that have impacted general and behavioral health care service since the mid-1980s.

- Access to care and cost containment targets were achieved with implementation of utilization review (UR) protocols and by limiting benefits, requiring significant co-payments and pre-certification administrative barriers.
- The second phase centered on managing benefits, with MCOs adding treatment planning to the UR function, adding fee-for-service provider networks, and developing selective contracting programs, such as provider panels.
- A shift then was from UR to managing care via utilization management with a emphasis on treatment planning, providing the most appropriate care in the most appropriate or least restrictive setting, and expeditiously moving patients through a rapid continuum of less intense services.
- The fourth identifiable phase of managed care continues to focus on outcomes, the integration of services systems, and moving both public and private patients through a continuum of services (*Kushner, 1995, p43*).

Seventy-eight million individuals were enrolled in employer-sponsored health plans in 1992. By 1998, six years later, the number of enrollees climbed to 156.6 million. A majority of these enrollees and their child and teenage dependents are eligible to access varying levels of treatment services, with substantial variations of intensity and duration, through a variety of managed care organizations. These insurance-based organizations are for-profit and not-for-profit entities that may be organized as health maintenance organizations (HMOs), preferred provider organizations (PPOs), managed behavioral health care organizations (MBHOs), government entities, or organized networks of health care providers.

During the mid and late 1990s, there was significant growth in the public sector with public entities shifting to managed care service models. By 1998 within the private sector, many smaller HMOs and other entities were participating in the rapid consolidations, acquisitions, and mergers as significant simultaneous changes were occurring in the public sector. As of the first quarter of 1998, the largest MBHOs had completed independent mergers or acquisitions that resulted in the six largest MBHOs covering a combined enrollee population of nearly 115 million (*Ford, 2000, p81*).

Private Treatment System - Financing

The National Treatment Center Study (NTCS) (Roman & Blum, 1997) ^{xx}funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was a nationwide sample of 450 private-sector treatment centers that evaluated how these programs were adapting in the rapidly changing behavioral health care field. The study involved a snap shot census and capacity comparison between level of care and the average proportion of patients as paying from identified funding sources: Medicare (16%), Medicaid (17.3%), Commercial Insurance (44.8%), Charity (4.7%), Public Funds (5.6%) and Self-pay (10.7%).

The NTCS study categorized the 450 treatment centers by four types: Non Profit, For Profit, Hospital and Freestanding. The researchers also assessed the retail charges of the treatment centers. The following reported data as to retail charges have not been adjusted for inflation.

Levels of Care - Adult, Adolescent, and Child

Table 1. Daily Retail Charges by Level of Care

Level of Care	Range	Mean	1 st quartile cutoff*	2 nd quartile cutoff*	3 rd quartile cutoff*
Detox	\$80-\$2000	\$585.68	\$420	\$525	\$700
IP CD, adult	\$47-\$1700	\$509.03	\$339	\$459	\$650
IP CD, adolescent	\$135-\$1500	\$591.59	\$348	\$466	\$863
IP Psychiatric, adult	\$186-\$1300	\$726.89	\$550	\$700	\$950
PHP / day program	\$75-\$700	\$726.89	\$200	\$250	\$323
IOP	\$22-\$400	\$136.29	\$97	\$130	\$162
OP	\$10-\$280	\$70.32	\$45	\$65	\$90

IP CD = Inpatient Chemical Dependency
 PHP = Partial Hospital Program

IOP = Intensive Outpatient Program
 OP = Outpatient

*Note: Quartile cutoff indicate relative distribution of charges across facilities, interpreting as follows: 1st quartile cutoff is the point below which 25 percent of facilities fall; 2nd quartile is the median range or the point below which 50 percent of facilities fall; and the 3rd quartile is the point below which 75 percent of facilities fall.

Tables 2 through 5 display retail charges of the 450 treatment facilities across categories within the study.

Table 2. Average Daily Retail Charges of Hospital-Based and Freestanding Programs

Level of Care	Whole Sample	Hospital-Based	Freestanding
Detox	\$585.68	\$603.92	\$542.80
IP CD, adult	\$509.03	\$529.99	\$467.93
IP CD, adolescent	\$591.59	\$594.03	\$589.42
IP Psych, adult	\$726.89	\$699.48	\$791.30
PHP / day program	\$266.71	\$256.88	\$292.53
IOP	\$136.29	\$137.56	\$132.99
OP	\$70.32	\$73.61	\$63.01

Table 3. Average Daily Retail Charges for Corporate-Owned and Non-Corporate Programs

Level of Care	Whole Sample	Corporate-owned	Non-Corporate
Detox	\$585.68	\$643.81	\$533.00
IP CD, adult	\$509.03	\$571.67	\$449.62
IP CD, adolescent	\$591.59	\$716.06	\$467.13
IP Psych, adult	\$726.89	\$794.75	\$612.86
PHP / day program	\$266.71	\$291.38	\$242.39
IOP	\$136.29	\$137.83	\$135.13
OP	\$70.32	\$68.46	\$71.75

Table 4. Average Daily Retail Charge for For-Profit and Non-Profit Facilities

Level of Care	Whole Sample	For-Profit	Non-Profit
Detox	\$585.68	\$711.76	\$515.57
IP CD, adult	\$509.03	\$633.18	\$429.41
IP CD, adolescent	\$591.59	\$760.91	\$440.58
IP Psych, adult	\$726.89	\$846.92	\$635.29
PHP / day program	\$266.71	\$324.05	\$234.17
IOP	\$136.29	\$145.07	\$131.76
OP	\$70.32	\$74.04	\$66.26

Table 5. Average Daily Retail Charges, 450 Participating Facilities, By Region

Level of Care	Northeast	Southeast	Great Lakes	Central	West
Detox	\$499.18	\$683.33	\$509.88	\$632.22	\$619.99
IP CD, adult	\$413.15	\$583.66	\$443.01	\$616.74	\$489.77
IP CD, adolescent	\$560.11	\$837.80	\$476.06	\$795.44	\$456.53
IP Psych, adult	\$728.43	\$802.42	\$573.44	\$815.52	\$728.98
PHP / day program	\$194.75	\$321.52	\$243.45	\$300.46	\$261.66
IOP	\$135.37	\$127.02	\$143.69	\$143.43	\$125.57
OP	\$74.04	\$76.16	\$70.51	\$68.86	\$57.06

Transition - Youth Focus

A majority of states have moved to a full or partial managed care plan involving a variety of health care services, and at least 88 Medicaid managed care plans exist. It is essential that the responsible state agencies assume a major role in framing their state's plans for substance abuse services. The financing of behavioral health services is shifting towards a capitation model in many systems (*Kushner, 1995, p23*). Specific contractual stipulations between States and managed care organizations or waivers with the federal government require due diligence in the framing and execution of agreements. At the state and local level, agreements must be concerned with risk management, benefit packages, access to services, and standards of care assurances. The external demands and shifts in reimbursement practices require technical assistance and support remain available for providers that have little choice but to be involved in new affiliations, mergers, integrated systems, and other changes in the service delivery landscape.

The development and expansion of substance abuse services and increasing capacity within these emerging models presents other significant challenges for many traditional substance abuse providers. Managed care principles that have emphasized cost containment, limiting access to treatment, and utilization review processes will require new responses from treatment providers. Investment of infrastructure systems that can respond to the valid managed care demands of third party payors must be also organized to validate outcomes that justify treatment plans.

Even at this late stage in the development of managed care practices, too many MCO behavioral health protocols are written for adults with cursory mention of children and adolescents. MCO contractual obligations and provider manuals would greatly benefit from clearly delineated language and agreement on six basic points:

- Include family members and parents as participants in treatment plans.
- Define responsibility for timely screening and assessments conducted on children and youth in potential need of mental health and substance abuse services.
- Coordinate school liaison for MCO and coordinate Individual Education Plans (IEPs) of youth with mental health impairments.
- Coordinate collaborative planning with youth welfare agencies, health services, and juvenile justice systems personnel.
- Outline protocol for disagreement between MCO and court orders.
- Develop guidelines for assignment of cost of service responsibilities for children and youth in state custodial care or under mandated court orders (*Bazelon, 1998, pp 75-82*).

Infrastructure support and resolution of these and other issues will clearly allow for more youth to access appropriate treatment services.

C. FOUNDATION, CORPORATE AND FUNDRAISING SUPPORT

There are four general types of foundations:

- Community foundations typically restrict awards to local or regional geographic areas and are governed by boards made up of community members.
- Private foundations are usually in the form of individual or family trusts and typically limit philanthropic support to areas of interest of the donor.
- Corporate foundations are legally separate from the commercial enterprise and typically are private, nonprofit, and have a tax exempt status. They generally fund local community programs and often target populations that are customer friendly.
- Operating foundations generally fund and operate their own programs and support a very limited number of other programs.

Foundations and corporations are in a position to provide a substantial amount of support for delinquency and substance abuse services. In 1992, over 30,000 U.S. foundations awarded more than \$8 billion from holdings of over \$150 billion in assets. Of the total awards, over \$41 million went to substance abuse prevention, treatment, and research (*Zarkin, 1995, p390*). In 1998, 142 of the largest foundations reported their combined grant awards totaled nearly \$7.7 billion, nearly as much as all the U.S. combined awards in 1992. Children and youth oriented programs received approximately 18 percent of all grant awards that in turn made up 16 percent of the total monies awarded in 1998 (*The Chronicle of Philanthropy*). Here again the data do not disaggregate information specific for youth involved in juvenile justice systems or substance abuse treatment.

Fundraising opportunities are typically developed and implemented from within the specific agency with funds "raised" for specific or general operating purposes. From hosting events to sponsoring activities, the range of possibilities is unique and encompasses a broad spectrum. Additional successful fundraising streams developed include annual giving campaigns, periodic direct mailings, and planned giving campaigns for major gifts that may include charitable trust transfers, pooled income funds, and gifts of annuities, property, or other assets. These funds can be extremely important because of their typical discretionary availability. In times of budgetary revenue shortfalls, these funds can be utilized to temporarily maintain operational expenditures especially in the event of unforeseen market shifts in any number of areas. These funds can be used to expand capacity and/or to diversify revenue streams as part of a long-term stabilizing strategy.

IV. PROMISING MODELS AND RESOURCES

A. Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Three programs were highlighted in 1997 by OJJDP that shared common features and were demonstrating promising approaches in substance abuse treatment with juvenile offenders:

1. Escambia County Drug Court, Pensacola, Florida.
2. Denver Integrated Treatment Network program.
3. South Carolina Bridge Program.

B. Washington State

1. CDDA legislative program, Juvenile Rehabilitation Administration & the Division of Alcohol and Substance Abuse. Citation- Juvenile Rehabilitation Administration (1997). 1996-97, The JRA Overview. Report for the Washington State Department of Social and Human Services.
2. Kings County Department of Community and Human Services, Crisis Triage Unit, Harborview Medical Center, Seattle. (Example of five systems blending funds in an adult pre-booking criminal diversion program for individuals with co-occurring disorders.)

C. The National Center on Addiction and Substance Abuse at Columbia University

1. The **Children At Risk (CAR)** program.
2. The **Striving Together to Achieve Rewarding Tomorrows (START)** program

D. CSAT Publications

1. Medicaid Financing for Mental Health and Substance Abuse Services for Children and Adolescents, TAP Series Number 2, Financing Subseries, Vol.1, PHD580
2. Funding Resource Guide for Substance Abuse Programs, TAP Series Number 9, BKD152
3. Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study. TAP 15, BKD176
4. Purchasing Managed Care for Alcohol and Other Drug Treatment, TAP Series 16, Financing Subseries, Vol. III
5. All CSAT TIP (Treatment Improvement Protocol) publications, specifically 3, 4, 13, 21, 23, 24, 30, 31, and 32.

E. Other Resources

1. *Confidentiality – A Manual for the Exchange of Information in a California Integrated Children's Services Program* by James Preis, JD, August 1999
2. *Substance Abuse Funding News*, CD Publications
3. *Substance Abuse Letter*, Pace Publications
4. a. Belenko, S. (2000): *The Challenges of Integrating Drug Treatment Into the Criminal Justice Process*. Albany Law Review, 3(3) 833-876.
b. Belenko, S., Peugh, J. (1998): *Fighting Crime by Treating Substance Abuse*. Issues in Science and Technology, 15(1), 53-60.
c. Tapper, D., Kleinman, P., Nakashiega, M. (1997). *An Interagency Collaboration Strategy for Linking Schools with Social and Criminal Justice Services*. Social Work in Education 19(3), 176-188.
d. Sealock, M.D., Gottfredson, D.C., and Gallagher, C.A. (1997). *Drug Treatment for Juvenile Offenders: Some Good and Bad News*. Journal of Research in Crime and Delinquency, 34, 210-236.

ⁱ Olin (December 1999) p. 47

ⁱⁱ Coffey (July 2000) p.ii

ⁱⁱⁱ Ford (June 2000) p. 48

^{iv} Ford (June 2000) p. 37

^v Solano (1997) p. 7

^{vi} Ford (2000) p. 25

^{vii} Califano (2001) p.16

^{viii} Dennis (1999) pp. 10-12

^{ix} Olin (2000) p. 22

^x Krisberg (1998) p. 6

^{xi} Snyder, (2000) p. 10

^{xii} Califano (2001) p. 24

^{xiii} Preis (1999) p. 3

^{xiv} Tau (2000) pp. 65-92

^{xv} Tau (2000) p. 23

^{xvi} ASAM (1996) p. 139

^{xvii} Zarkin (1995) p. 389

^{xviii} Ford (2000) p. 27

^{xix} Federal (1996)

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