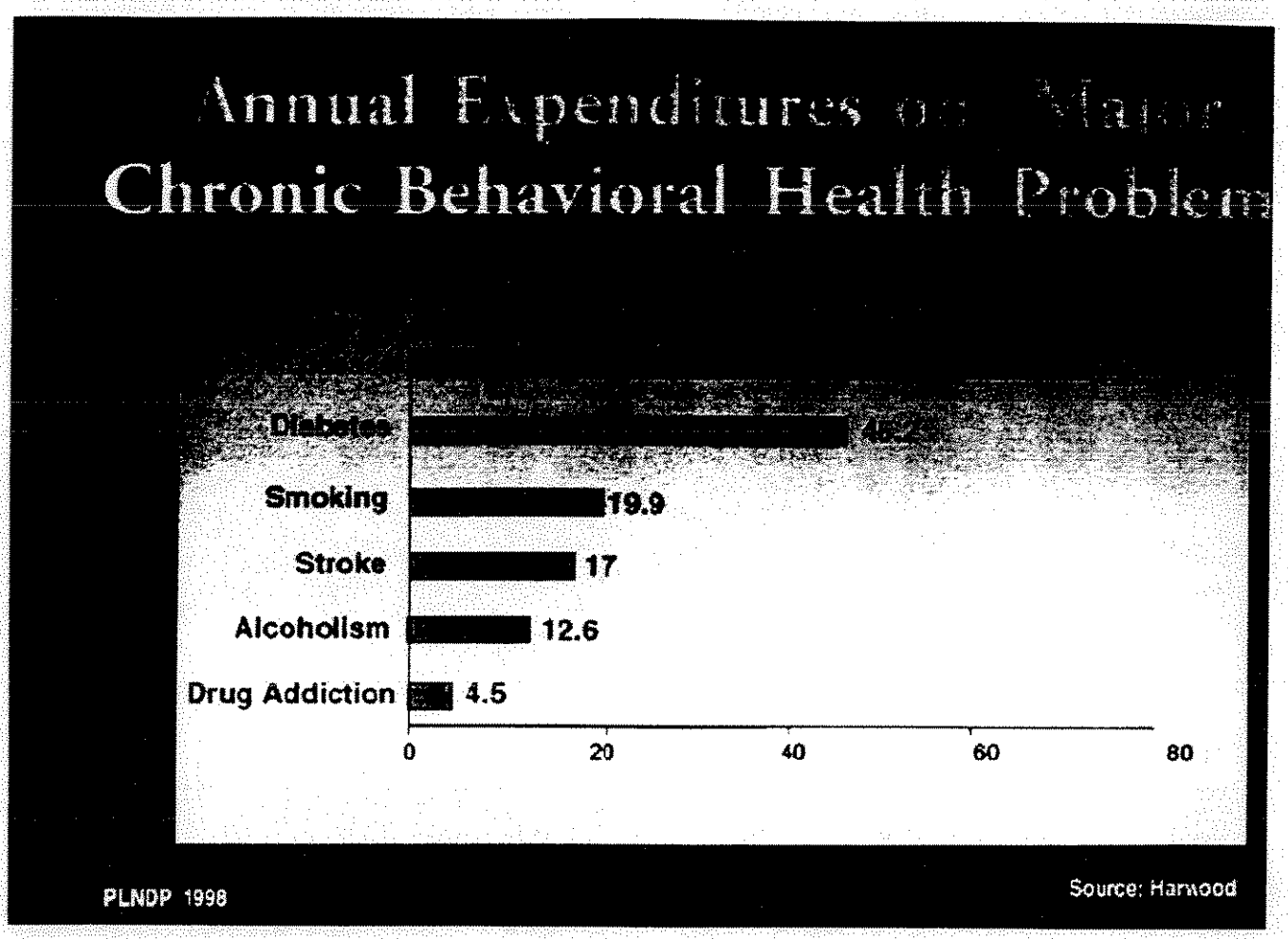
Annual Expenditures on Major
Chronic Behavioral Health Problem
Diabetes
Smoking
19.9
Stroke
17
Alcoholism
12.6
Drug Addiction
4.5
0
20
40
60
80
PLNDP 1998
Source: Harwood

Productivity Losses Due to Major Chronic Behavioral Health Problems

Aggregate productivity losses (employment, and household productivity) from alcohol and drug disorders are very comparable to those for the other selected disorders with health behavior elements. Note that a major part of the lost productivity for alcohol abuse is associated with alcoholics "on the job", but working at impaired levels of effectiveness, while drug abuse costs are elevated primarily because about a small minority of drug addicts "drop out" of the legitimate labor market for crime careers.

Source: National Institutes of Health (1997). Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update. Department of Health and Human Services.

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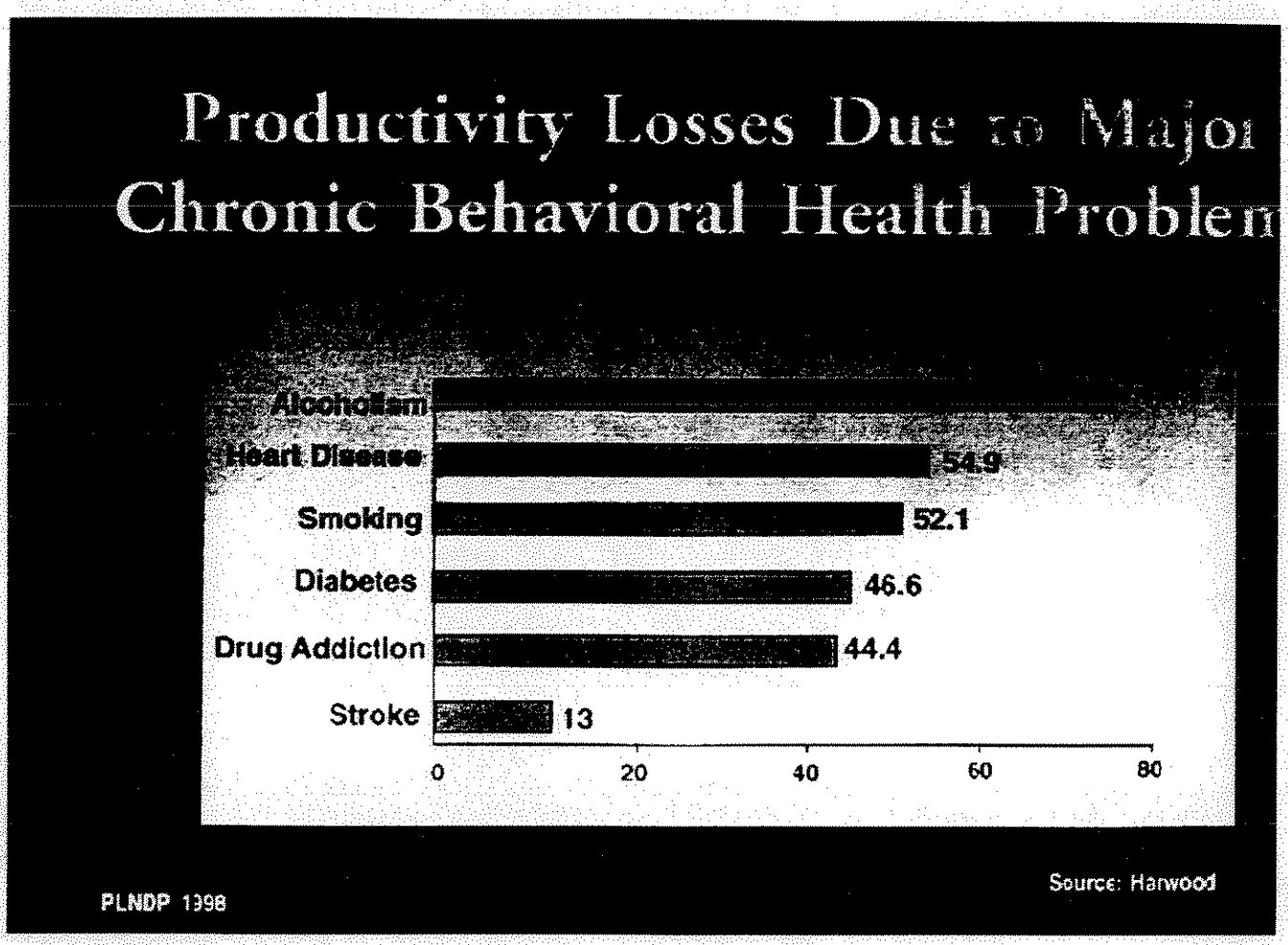
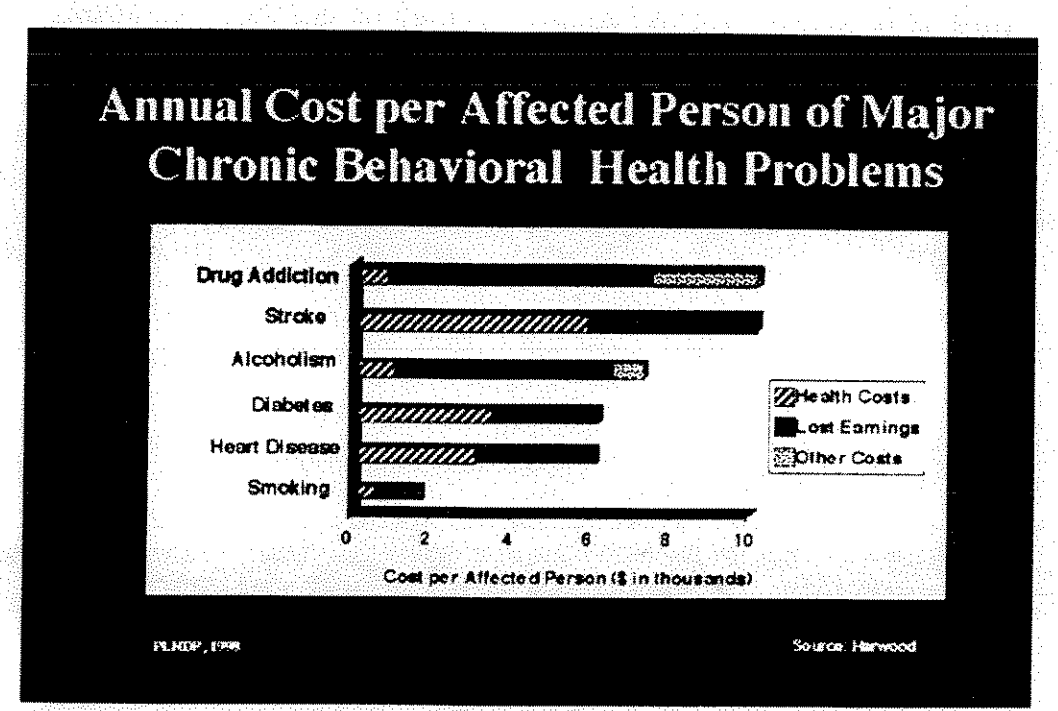

Productivity Losses Due to Major
Chronic Behavioral Health Problem
Alcoholism
Heart Disease
Smoking
Diabetes
Drug Addiction
Stroke
54.9
52.1
46.6
44.4
13
0
20
40
60
80
PLNDP 1998
Source: Harwood



Comparison of annual health and productivity costs to prevalence estimates demonstrates that the health costs per case of alcohol and drug abuse are materially lower than for heart disease, stroke, and diabetes. In contrast, the productivity losses per person are somewhat greater for alcohol and drug abuse than for the other three disorders, although the origin and nature of these costs are quite different from the other health behavior problems. In addition, alcohol and drug abuse involve costs typically outside of the health cost framework: notably property destruction (crashes) and criminal justice system expenses.

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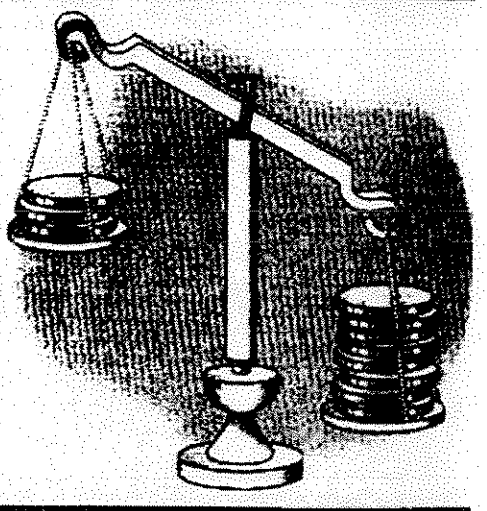
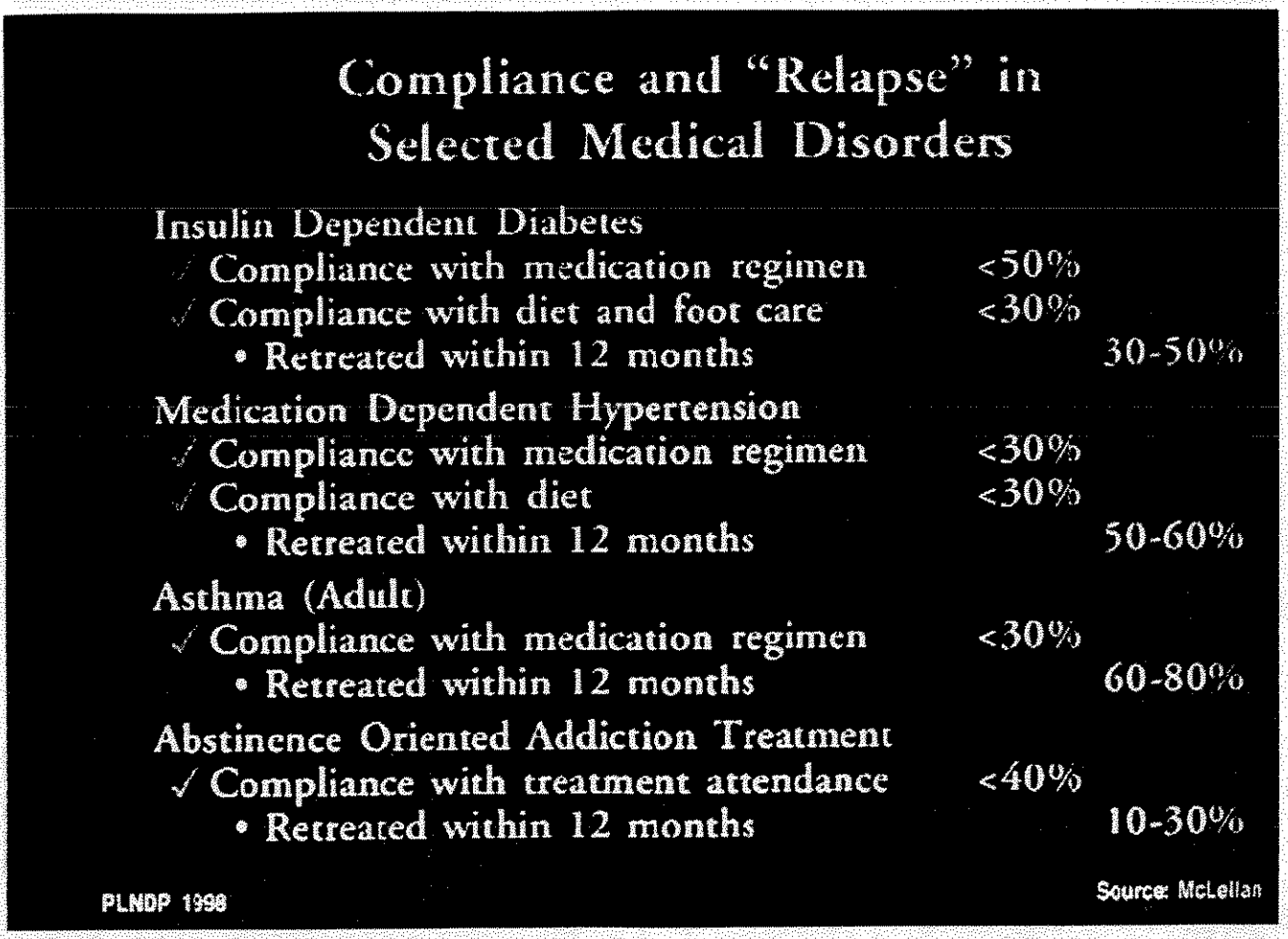
Weighing the Costs
Annual Cost per Drug Addict

Regular Outpatient	$1,800
Intensive Outpatient	$2,500
Methadone Maintenance	$3,900
Short Term Residential	$4,400
Long Term Residential	$6,800
Incarceration	



Physician Leadership on National Drug Policy 1998

PLNDP 1998


Compliance and "Relapse" in Selected Medical Disorders
Insulin Dependent Diabetes
✓ Compliance with medication regimen <50%
✓ Compliance with diet and foot care <30%
• Retreated within 12 months 30-50%
Medication Dependent Hypertension
✓ Compliance with medication regimen <30%
✓ Compliance with diet <30%
• Retreated within 12 months 50-60%
Asthma (Adult)
✓ Compliance with medication regimen <30%
• Retreated within 12 months 60-80%
Abstinence Oriented Addiction Treatment
✓ Compliance with treatment attendance <40%
• Retreated within 12 months 10-30%
PLNDP 1998
Source: McLellan

Mental Health Parity

"Just the Facts"

PricewaterhouseCoopers, L.L.P. has consolidated and updated various studies and reports that analyze the most recent cost data and actual experience results of states (and states as employers) that have implemented Mental Health Parity coverage. The data relates to aggregate state-wide results following state mandated parity, to the State Employee Health Benefit Plans, and finally to the Federal Employee Health Benefit Plan.

Recent and historical cost projections for mental health parity at the federal and state level are also provided. These projected costs are calculated by a wide variety of sources (PricewaterhouseCoopers, UCLA/Rand Research Center, Congressional Budget Office, Milliman & Robertson, and others). The studies specifically analysing mental health parity are remarkably similar in their conclusions that mental health parity with reasonable cost management is affordable.

Studies that are quoted by opponents of mental health parity typically use questionable or unreasonable assumptions to generate high cost estimates. The most common error in the high cost studies is that case management and/or other utilization controls will not be allowed under mental health parity. As stated by the UCLA/Rand Research Center, "...policy decisions were often based on incorrect assumptions and outdated data that led to dramatic overestimates."

By consolidating the data and experience studies into a single source, it is hoped that this book will provide documentation and identification of needed facts to demonstrate the recurring theme emanating from study after study – mental health parity is affordable and in many cases will lower the cost of overall healthcare.

"Just the Facts" can be a tool for bebunking the myths of high costs and mental health as the black-hole of expenses. To date, there are **no examples** where mental health parity has been enacted in a state and costs have dramatically increased. There are **no examples** where mental health parity has been enacted in a state and a measurable increase in uninsured has been detected. For those who doubt the results of the past few years – read this material, forget the myths of the past, and learn **"Just the Facts."**

This document was prepared for the American Psychological Association's 2000 State Leadership Conference. Ultimately this material should be useful to both proponents and opponents, for academics and the general public, and for state and federal policymakers. The debate over mental health parity is an appropriate one with policy arguments on both sides. It seems unnecessary to argue misrepresentations of the costs when **"Just the Facts"** will do.

The Impact of Managed Care on Substance Abuse Treatment: A Report of the American Society of Addiction Medicine

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Daniel S. Keller, PhD
Helen Dermatis, PhD
Susan Egelko, PhD

ABSTRACT. This report examines the impact of managed care (MC) and related developments on substance abuse treatment, and evaluates how it has been associated with a decline in the availability of proper treatment for many addicted patients. A trend toward carve-out and for-profit MC organizations is associated with lower financial incentives for intensive treatment than in earlier staff-model and not-for-profit MC organizations. The value of substance abuse insurance coverage has declined by 75% between 1988 and 1998 for employees of mid-to large-size companies, compared with only an 11.5% decline for general health insurance. The shift towards MC has also been associated with a drastic reduction in frequency and duration of inpatient hospi-

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This report was approved by the ASAM Board of Directors on April 29, 1999. It has been endorsed, as well, by the American Academy of Addiction Psychiatry and the National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism.

This project was supported by grants from the Robert Wood Johnson, Achelis, and J.M. Foundations, and the USDHHS Center for Substance Abuse Treatment. Consultation was provided by Thomas D'Aunno, PhD, Michael T. French, PhD, Edgar Nace, MD, Carole Siegel, PhD, Steven S. Sharfstein, MD, Roland Sturm, PhD, and Constance Weisner, PhD.

talization, and there is no clear evidence that this reduction has been offset by a corresponding increase in outpatient support. In a survey of physicians treating addiction, the majority felt that MC had a negative impact on detoxification and rehabilitation, and on their ethical practice of addiction medicine. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com>]*

The recent and dramatic shift toward pre-paid health insurance and cost containment strategies known as managed care has rapidly encompassed virtually all areas of the American health care system. According to a recent Institute of Medicine report 161 million Americans (i.e., more than 60% of the total US population) belong to some form of managed health care plan.[1] Moreover, the same report noted that only slightly less (142 million) already have managed behavioral health (i.e., mental health and substance abuse) coverage.[1] Thus, it is likely that the managed care revolution has had and will continue to have an enormous impact on the treatment received by substance abuse patients.

It is well known that substance use disorders are among the most frequently occurring mental health problems in the United States.[2-5] The National Comorbidity Survey (NCS) data estimated the prevalence of lifetime substance abuse disorders including both alcohol and/or drug abuse or dependence using DSM-III-R criteria to be 11.3% of the population.[6] Other studies have indicated even higher rates in a variety of sub-groups including those with concurrent medical and mental illness.[2,7,8-10] Moreover, the costs to society associated with these prevalence rates of substance abuse are enormous.[1,11] For example, in one of the most extensive studies to date, the US Department of Health and Human Services and the National Institutes of Health (1998) has estimated that costs associated with alcoholism and substance abuse for 1992 were nearly 250 billion dollars with projections for 1995 estimated to exceed 276 billion dollars.[12] Extensive research has confirmed that treatment can reduce the cost to society of drug and alcohol abuse[13-22] on a variety of factors for both patient and collateral health care as well as multiple societal correlates. As such, treatment of substance abuse will need to rank among top national priorities if these costs are to be managed effectively.

But does it? Despite an explosion in the development of empirically tested treatments for substance abuse,[23,24] these disorders continue to

be vastly *undertreated*.[1,25] Many factors play a role in undertreatment of substance abuse including patient stigmatization and lack of diagnostic skills among medical providers. However, a concern increasingly voiced by clinicians, patients, and families of patients is that the transition of the health care system to one dominated by managed care organizations may be inimical to adequately addressing the overall treatment needs of substance abusers. Research, too, substantiates this concern.[26,27]

Given the persistent need for substance abuse treatment and its associated costs, it is therefore legitimate and timely to inquire into the extent to which managed care has impacted on substance abuse treatment. The remainder of the paper is devoted, therefore, to an assessment of these issues.

The first section of the paper briefly reviews the structure and functioning of the varieties of managed behavioral health care. We then discuss the impact of managed care on: (1) employer-sponsored insurance; (2) access to and utilization of treatment for substance use disorders; (3) Medicare and Medicaid patients; and (4) specialist professionals. Many of these areas are only just now receiving sufficient empirical scrutiny. We, therefore, present empirical data bearing on these areas where available but make use of other sources as well.

WHAT IS MANAGED CARE?

Managed care is an umbrella term used to cover a variety of organizational structures, insurance benefits, and regulations which both provide for and control the cost of health care procedures.[26] When applied to substance abuse and mental health, the term *managed behavioral health care* (MBHC) is most often employed.[1] As noted in a recent report[7] MBHC was virtually unheard of ten years ago but appears to be one of the fastest growing areas in managed care which covered 142 million Americans in 1995 and has continued to expand in its penetration of the health market since then.

Like other forms of managed care, MBHC attempts to control costs of treatment. One prominent approach to cost control is achieved through limiting the utilization of services. Utilization is limited through imposing a variety of financial incentives and restrictions on which services are covered and which practitioners may be selected. For example, an approach often used and one that typified the earliest

forms of managed care is the *managing of benefits*. Such benefit management is most often associated with annual and lifetime maximums, co-payments, gatekeeping procedure such as preauthorizations, retrospective denial of reimbursements and the like. These procedures have been well-chronicled in the media usually in a negative light.

It is important to note that managing benefit structures is but one of a number of procedures employed to contain costs effectively. In recent years, managed care organizations have broadened the way in which cost-containment may be conceptualized. In particular, nowadays MBHC organizations frequently speak of *managing care* in addition to managing benefits by which it is meant that care is taken to ensure that only appropriate and necessary care is delivered in the least restrictive settings by qualified professionals. Thus, it is nowadays more common to see the use of level of care placement criteria, standardized treatment planning methods, and the small but increasing use of evidenced-based treatments. In this way, expensive treatments such as 30-day inpatient alcoholism programs are utilized more judiciously, at least in theory.

Although the market place in health care has proliferated with different types of managed care, MBHC is most often accessed through one of two types of managed care organizations: (1) staff model HMOs; and (2) managed behavioral health care organizations (MBHCOs).[1,28]

In the *staff models*, enrollees receive substance abuse or mental health treatment from specialist in-house staff providers. There are certain advantages to the management of behavioral health under this type of arrangement. For example, a patient's overall treatment is consolidated among one provider group leading to better communication and coordination, which can be especially important for patients with multiple medical, psychiatric and substance abuse problems. In addition, there are financial incentives since reductions in mental illness and substance abuse are reported to offset medical costs.[28]

In contrast, MBHCOs, which are also referred to as *carve-out vendors*, are managed care organizations hired by employers to organize specialized mental health and substance abuse treatment for enrollees independently from overall health care. MBHCOs contract with mental health and substance abuse specialist groups or preferred provider networks. Typically, MBHCOs employ specialist "gatekeepers" to assess and monitor patient need for access to and utilization of treat-

ment within the network. Carve-out arrangements now administer the vast majority of behavioral health care for people with private health insurance.[27] Increasingly, staff model HMOs and traditional fee-for-service insurers are employing carve-out vendors to provide managed behavioral health care.[28]

The carve-out format is attractive to the insurer in that it entails the potential advantage of offering more highly specialized treatment and personnel than in the staff model HMO. These may be more successful in effecting a cost conscious approach to providing care. A potential disadvantage, however, is that MBHCOs, which do not stand to benefit from the medical cost-offset, lack an inherent financial incentive to provide more costly treatment of behavioral disorders if it is more effective.[26] This can lead to promoting less costly short-term approaches over ones which could effect a more beneficial long-term outcome.

It is important to note that not all managed care organizations operate on a for-profit basis.[30,31] The emergence of for-profit managed care is a relatively recent phenomenon and represents a (some would say radical) departure from the non-profit managed care industry which characterized these organizations from 1940-1980. Indeed, the proportion of HMO members enrolled in for-profit plans has risen from 12 percent in 1981 to over 60 percent today.[30] Clearly, a for-profit entity is more likely to place pecuniary benefit as a primary organizational goal, likely competing with the provision of care as a priority.

WHAT IS ITS IMPACT ON INSURANCE COVERAGE?

Employers have clearly pushed for managed care.[1,32,33] By 1996 approximately 100 million Americans were enrolled in either employer-sponsored HMOs or PPOs.[34] This dramatic shift was achieved largely through employers either offering incentives to employees to shift to managed care plans or by offering managed care insurance only.[32,33] In turn, this has led to decreased choice of healthcare providers and treatment dictated by the insurer rather than the healthcare provider.

Not only has general health insurance coverage changed in the managed care era but the shift toward employer provided managed care as a means of cost containment has been particularly noticeable in the area of managed behavioral health care.[1,27,32,33] Indeed, the num-

ber of Americans covered by carved out managed behavioral health care arrangements increased from 78 million in 1992 to 150 million in 1997.[35] This shift began in the late 1980s when empirical reports and media coverage warned that the overall rate of growth in behavioral health care spending greatly exceeded increases in general health care expenditures,[36] sometimes by as much as 20 to 30 percent annually.[37] Thus, it was felt that managed behavioral health care plans would have a broad appeal for employers seeking to provide behavioral health care to a large portion of the population while holding down costs.[1,27]

To what extent do empirical evaluations bear these trends out? On the positive side, there appears to be consensus that more people have access to employer-sponsored behavioral health care insurance than ever before.[1,38,39] For example, Jensen et al. (1998) report that among all insured workers access to mental health coverage increased from 86% in 1991 to 92% in 1995. On the other hand, the depth or value of coverage appears to be shrinking.[39-41] Let us consider this.

The ASAM/Hay Report

As an example, the ASAM/Hay Benefits Report[41] presents data on the typical design of health care benefits provided by medium and large employers in the United States. In 1998, ASAM commissioned the Hay Group, an independent health insurance analysis organization to evaluate substance abuse treatment benefits relative to those for overall health care. These data were collected from 1017 US employers, representing a broad industry and geographic mix, between 1988-1998. According to Hay report, the value of benefits offered by employers has changed substantially over the past decade. To determine benefit value, Hay has developed and employed a benefits value comparison (BVC) model which extracts plan design information (e.g., deductibles, co-payments, coverage limitations, etc.) yielding a standardized estimate of the value of plans. The BVC approach has been employed widely within the private sector as well as by NIMH, and the Congressional Research Service to analyze cost and prevalence of benefits in the U.S.[41]

Overall, the total value of employer provided health benefits deceased, in constant dollars, by 14.2% from 1988-1998 thus indicating that the depth of coverage provided in employer sponsored health care insurance was substantially reduced during that period. However, when this general decline is disaggregated into component benefits,

the Hay data indicate that the value of general health benefit expenditures declined by only 11.5%; by contrast, substance abuse and mental health benefit values decreased by 74.5% and 52.3%, respectively, between 1988-1998. Stated otherwise, whereas substance abuse benefits (on average) accounted for 0.7% of a plan's overall value in 1988, it accounts for only 0.2% today. Likewise, mental health accounted for 5.4% of total plan value in 1988, but only 3% currently. While these data are not equivalent to actual employer expenditures, they do suggest that the value of plans, on average, has markedly decreased in terms of the value of benefits for substance abuse and mental health treatment.

What factors are most responsible for driving down these plan values? According to Hay,[41] the single most important factor is that the type of plans offered has substantially changed. According to the Hay data, there has been a dramatic shift in the kinds of coverage for employees. For example, in 1987 92% of employers reported fee-for-service (FFS) plans as the most prevalent plan type. By contrast, the most recent data reveal that PPOs are the most prevalent followed by HMOs (24%), point of service (POS) plans (22%) and FFS plans (20%).[41] In general, these managed care alternatives are less generous especially with respect to substance abuse and mental health than in terms of general health. Hay[41] further reports that increased day and dollar limits on inpatient care also contribute to overall decreasing value benefits value.

This report provides convincing empirical evidence of the concern, held by a wide variety of practitioners, that substance abuse treatment has declined in the managed care era. That is to say, under managed care plans purchased by middle to large scale employers, inpatient substance abuse treatment is virtually no longer available (except in life-threatening situations). Moreover, unlike general healthcare, where outpatient visits have increased to compensate for decreases in inpatient treatment, in some cases substance abuse outpatient visits have declined even in the context of virtually non-existent hospitalization for substance abuse.[41]

Other Reports on Impact

Other empirical reports appear to parallel these trends reported in the Hay data. For example, Bureau of Labor Statistics show that coverage became increasingly restrictive between 1988-1993 for sub-

in the section above on cost. Although naturalistic and lacking controls, all of these studies have the value of comparing managed care with unmanaged care or different types of managed care.

Access to treatment was assessed in three of the four studies cited above and provide a mixed picture on the effect of managed care on this variable. For example, Callahan et al.[43] compared substance abuse treatment for Medicaid patients before and after the Massachusetts Medicaid Program was converted from a fee-for-service to a managed care system. Access was defined as the number of service users per 1000 enrollees and actually increased 4.6%. In contrast, Ellis[44] examined access to treatment among employees of a single large employer (n = 140,000) over a four year period in which the employer mandated managed care midway through the time period. Access dropped 43% overall for the two year period in which managed care was mandated. Finally, Asher et al.[45] studied the Pennsylvania Medicaid Program for drug abuse treatment which was comprised of four types of coverage: (1) HMO; (2) PPO; (3) mixed managed/unmanaged; and (4) FFS. Patients in the mixed coverage group has greatest access (4.9% eligible recipients) followed by PPO (3.9%) and HMO (2.0%) patients, respectively (FFS patients were not studied here).

Based on these studies, a mixed picture emerges regarding the impact of managed care on access to treatment. In the Callahan et al.[43] study, access to treatment under managed care appears to have increased, although modestly. On the other hand, Ellis' data[9] suggests a dramatic reduction in access.

These same studies report utilization of service data which point in the direction of reductions under managed care. For example, in Callahan et al.,[43] inpatient admissions declined by 69% in the first year accompanied by a surge in outpatient detoxification utilization. At the same time, outpatient admissions did not increase but rather declined by 4%. Likewise, the Minnesota Consolidated Chemical Dependency Treatment Fund, which transitioned from a FFS to a managed care operation, evaluated utilization rates during the transition phase. Managed care clients were less likely to receive inpatient treatment than FFS clients (MC = 27% versus FFS = 48%) even though there were no differences in severity of inpatient admissions.[45] Finally, in the study by Asher,[44] patients in the mixed managed/unmanaged care had the greatest utilization rates followed by FFS, PPO, and HMO patients,

stance abuse and mental health benefits in behavioral health plans offered by employers with 100 or more employees. Limitation increases included both inpatient and outpatient services in terms of limits on days, visits, total dollars for care, and cost sharing requirements.[42] Buck and Umland[40] report statistical trends similar to the BLS data. They report that although more people employed by middle to large scale employers have behavioral health care coverage, the coverage itself has become more restrictive over the last decade due mainly to the growth of managed behavioral health care. Buck and Umland report on data for 1995 from 171 large employers surveyed by Foster Higgins, an employee benefits consulting firm. They found (1) employees are more often enrolled in managed care as opposed to indemnity plans; (2) two-thirds of employers offer mental health and substance abuse insurance that does not cover services to the extent of other medical services; and (3) there are more restrictive limits and different cost-sharing requirements for mental health and substance abuse services than for other health care services.[40]

In addition, the 1995 data were compared to the same data collected in 1989. This comparison revealed that mental health and substance abuse services accounted for only 4% of total plan costs in 1995 compared to about 9% of employers' total medical plan costs in 1989. Finally, the percentage of employers with special limitations on substance abuse benefits grew from 76% to 93% from 1989 to 1995.[40] All of these data provide further support for the conclusions of the ASAM/Hay report that substance abuse coverage has been eviscerated and has declined even more dramatically than coverage for general health care.

To what extent have costs been contained and for whom? Several studies from the early to mid-1990s estimated costs associated with various forms of managed versus fee-for-service substance abuse care. Each found managed care to be more cost effective than indemnity coverage.[42-45] However, all studies were naturalistic, lacking random assignment and other controls, and all but one were performed on Medicaid populations limiting generalizability. More recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a comprehensive investigation of nationwide spending trends in mental health and substance abuse treatment over the decade spanning 1986-1996.[38] They found that annual rate of growth of overall substance abuse and mental health expenditures was 7.2%. While

this figure exceeded the annual rate of growth in the CPI (3.5%) over the same period, it was actually a full point lower than the annual growth rate in expenditures for general health care (8.3%). The discrepancy holds true when considering expenditures from private insurance sources (substance abuse/mental health [SA/MH]: 8.0% versus general health 8.9%). Clearly, while SA/MH costs have grown they do not appear to have skyrocketed to the degree suggested by earlier warnings.[36]

Finally, Schoenbaum, Zhang, and Sturm[29] have recently reported on costs of substance abuse treatment based on insurance payments for 93 private sector behavioral health care plans in 1995 covering over 600,000 members. They found that substance abuse coverage accounts for only a small percentage (13%) of insurance payments for behavioral health care and an extremely small fraction (0.4%) of insurance payments for total health care.

WHAT IS ITS IMPACT ON TREATMENT?

The literature on managed care thus far suggests that (1) the majority of insured Americans have mental health and substance abuse covered by managed behavioral care organizations; (2) the value of benefit structures of such coverage are on the whole more restrictive than previous insurance arrangements; and (3) while overall cost has been held in line with general medical health care, the value of coverage for substance abuse has tended to decline on average. To what extent has this impacted actual availability and delivery of treatment for substance use disorders?

There is a consensus among clinician and researchers that substance abuse is undertreated;[1,25,26] and there are several major studies of substance abuse treatment under managed care that shed light on access, utilization, and treatment intensity. We now review the results of these.

Access and Utilization

Several major studies have investigated the effect of managed care on substance abuse treatment[43-46] the results of which were summarized by the Institute of Medicine.[28] We have already referred to these

respectively, with FFS patients receiving the greatest amount of inpatient care and HMO receiving the least.

Thus, these studies apparently support the view that inpatient substance abuse treatment has been curtailed under managed care. While outpatient substance abuse treatment is effective for many uncomplicated substance abuse case,[46] many other more severely compromised patients (e.g., dual diagnosis patients) may need inpatient services. The above data suggest this may be harder to achieve under managed care. In addition, the lowered inpatient utilization rates above do not appear to show corresponding increases in outpatient utilization of services which support the notion that managed care practice may lead to under treatment of substance abuse.[26]

Illustrations

To illustrate how managed care practices can impact upon access to and utilization of clinical care, we solicited leading substance abuse administrators/practitioners to submit examples of typical difficulties they face on a day-to-day basis. Here are two such illustrations.

The first illustrates how administrative barriers and pre-determined criteria presented significant roadblocks to a patient attempting to follow through with a treatment plan.

- A 39-year-old divorced mother called her physician stating that she was depressed, drinking excessively, and needed help. She was brought to the admission office of a psychiatric hospital where it was determined that she had been spending most of her time in bed drinking eight to 12 beers a day, and was clinically depressed. The clinician was concerned over the decline in her clinical status and the likelihood of a continued increase in drinking severity and suicide risk. After numerous phone calls to the managed care entity the admissions office was told that since her diastolic blood pressure was not over 100 (i.e., a criterion for alcohol withdrawal) she would not be eligible for inpatient admission. The patient was taken home to her family and she never entered specific treatment for her combined substance abuse disorder and depression. This case illustrates the not uncommon scenario of misapplication of preset criteria leading to denial of appropriate patient care. Furthermore, it illustrates as well that health care decisions are being made by the insurer rather than the patients' physician.

In some cases this type of decision making can even lead to more

serious consequences, as in the next case. A 28-year-old man with a history of polysubstance abuse was hospitalized at a private psychiatric hospital. His stay as an inpatient was initially limited to three days by his managed care company. While in the hospital, in addition to his polysubstance abuse including alcohol and cocaine, it was noted that there was a strong family history of bipolar illness and the patient reported both highs and lows while not on various substances. The diagnosis of bipolar disorder was, therefore, added to his substance abuse diagnosis. Following his three day inpatient stay, he was referred to an outpatient chemical dependency program for which his managed care company approved only six visits per year.

After showing up for his first visit, he dropped out of treatment and wound up at an emergency room some time later, stating: "I don't know what I will do with myself. I'm just totally lost. I need help." A call to the case reviewer led to a denial of further inpatient care since his insurance would cover only one hospital stay during the course of the year, and his relapse was blamed on the patient in the form of denial of further care and treatment. Since the hospital appreciated that this patient absolutely required extended inpatient treatment, it sought to transfer him to a state hospital; however, amid this confusion the patient suddenly bolted from the emergency room. He was found two days later frozen to death under a railroad bridge.

This case illustrates that inadequacies of making clinical decisions based on actuarial or economically-grounded guidelines. Such decisions are best made by a physician who is directly examining the patient rather than a managed care case reviewer.

WHAT IS ITS IMPACT ON MEDICARE AND MEDICAID?

The rapid growth of expenditures in government entitlement programs has been a central topic of socio-political discourse within the United States over the past two decades. Of the estimated $100 billion spent on mental health and substance abuse conditions in 1995, Medicare and Medicaid programs spent 22% and 38%, respectively, according to 1990 government projections.[48] Encouraged by the federal government, there has been a trend to implement Managed Care programs for Medicare and Medicaid enrollees in order to contain these costs. Despite early optimism, however, the transition has at best occasioned mixed results. It is important to note that medicare and

medicaid managed care programs differ from those in the private sector. Although it is not possible, therefore, to generalize criticisms of one system to the other, we briefly describe these governmental forms of managed care to illustrate emerging problems within that sphere.

Medicare

Medicare HMOs were recently reported to be growing at a rate of nearly 25% per year.[48] This has not been a process without difficulties. A number of managed care companies were forced to discontinue providing coverage to elderly medicare patients.[49] It is estimated that a total of 400,000 Medicare beneficiaries dropped by these managed care companies will have to find a new HMO or go into the traditional fee-for-service Medicare program.[50] One reason for this chaotic situation is that managed care companies in certain regions of the US made inaccurate financial projections and were unable to provide comprehensive care at the cost they expected. The fact that this shortfall was experienced in a number of regions throughout the United States suggests that this is not a short term issue but rather points to a systemic problem.

Medicaid

The shift of Medicaid patients into managed care arrangements has been widely heralded though only a few such transitions have been studied empirically. Perhaps the most widely cited of these involved the Massachusetts Medicaid study which assessed the impact of managed behavioral care on mental health and substance abuse treatment for enrollees.[42] In Massachusetts, all Medicaid enrollees not covered by an HMO, approximately 350,000 people, were covered under a MBHC carve-out program in July, 1992. An evaluation of this program, the first statewide behavioral health carve-out for MH and SA, showed (1) access to care increased, (2) perceived quality of services was maintained, (3) expenditures for MH and SA services declined 22%.[51] The savings were achieved due to a dramatic 94% reduction in the use of inpatient hospital detoxification services for SA and diversion to non-hospital detoxification services. These initial results were regarded therefore as extremely promising.

Further evaluation of these data, however, suggests there may have

been significant cost shifting in the form of increased demand for other medical services among Massachusetts Medicaid patients (e.g., medical inpatient services, emergency room visits, etc.).[52] Thus, many patients denied adequate substance abuse services (e.g., brief inpatient detoxification and hospitalization) *seek and receive treatment* elsewhere within the same system thus shifting costs. Not only are costs shifted but patients are treated by non-specialist clinicians thereby increasing the likelihood that patients will reenter the system for continuing substance abuse problems over the long term.

Despite the early optimism generated by the Massachusetts experiment, at least two states have had severe difficulties implementing the transition to Managed Care. Tennessee carved out MH/SA services from the general Medicaid MC program, TennCare making use of a subcontractor. When the subcontractor declared bankruptcy, TennCare Partners deteriorated into a crisis where many patients did not receive care or lost continuity of care.[53] Not only did this transition cause problems in patient care but health care providers were left unpaid for services rendered. According to Newman,[55] when the Tenn. MCO declared bankruptcy, $300,000 in unpaid reimbursement was left for behavioral health services. Likewise, in a New Jersey medicaid HMO program, health providers were owed more than $100 million in past claims.[55]

In sum, Medicare and Medicaid programs have increasingly relied on managed care to contain costs. However, recent trends indicate (1) managed care organizations are pulling out of the medicare market altogether; and (2) managed behavioral health care for medicaid patients may lead to cost-shifting and perhaps inappropriate treatment. More extensive research is need in each of these areas.

HOW DO PROFESSIONALS FEEL?

The introduction of managed care has raised a number of shared concerns among the various healthcare disciplines directly involved with the delivery of addiction treatment. While the managed-care driven emphasis on credentialing and setting standards for providers of addiction treatment has the potential for improved level of services delivered, other developments related to this shift towards managed care are deeply troubling to healthcare providers. Perhaps no issue is of greater concern than the shift in clinical care decision-making from

the providers to the insurance industry, with legal liability remaining solely with the former group. Examples of clinical care decision-making pertinent to addiction care include: increasingly restrictive policy on inpatient detoxification; financial coverage for only brief outpatient psychotherapeutic treatment directed at alleviating acute symptoms of addiction; and an emphasis on prescription of psychiatric medication. This nominally "medicalized" approach to the immediate symptoms of the addictive disorders ignores the reality that such disorders are chronic, relapsing conditions. As noted in the earlier case illustrations, patients with addictive disorders may present as uncooperative in following through on treatment. While the healthcare community might be more inclined to see motivational difficulties as part of the very symptom complex of the addictive disorder, the insurance industry is more likely to take the position that a negative attitude represents a "lifestyle choice," thereby forfeiting the prospective patient's right to health insurance benefits.

Other changes introduced by managed care which affect healthcare providers of addictive treatment services are: below-market rigid reimbursement rates, commensurate with professional discipline only and not level of experience (e.g., both novice and seasoned clinician mandated to be reimbursed at the same rate); an onerous system required for authorizing treatment, confusing policies regarding benefit coverage, frequent delays and cumbersome paperwork, all of which might deter all but the most motivated (and perhaps less severely compromised) patients from receiving treatment; and increased requirements for disclosure of the specifics of treatment, thereby eroding confidentiality, a concern that may be particularly salient in addiction treatment. These changes in the delivery of addiction services towards a managed care approach have presented healthcare providers with an increasing level of ethical concerns and pressure to reconcile discrepancies between their own judgment regarding proper course of treatment and the managed care directives. These concerns have resulted in the healthcare providers supporting certain lawsuits in which complaints concerning managed care practices are at issue and lobbying Congress for legislation designed to enhance the delivery of addiction services.

ASAM Survey

Several surveys have been conducted to assess the impact of MC on physicians' practices and attitudes concerning how MC has influenced

the quality of patient care. Grumbach et al.[56] surveyed 766 primary care physicians employed in MC settings as to the types of incentives they encountered, pressures imposed on their practices and impact on patient care. Nearly 40% of the respondents reported that their contracts with MC organizations included some form of incentive. Incentives that involve limiting referrals or increasing patient caseloads were considered to negatively impact on patient care.

In a 1998 physician survey conducted by ASAM,[57] the majority of 200 respondents felt that MC had a negative impact on the following substance abuse treatment services: inpatient detoxification (67%), inpatient rehabilitation (86%), and outpatient rehabilitation (65%). Seventy-nine percent indicated that managed care impacted negatively on quality of patient care. Most respondents indicated a negative impact on their own practices with regard to the ethical practice of addiction medicine (79%), and income (56%) as well. Although cost savings might be derived from diminished income, it should be noted that a majority (63%) indicated that MC was adding rather than subtracting work effort to their clinical time. Only a minority (37%) reported that it resulted in less time demanded of them.

Other professional organizations have also increasingly acted to offset what are perceived to be unfair practices on the part of managed care organization. For, example, the American Psychological Association, the largest organization representing psychologists, has been in the forefront of supporting initiatives aimed at holding Managed Care plans legally accountable for their treatment decisions, increasing public awareness regarding the need for improved access and quality in Managed Care health plans and promoting a legal advocacy agenda.[57] Thus, various state psychological associations have supported litigation aimed at eliminating potentially harmful MC strategies and procedures such as (1) usurping treatment decision-making by the patient's doctor;[55] (2) advertising to employers, employees, and others treatment benefits ranging from 20 to 50 outpatients per year but typically providing only a small fraction (e.g., *only 3 or 4 outpatient sessions*;[55] (3) terminating providers from managed care panels who advocate for necessary patient services labeling them as "managed-care incompatible" when, in reality, their practice patterns did not fit the financially determined standards of the managed care organization;[55] and (4) banning "gag rules" that prohibit providers from telling patients about expensive treatment options, allowing patients to challenge a plan's

denial of care, and prohibiting plans from discriminating against health-care professionals solely on their licensure or certification.[58]

CONCLUSIONS AND RECOMMENDATIONS

There is little question that managed care has had a tremendous impact on the delivery of substance abuse treatment services. This review indicates that managed care procedures have contained costs, an achievement of no small consequence given the spiraling costs of healthcare. Nevertheless, one unintended consequence of the managed care revolution has resulted in decreased value of substance abuse treatment benefits, decreased availability of appropriate care, and decreased autonomy of clinicians to make treatment decisions for *their* patients. While these trends mirror changes noted elsewhere in the health care system, there is strong evidence that they are particularly egregious in the area of substance abuse treatment.[38] Given the overwhelming cost that substance abuse imposes on our society (nearly a quarter trillion dollars per year), it is vital that these trends be reversed. We therefore make the following recommendations:

Economic

1. Substance abuse treatment is a cost-effective approach to a problem that poses an enormous financial burden to society. Because of this, the society saves money by providing treatment necessary to achieve symptom relief and remission. Substance abuse treatment benefits should therefore be given parity with those for general health.
2. When higher quality treatment is made available by removing ceilings on reimbursement, costs have not escalated appreciably. Major constraints on expenditure are apparently not necessary and should be rescinded.
3. Reimbursement levels for clinicians treating substance abuse should be commensurate with the time and experience required for each service, relative to other medical treatments. Clinicians should not be forced out of the field by an inadequate reimbursement structure or by unwarranted exclusion from provider panels.
4. The criteria for reimbursement applied by managed care organizations should be available to both patients and healthcare providers on request.

5. Parity in coverage with other medical illnesses should be established. It should, however, not be secured at the expense of access to treatment or at a prohibitively low reimbursement rate.

Clinical

1. Adequate treatment requires the use of a set of criteria for patient care which are empirically developed by clinicians, such as the ASAM Patient Placement Criteria.
2. Patient placement criteria should be flexible enough to address the medical and psychosocial problems that impede recovery. Clinicians' judgment should therefore be respected in defining limits of care, even beyond criteria usually applied.
3. Special attention needs to be paid to patients with addiction and other disorders. Specifically, patients with concomitant medical illness such as hepatic disease or psychiatric illness such as bipolar disorder will require additional intensive treatment.
4. Treatment should include support for patients' entry into care. Motivational difficulties and denial are part of addictive illness and must be addressed with support for initiating treatment.
5. There is need for legislation to ensure proper minimal standards of care. Otherwise treatment may be defined with appropriate clinical care secondary to economic gain.

Managed Care Organizations' Responsibility

1. Insurers should be liable for the constraints they apply to treatment. This is particularly relevant when they operate contrary to the preferences of the treating clinician. The repeal of ERISA legislation would be a step towards addressing this issue.
2. It should be possible to appeal denial or restriction of treatment. Such appeals should be conducted by a group independent of the managed care insurer or provider.
3. Any arbitration should be done with full participation of independent professional organizations, as well as the managed care entity.

Research

1. The nature and extent of cost shifting caused by reductions in care should be determined and quantified. Is there increased

morbidity due to decreased addiction treatment and does it produce greater costs for treating medical sequelae?

2. Are patients leaving treatment due to the interaction between denial of illness and increased out-of-pocket cost for care?
3. With less support for treatment, is there less opportunity for teaching? Is this affecting the quality of addiction training for physicians?

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3. Why Should Legislators Be Concerned About Alcoholism and Drug Addiction?

Economic Consequences

Alcoholism and drug addiction place financial burdens on states and taxpayers. Untreated substance abuse costs the nation billions of dollars each year as a result of increasing health care costs, loss of productivity at work, judicial and law enforcement costs, unemployment and the costs of social services. The costs of alcoholism and drug abuse were estimated in 1992 by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to be more than $246 billion annually. The costs of alcoholism are expected to increase every year due to population growth and inflation.[1] In direct costs to the community, however, states bear the greatest financial burden.

National expenditures for the treatment of alcoholism and drug addiction exceeded $12 billion in 1996. This amount is relatively low when compared to the $246 billion that substance abuse costs society. State governments spend billions of dollars each year on alcohol and drug-related treatment. Additional billions are spent on alcohol and drug-related crimes, accidents and social problems that arise in the work place, the community and the home. Problems include lost worker productivity, increased homelessness, and mental health and family problems.

Studies from several states have shown that drug treatment is cost effective. These state experiences demonstrate that substance abuse treatment results in marked decreases in drug use, medical expenses and illegal behavior, which translates into savings for employers, for the health care system and for taxpayers.

State legislators need to know the economic, health and social consequences of alcoholism and drug addiction to make cost-effective public policy decisions.

Source: *Although the Costs of Increased Substance Abuse Benefits Are Low, the Advantages Are Significant* (Washington D.C.: Office of Managed Care, Center for Substance Abuse Treatment, February 1999).

Addiction treatment substantially improves patients' lives by reducing substance use, crime and hospitalizations, while also strengthening employment, according to a review by the New York Office of Alcoholism and Substance Abuse Services (OASAS). Results from the state report are shown in figure 2.

Other states have produced similar reports. The California Drug and Alcohol Treatment Assessment (CALDATA) found that, for every $1 invested in substance abuse treatment an average of $7 was seen in return. This study showed that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent and hospitalizations declined by 33 percent among individuals receiving drug and alcohol treatment.[2]

An Oregon study of societal outcomes and cost savings found that taxpayers save approximately $5.60 for every $1 spent on individuals who complete treatment. In Multnomah County, a comprehensive study of 440 drug courts found a two-year savings to the state of $10.2 million. This includes savings in the criminal justice system, victimization, theft reduction, public assistance and medical claims.[3]

In Washington, a study was conducted to estimate the total cost of untreated and treated alcohol and drug addiction. Treatment dollars totaled approximately $160 million. Untreated costs totaled an estimated $2.54 billion (see figure 3) with the majority of the costs related to the following:

The Oklahoma Governor's Task Force on Substance Abuse also found staggering costs directly related to substance abuse in the state (see figure 4).

Health Consequences

According to the National Household Survey on Drug Abuse, an estimated 9.7 million people were dependent on alcohol in 1998, and 1.7 million people reported receiving treatment or counseling for their alcohol use.[4] Although alcohol and other drugs are implicated in deaths caused by motor vehicle crashes, drownings, falls and fires, it is difficult to measure the connection between alcohol and morbidity. Excessive use of alcohol is harmful to every organ and tissue in the body. Alcohol affects the liver, esophagus, stomach, intestines, heart, brain, nerves, hormones and immune system and also can lead to other health problems.[5] Some studies also show that moderate use of alcohol is good for an individual's heart because it boosts HDL cholesterol levels. However, aerobic exercise and weight loss also provide the same result. Alcohol intake is not recommended solely to have a healthier heart because alcohol can raise blood pressure and cause many other negative health effects.

The Substance Abuse and Mental Health Services Administration estimates that in 1998, 13.6 million Americans were current illicit drug users. This represents 6.2 percent of the population age 12 and older.[6] Alcohol and other drug abuse causes damage to the health of a substance abuser and can impede his or her ability to function at a normal level.

According to a research study conducted by Rutgers University, treatment of alcoholism and drug addiction causes sharp reductions in medical care utilization and encourages more appropriate utilization when services are delivered. These cost offsets are a stable, long-term effect of treatment from which society will reap benefits for a period longer than any research team has followed to date.[7]

Figure 2. Treatment Works in New York

As part of Alcoholism and Drug Addiction Recovery Month, Commissioner Jean Somers Miller said the preliminary analysis of nearly 59,000 patients who received at least six months' treatment during 1997 and 1998 showed:

- The number of people jailed was reduced 77 percent.
- The number of clients using inpatient detoxification facilities decreased 76 percent.
- The number of treatment patients using hospital emergency rooms fell 39 percent.
- Use of the primary substance was eliminated in 68 percent to 91 percent of the cases, depending on the type of program.
- At the same time, employment status was either maintained at full-time or improved in 35 percent to 53 percent of the cases, varying according to type of program.

"This study provides more solid evidence that treatment saves lives and saves money," the commissioner said. "By substantially reducing alcohol and drug use, arrests and hospitalizations, while at the same time strengthening job prospects, treatment reclaims lives and rebuilds communities."

John Coppola, executive director of the Alcoholism and Substance Abuse Providers (ASAP) of New York state said, "Treatment is a great investment in the state's future. Each dollar invested in treatment saves $7 in other costs. In their day-to-day work, treatment agencies serve as a bridge to help persons from dependence to independence, where they make vital contributions to the state's well being."

The OASAS analysis was based on admission and discharge forms for 58,846 patients who spent at least six months in treatment in 1997 and 1998 (or about 27 percent of all patients discharged during that period). It covered four major program categories: residential drug-free, ambulatory drug-free (including medically supervised outpatient clinics), alcoholism outpatient clinic and halfway houses. Results by area showed:

- **Less Crime:** Only about one-third of the patients were arrested before or during treatment. The number arrested fell from 18,633 to 5,513, down 72 percent. The number incarcerated fell from 15,052 to 3,520, down 77 percent. The average number of arrests per client fell in a range from 65 percent to 94 percent, depending on the type of program.

- **Fewer Hospitalizations:** The number of patients using inpatient hospital detoxification fell from 9,382 to 2,273, down 76 percent. The number of patients hospitalized for other reasons dropped from 4,237 to 2,267, down 46 percent. The number using emergency rooms fell from 5,440 to 3,294, down 39 percent.

- **Reduced Substance Use:** The share of patients who discontinued use of their primary substance ranged from 68 percent in ambulatory drug-free clinics to 91 percent in halfway houses.

- **Improved Employment:** The portion of those who maintained full-time jobs or otherwise improved their employment status ranged from 35 percent in halfway houses to 53 percent in alcoholism outpatient clinics.

Source: OASAS Press Release, Sept. 20, 1999. Gwenn B. Lee (518) 485-1768; E-mail: leeg@oasas.state.ny.us Web Page: http://www.oasas.state.ny.us.

Figure 3. The Economic Costs of Drug and Alcohol Abuse in Washington State

• Substance abuse-related premature mortality	$929 million
• Crime	$541 million
• Medical care	$211 million
• Other diseases	$ 81 million
• Other related costs	$254 million
• Morbidity	$369 million

Source: Wickizer, Thomas M., The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996, report prepared for the Division of Alcohol and Substance Abuse, Washington Department of Social and health Services, March 1999, pp.vii-viii.

Fetal Alcohol Syndrome

Drinking alcohol during pregnancy can produce infants with fetal alcohol syndrome (FAS) or infants with fetal alcohol effects (FAE). Characteristics of FAS include prenatal and postnatal growth retardation, evidence of craniofacial anomalies, central nervous system dysfunction and malformations in the major organ systems. FAE is a lesser set of the same symptoms that make up FAS. At least 5,000 infants are born each year with FAS; another 50,000 children show symptoms of FAE.[8]

Studies have examined babies born with FAS at later developmental stages to determine its long-term effects. Overall improvement could be seen in some areas: the appearance of the children, their clumsiness, impaired concentration, difficulties with siblings, tantrums, negativity and phobias. However, other factors persisted, including hyperactivity, speech defects and anxiety. There was a greater need for special education for these children as they reached school age and, the more mentally challenged these children were at birth, the less improvement they showed as they grew older. Most of these children continue to need special health, education and social services as they grow older.[9]

Figure 4. Oklahoma—The Cost of Substance Abuse

The annual costs of substance abuse in the state are almost $2 billion.

	Cash Costs	
Federal Taxpayer	$860 million	47 percent
State Taxpayer	$329 million	18 percent
Local Taxpayer	$130 million	7 percent
Private Business	$547 million	28 percent
Total Expense	$1.866 billion	100 percent
Health Care	$254 million	14 percent
Public Safety	$355 million	19 percent
Social Services	$838 million	45 percent
Costs to Business	$297 million	16 percent
Property Loss	$123 million	6 percent
Total Expense	$1.866 billion	100 percent

Source: *Governor's Task Force On Substance Abuse, Findings and Recommendations*, 1998.

AIDS

The incidence of reported cases among injection drug users (IDU) is accelerating at an alarming rate. According to the U.S. Centers for Disease Control and Prevention, sharing syringes and other equipment for drug injection is a well-known route of HIV transmission, yet injection drug use contributes to the epidemic's spread beyond the circle of those who inject. Since the epidemic began, injection drug use has directly and indirectly accounted for more than 36 percent of AIDS cases in the United States. This disturbing trend appears to be continuing. Of the 48,269 new cases of AIDS reported in 1998, 31 percent were IDU-associated. People who have sex with an IDU also are at risk of infection through the sexual transmission of HIV. Children born to mothers who contracted HIV through sharing needles or having sex with an IDU may become infected as well.[10]

Pregnant Women and Drug-Affected Babies

Drug and alcohol use by pregnant women has gained national attention. When pregnant women use drugs, alcohol or cigarettes, the substances cross the placenta and affect the developing fetus. Cocaine use can cause miscarriage, fetal stroke, premature delivery, and maternal and infant hemorrhaging. Narcotics such as opium and heroin can cause fetal

addiction, which can lead to infant withdrawal, respiratory distress and convulsions. In addition to physical abnormalities, drug-affected babies use costly medical services and a variety of other support services.

In 1997, the Substance Abuse and Mental Health Services Administration released the first major analysis of alcohol, illicit drug and tobacco use in a nationally representative sample of women. The findings indicated:

- About 21.5 percent of pregnant women under age 44 had used alcohol in the past month and, of this group, nearly a one-third reported having three or more drinks on the days they drank.
- An estimated 62,000, or 2.3 percent, of all pregnant women under age 44 reported using an illicit drug in the past month. [11]

A 1998 study by the National Institute on Drug Abuse (NIDA) showed in increase in the use of illicit drugs by pregnant women who used an illicit drug during pregnancy to 5.5 percent, or 221,000 women.[12]

Mental Health

Estimates suggest that each year up to 10 million people across the nation are suffering from at least one co-occurring mental health and substance abuse disorder.[13] The National Comorbidity Study results indicate that 41 percent to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder. In addition, almost 51 percent of individuals with one or more lifetime mental disorders also have a history of at least one substance abuse disorder.[14] Although a causality relationship between substance abuse disorders and mental disorders has yet to be established, there are indications that individuals who suffer from mental illnesses may self-medicate with alcohol and other substances, leading to addictive disorders.

Welfare Recipients

Drug and alcohol abuse are barriers to self-sufficiency for welfare recipients. Substance abuse poses a particular challenge for state welfare reform efforts. It is difficult for addicted welfare recipients to follow welfare rules. It is even more difficult for these recipients to find and retain employment. Failure in work and job placements also can contribute to an already low self-esteem in these recipients. Addicted recipients often face sanctions for noncompliance with welfare rules. These sanctions may include a reduced amount of cash assistance or denial of aid, leaving the children of addicted welfare recipients vulnerable to neglect and abuse.

Drug and alcohol abuse are barriers to self-sufficiency for welfare recipients.

Welfare caseloads have dramatically declined since welfare reform. Those who remain on the caseload face multiple barriers to employment. Thirty percent of the caseload has an addiction to alcohol or drugs or a mental health diagnosis. These recipients face time limits—a federal limit of 60 months of assistance and some state time limits of shorter duration. Welfare recipients with substance abuse problems jeopardize state efforts to meet increasingly strict federal work participation requirements, which could result in federal financial penalties.

Social Consequences

Families, friends, associates and communities—the entire fabric of society—are affected by the problems associated with alcoholism and other drug abuse. People who misuse drugs and alcohol are often less productive on their jobs than others. In addition to motor vehicle accidents, alcohol and other drug abuse contributes to accidental injuries and fatalities, traumas, suicide, homelessness, mental health problems, crime and family violence and dysfunctional families.

Accidents

Alcohol and drugs have been implicated in the four leading causes of accidents: motor vehicle collisions, falls, drowning, and burns and fires.

Alcohol and drugs have been implicated in the four leading causes of accidents: motor vehicle collisions, falls, drowning, and burns and fires.

Automobile accidents are the leading cause of death by injury in the United States for people ages 1 to 34. The National Highway Traffic Safety Administration (NHTSA) estimates alcohol was involved in 39 percent of fatal crashes and 7 percent of all crashes in 1998.[15] The 15,935 fatalities in alcohol-related crashes represent an average of one alcohol-related fatality every 33 minutes. Police reported alcohol was a factor in more than 305,000 crashes that resulted in personal injury. This averages to approximately one person injured in an alcohol-related accident every two minutes.[16]

Burns and fires are accountable for at least 5,000 deaths and 1.4 million injuries every year.[17] Further, a review of five recent studies shows that between 33 percent and 61 percent of those who died as a result of burns from fires were drinking.[18]

Another means of alcohol-related accidental death and injury is drowning. Drownings, including boating accidents, are the third most common cause of unintended death for all ages.[19] Data from seven general population studies indicated than an average of 34 percent of 2,151 drownings involved alcohol use.[20]

Alcohol may increase the risk factors that contribute to injury or death in any of these activities as a result of slower response time, decreased coordination, desensitization to pain, and drowsiness. All these are effects of alcohol consumption.

Suicide

Suicide is the eighth leading cause of death in the United States and the third leading cause of death for youth, according to a 199[illegible] report released by the American Association of Suicidology. The results of one such study indicated that almost 36 percent of suicide victims had a positive blood alcohol content (BAC) level.[21] Although the data did not prove a causal relationship between alcohol and suicide, the authors suggested that, for some people, alcohol may have contributed to the decision to commit suicide.

Trauma

Alcohol and drug abuse are a major contributing factors in thousands of traumatic injuries each year. The Drug Abuse Warning Network (DAWN) is a national probability survey of hospital emergency departments (EDs) conducted annually by the Substance Abuse and Mental Health Services Administration to capture data about emergency department epi-

sodes induced by or related to the use of an illegal drug or the non medical use of a legal drug. Data for 1998 showed an estimated 542,544 drug-related ED episodes and 982,856 drug mentions.[22] (A drug mention refers to a substance that was mentioned during a drug-related ED episode.) In drug-related ED episodes, overdose (245,164) was the most frequently cited reason for the visit. The most frequently cited motives for taking the substance were suicide (189,897) and dependence (189,094).[23]

Homeless People

According to the National Coalition for the Homeless (NCH), surveys of homeless populations conducted during the 1980s found high rates of addiction. Although there is no ... "magic number with respect to the prevalence of addiction disorders among homeless adults," untreated addictive disorders do contribute to homelessness.[24] Homeless and addictive disorders are relational in that some people are more predisposed to poverty and homelessness because of their addictions. There are also indications that some homeless people begin to use substances to escape the reality of their homelessness and helplessness.

Crime and Family Violence

Based on victim reports, 183,000 (37 percent) rapes and sexual assaults involve alcohol use by the offender, as do 197,000 (15 percent) robberies, 661,000 (27 percent) of aggravated assaults and nearly 1.7 million (25 percent) simple assaults each year.[25]

In addition, a survey conducted by CASA in 1997 revealed that, when children in America are being abused or neglected, it is likely their parents are drunk or high from alcohol or drugs (such as cocaine) or suffering from a hangover or withdrawal symptoms.[26] Almost three of four child welfare professionals in the survey cited substance abuse and addiction as one of the top three causes for the dramatic rise in child maltreatment since 1985. Also, in a study that controlled for income, family size, degree of social support, parental depression and anti-social personality, children whose parents were abusing substances were three times more likely to be abused and four times more likely to be neglected than children whose parents were not substance abusers.[27]

Dysfunctional Families

Alcoholism and drug addiction affect the entire family, not only the individual who suffers from the addiction. Evidence drawn from numerous studies across the nation indicates that 40 percent to 80 percent of families in the child welfare system (child protection, abuse and neglect, foster care, adoption, family preservation and support services) have alcohol or other drug abuse problems and those problems are connected with the abuse and neglect experienced by their children.[28] Day-to-day abuse and neglect can result in long-term emotional and psychological problems. In addition, children of alcoholics are four times more likely to develop alcoholism than children of non-alcoholics.[29] Children who live with a non-recovering alcoholic score lower on measures of family cohesion, intellectual-cultural orientation, active-recreational orientation and independence. They also usually experience higher levels of conflict within the family.[30]

Forty percent to 80 percent of families in the child welfare system have alcohol or other drug abuse problems.

Children are not the only family members who are affected by alcohol and drug abuse. Separated and divorced men and women were three times as likely to say that they had been married to an alcoholic or problem drinker.[31]

SEP 2 4 2001

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September 21, 2001

Senator Rodney Moen
Chairperson, Committee on Health,
Utilities, Veterans, and Military Affairs
Wisconsin State Capitol
PO Box 7882
Madison, WI 53707-7882

Dear Senator Moen,

As a public interest law firm with extensive experience helping consumers with health care denials and insurance law, we write in support of the Wisconsin Mental Health Parity Act (SB 157). We are encouraged by the strong bipartisan support for Senator Panzer's effort to bring health benefits for persons with mental illness and substance abuse problems in line with those suffering from physical ailments. It is a necessary step for our state. It is unconscionable that someone dealing with schizophrenia may be treated with a lesser level of care than someone with arthritis. This imbalance creates an unfair burden for families. Even families with health insurance routinely face out of pocket expenses ten to twenty times higher than they would if they were seeking treatment for a physical ailment, according to the Surgeon General's report on mental illness. Families are forced to incur these costs because insurers can arbitrarily cap the length of hospital stays or number of outpatient doctor visits while charging mental health consumers higher co-pays and deductibles for services.

Opponents Panzer's legislation in the insurance industry argue that rather than expanding coverage for mental illnesses, the new laws will force companies to drop mental health coverage altogether. They would have you believe that the cost of mandated increased coverage will be prohibitive for employers. Existing empirical evidence should relieve these fears. Studies of states that have implemented mental health parity laws show that increased mental health coverage does not dramatically increase premiums. Texas adopted a parity mandate for its state employees in 1992 and over the next three years the cost of mental health and substance abuse treatment dropped 47.9 per cent. In other states we have seen an increase in premiums of only .6 per cent. This makes it unlikely that parity legislation will force employers to drop mental health insurance for their employees. Moreover, employers will experience the benefit of better health care coverage via increased worker productivity and decreased absenteeism.

If these proposals are passed and signed into law, insurance plans will not be able discriminate against people with mental health needs by arbitrarily imposing limits on mental health inpatient and outpatient stays or increasing deductibles and co-pays for mental health care. Wisconsin employees will gain coverage for substance abuse treatment, and experience an increase in the quality of their health care. Families pushing to the brink by exorbitant mental health care bills or untreated mental illnesses will receive relief. Above all, this legislation will provide effective health care to Wisconsin residents with mental health care needs. We call upon our legislators to pass the Wisconsin Mental Health Parity Act.

Sincerely,

ABC for Health, Inc.

Robert Peterson, J.D.
Executive Director

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 5 2001

Dear Recovery Month Participant:

As I begin working on the Nation's health issues, I welcome the opportunity to support the "National Alcohol and Drug Addiction Recovery Month" (*Recovery Month*), now in its 12th year of celebration. I am privileged to join your organization and many others in promoting this year's theme—*"We Recover Together: Family, Friends, and Community."* As you know, substance abuse is a national health problem, affecting millions of Americans. Not only does substance abuse ravage the lives of those suffering from addiction, it is an illness that affects everyone in our Nation.

There has never been a better time to unite our efforts and resources. It is together that we can spread the message that recovery from substance abuse in all its forms is possible. Not only does treatment save lives, but it also saves money and resources. This *Recovery Month* effort is an important step in bringing to light the need to dedicate ourselves to helping make our country become drug-free.

Thank you for your continued efforts. Your commitment to the Nation's health is greatly admired and appreciated.

Sincerely,

Tommy G. Thompson

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

Dear Friends:

This is the twelfth year of the "National Alcohol and Drug Addiction Recovery Month" (*Recovery Month*) celebration. *Recovery Month* highlights the societal benefits of substance abuse treatment, lauds the contributions of treatment providers and promotes the message that recovery from substance use in all its forms is possible. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) sponsors the celebration to encourage citizen action to help expand and improve the availability of effective addiction treatment for those in need. Substance use continues to be a national public health problem affecting millions of people, and it is critical to educate the public on the crucial role substance abuse treatment plays in reclaiming lives ravaged by alcoholism and drug addiction.

This year's theme, *"We Recover Together: Family, Friends, and Community"* is intended to focus the Nation's attention, for the month of September, on the needs of Americans who severely need substance abuse treatment. According to the National Household Survey on Drug Abuse, 57 percent of people with a severe drug problem – about 2.9 million people in need of treatment – did not receive it.

The enclosed materials are designed to provide information and resources to be utilized to spread the word that those suffering from addiction can be helped and freed through treatment. In addition, the kit is geared to show others in your State and community that greater local resources, health insurance coverage and employer support will result in less crime, more productive schools and workplaces, earlier intervention, and savings to the health care system. Specifically, these materials target parents and families, schools and the education community, health policymakers and insurers, criminal justice systems, health professionals, community organizations, the faith community and employers. In addition, the kit includes information and resources needed to launch a comprehensive public education initiative to support local print and broadcast media efforts. It is our hope that as SAMHSA and CSAT work on *Recovery Month* on a national scale you will work at the local level to share this information with others in your State and community who can make a difference for those in need of treatment, and support those in recovery.

We thank you for your efforts to educate others on the benefits of addiction treatment. We can make a difference and help reduce this national epidemic that touches every American. Together, we can help families, friends and communities reclaim their lives from substance use.

Sincerely yours,

Joseph H. Autry III, M.D.
Acting Administrator

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment

Enclosures

General Facts About Drug and Alcohol Addiction, Treatment, Recovery, and Use

Drug and alcohol use, abuse, and addiction continue to be among the nation's leading public health problems. Millions of Americans struggle every day with their own drug and alcohol problems. The toll these problems take on these individuals is considerable, as they are at increased risk for very serious health problems, criminal activity, automobile crashes, and lost productivity in the workplace. But individuals with drug and alcohol problems are not the only casualties. Their families, friends, and communities, in fact, society as a whole, also suffer greatly.

The good news is that treatment from drug and alcohol addiction is available and effective. Run by qualified, accredited, and dedicated professionals, treatment programs and services that meet rigorous state standards are the backbone of the public health response needed to address this nationwide epidemic. The range of treatment and recovery program options is considerable; however, it is still not as comprehensive, available, or affordable as it needs to be to ensure that everyone who needs effective treatment can get it. In fact, of the five million people with severe drug or alcohol addiction, only a little more than two million receive treatment — a gap of almost 60 percent.[1]

For those individuals who are able to receive treatment for their drug or alcohol problems, one irrefutable fact remains — the support of family, friends, and the community at large is a critical facet of the overall recovery process. Their role in timely intervention, motivating the individual with the problem to seek help and supporting that person throughout his or her efforts to maintain sobriety cannot and should not be underestimated.

Here are some key facts about addiction, treatment, recovery, and alcohol and drug use that everyone should know:

Understanding Addiction and the Recovery Process

- Although addiction to drugs or alcohol begins with a personal choice to use these substances, research shows that, for many, a physiologically based dependence soon sets in. Drug dependence produces significant and lasting changes in brain chemistry and function.[2]
- Most individuals who use illicit drugs or alcohol stop at the "experimental" or "recreational" stage. For a variety of complex reasons, which may involve heredity, social or environmental factors, or other variables, some individuals' use progresses to a more problematic phase, or substance abuse. Without appropriate intervention, use may become habitual and evolve into physical and psychological dependency, or addiction.
- Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes in brain function may have behavioral consequences, including the compulsion to use drugs despite adverse consequences — the defining characteristic of addiction.[3]
- Alcoholism comprises a set of complex behaviors in which an individual becomes increasingly preoccupied with obtaining alcohol. These behaviors ultimately lead to a loss of control over

consumption of the drug and to the development of tolerance, dependence, and impaired social and occupational functioning.[4]

- Addiction is a chronic medical illness, much like type 2 diabetes mellitus and hypertension, that can be treated. Often it is the result of some combination of genetic heritability, personal choice, and environmental factors.[5]
- In the past, drug dependence has been treated like an acute illness, one that can and should be "cured" virtually overnight. More often than not, this unrealistic expectation is not met. However, when addiction is treated as the more long-term, chronic, relapsing illness it really is, success rates are comparable to those associated with treating other chronic health problems, such as hypertension, diabetes, and asthma.[6]
- Recovery from drug or alcohol addiction is a process, one that by its very nature may include relapse. Occasional relapses during recovery are to be expected and are not an indication of failure by any means. For some individuals, recovery is a more lengthy process than it is for others. So long as efforts are being made on the part of the recovering individual to maintain sobriety and adhere to treatment and recovery program guidelines, progress in the process is being made.
- Family members and friends of individuals with drug and alcohol problems also experience a host of negative physical, emotional, and spiritual repercussions. They too need ongoing support programs and services to help them cope with addiction, understand and deal with the recovery process, and support their loved one's efforts to get well.

Social Benefits of Drug and Alcohol Treatment

- Treatment for drug and alcohol addiction cuts drug use in half, reduces criminal activity up to 80 percent, increases employment, decreases homelessness, improves physical and mental health, reduces medical costs, and reduces risky sexual behaviors.[7]
- The cost of untreated drug and alcohol addiction in the U.S. in a given year is estimated at $276 billion in lost productivity, law enforcement, health care, justice, welfare, and other programs and services. That's an annual cost of $1,050 for every man, woman, and child in America.[8] In contrast, it would cost about $45 per year per each American to provide the full continuum of services needed to effectively treat addictive disorders.[9] Of course, the return on investment in terms of restored lives is incalculable.
- According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.[10]
- Treatment also produces major savings to the individual and society in the form of significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.[11]

Understanding Effective Drug Addiction Treatment[12]

- Drug addiction treatment should include behavioral therapy such as counseling, cognitive therapy or psychotherapy, or any combination thereof and may include medications.

- In order to be truly effective, especially when treating at-risk or hard-to-reach populations, treatment programs must provide a combination of culturally competent therapies and other services. Factors that must be considered include: age, race, culture, language, sexual orientation, gender, pregnancy status, parental responsibilities, housing and employment, physical disability, the existence of co-occurring mental illness, and any past history of physical and sexual abuse.
- Because drug and alcohol addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence.

The Role of Family, Friends, and Community in Treatment and Recovery[13]

- Successful treatment outcomes often depend upon retaining the person with the drug or alcohol problem long enough to gain the full benefits of treatment. Whether or not a person stays in treatment depends on a number of factors, including: personal motivation to change behavior; the degree of support provided by family and friends; and whether or not there is pressure to stay in treatment from the criminal justice system, child protection services, employers, or the family.
- Community-based recovery groups, most often in the form of 12-step programs, can complement and extend the effects of professional treatment by supporting individuals throughout the recovery process.
- Family and friends can play critical roles in motivating individuals with drug and alcohol problems to enter treatment, stay in it, and maintain sobriety. Family therapy is also important, especially for adolescents. Additional support is available through the recovery community in the form of 12-step programs.
- Family members and friends who attend 12-step support programs report strong improvements in their mental health/well-being, ability to function each day at home/work/school, and overall health status as a result.[14]

To learn more about drug addiction and treatment, as well as the many kinds of treatment programs and approaches currently available, anyone can order a free copy of the National Institute on Drug Abuse's 52-page booklet, *Principles of Drug Addiction Treatment: A Research-Based Guide* (DHHS Publication No. 00-4180, printed in October 1999, and reprinted in July 2000). Orders can be placed for up to eight free copies by contacting the National Clearinghouse for Alcohol and Drug Information at 800-729-6686 or 301-468-2600, or accessing them via the Internet at www.health.org or by email at info@health.org.

Current Facts About Alcohol and Other Drug Use in the U.S.

Substance Dependence in 1999

- Males were more likely to be dependent on illicit drugs and alcohol than females, except in the case of young people, ages 12-17. Their rates of use were essentially the same.
- Adults who first used drugs at a young age were more likely to be dependent on drugs (8.9 percent) than adults who initiated use at a later age (1.7 percent).

Overall Illicit Drug Use in 1999[15]

- Approximately 14.8 million Americans were current illicit drug users, meaning they used at least once in the past 30 days.
- 10.9 percent of youths between the ages of 12 and 17 were current users of illicit drugs.
- Current illicit drug use among the major racial/ethnic groups was as follows: 6.6 percent whites, 6.8 percent Hispanics, 7.7 percent African Americans, 10.6 percent American Indian/Alaska Natives, 11.2 percent multiple race, and 3.2 percent Asian/Pacific Islanders.

Overall Alcohol and Tobacco Use in 1999

- 12.4 million Americans, age 12 and older, were heavy drinkers (5 or more drinks on one occasion 5 or more days in the past 30 days), while 6.8 million underage drinkers (ages 12-20) engaged in binge drinking (5 or more drinks on one occasion in the last 30 days), including 2.1 million of them who could be classified as heavy drinkers.[17]
- Alcohol use among teens is extremely widespread. Four out of five students (80 percent) have consumed alcohol by the end of high school; about half (52 percent) have done so by 8th grade.[18]
- 30.2 percent of the American population, age 12 and older, reported they used some form of tobacco in the past 30 days.[19]
- Nearly two-thirds (65 percent) of young people have tried cigarettes by 12th grade, and over a third (35 percent) of 12th graders are current smokers.[20]

Usage Data and Other Information Regarding Specific Illicit Drugs

Marijuana[21]

- Marijuana is the most commonly used illicit drug, used by 75 percent of illicit drug users.
- An estimated 2.3 million persons first used marijuana in 1998, which translates into about 6,400 new users per day. More than two-thirds of these new users were under 18.
- The rates of marijuana initiation for youth during 1995 through 1998 are at their highest levels since the peak in the late 1970s.

Cocaine/Crack

- Cocaine is a powerfully addictive stimulant that directly affects the brain. It is generally sold on the street as a fine, white, crystalline powder, known as "coke," "C," "snow," "flake," or "blow."[22]
- Crack is the street name given to the freebase form of cocaine that has been processed from the powdered cocaine hydrochloride form to a smokable substance. Because it is smoked, it produces an immediate, euphoric high. It is also inexpensive to produce and buy.[23]
- In 1999, an estimated 1.5 million Americans were cocaine users, and 413,000 used crack.[24]

- The long-term effects of cocaine include: addiction, irritability and mood disturbances, restlessness, paranoia, and auditory hallucinations. The medical consequences of cocaine abuse include: disturbances in heart rhythm, heart attacks, chest pain, respiratory failure, strokes, seizures and headaches, abdominal pain, and nausea.[25]

Hallucinogens

- An estimated 900,000 Americans were hallucinogen users in 1999.[26]
- Hallucinogens include LSD (lysergic acid diethylamide, also known as acid, blotter, boomers, cubes, microdot, or yellow sunshines), mescaline (also known as buttons, cactus, mesc, or peyote) and psilocybin (also known as magic mushroom, purple passion, or shrooms).[27]

Heroin

- Heroin is the most abused and rapidly acting of the opiate class of drugs and is highly addictive. It is typically sold as a white or brownish powder or as a black, sticky substance known on the streets as "black tar heroin."[28]
- The long-term effects of heroin abuse include: addiction, substantially increased risk of infectious diseases such as HIV/AIDS and hepatitis B and C due to intravenous use or risky sexual behaviors, collapsed veins, bacterial infections, abscesses, infection of heart lining and valves, and arthritis and other rheumatologic problems. Because most street heroin is "cut" with other drugs or substances, users do not always know the strength of the drug or what is in it. As a result, they are at increased risk of overdose or death.[29]
- An estimated 200,000 Americans were heroin users in 1999.[30]

Methamphetamine[31]

- Methamphetamine and amphetamine use has been on the rise since 1994.
- Methamphetamine is a powerfully addictive stimulant associated with serious health conditions, such as memory loss, aggression, psychotic behavior, heart and brain damage, and increased risk of sexual behavior contributing to contraction of hepatitis and HIV/AIDS.

MDMA, or "Ecstasy"

- Ecstasy is a stimulant, a so-called "club drug" because of its popularity with young people at night clubs and "raves."[32]
- The use of ecstasy among older teens jumped sharply in 1999, following several years of gradual decline. About one in twenty 10th and 12th graders used ecstasy during the past year.[33]
- Side effects and health consequences of ecstasy use include increased heart rate, blood pressure, and metabolism; feelings of exhilaration, energy, and increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, and heart failure; mild hallucinogenic effects and impaired memory and learning.[34] Using ecstasy can result in death for habitual users as well as first-time users.

Usage Data and Other Information Regarding Other Substances of Note

Inhalants

- Inhalants are volatile substances that produce chemical vapors that can be inhaled to induce a psychoactive, or mind-altering, effect.[35] They include solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexl), laughing gas, poppers, snappers, and whippets.[36]
- Inhalants are the only class of drugs that tend to be more popular among younger teens than among older ones. Annual prevalence rates for 8th, 10th, and 12th graders in 1999 were 10 percent, 7 percent, and 6 percent respectively.[37]
- Signs of inhalant abuse include: chemical odors on breath or clothing; paint or other stains on face, hands, or clothes; hidden empty spray paint or solvent containers and chemical-soaked rags or clothing; drunk or disoriented appearance; slurred speech, nausea, or loss of appetite; inattentiveness, lack of coordination, irritability or depression; and sudden death, which can happen to novice or habitual users.[38]
- Inhalants are especially dangerous because most of the substances are legal and are readily available in most households.
- Chronic inhalant exposure causes long-lasting damage to the brain and other parts of the nervous system. Inhalant abuse can also cause death.[39]

Steroids

- "Anabolic steroids" is the familiar name for synthetic substances related to the male sex hormones (androgens). They promote the growth of skeletal muscle (anabolic effects) and the development of male sex characteristics (androgenic effects).[40]
- Steroid use among younger male teens is on the rise. Roughly one in every 40 boys in 8th and 10th grades indicated some steroid use during the past year.[41]
- Steroids can be taken orally, as well as by injection. The possible health consequences associated with their use include: infertility, breast development, and shrinking of the testicles in males; baldness; short stature; tendon rupture; heart attacks or enlargement of the heart's left ventricle; cancer and certain kinds of hepatitis; acne and cysts; HIV/AIDS; and disturbing psychiatric effects, such as homicidal rage, mania, and delusions.[42]

Ritalin

- Methylphenidate, also know as Ritalin, JIF, MPH, R-ball, Skippy, the smart drug, and vitamin R, is a schedule II drug with high potential for abuse. It can be injected, swallowed, or snorted, and can cause an increase or decrease in blood pressure, psychotic episodes, digestive problems, loss of appetite, and weight loss.[43]
- Ritalin abuse may be increasing. Eight sites in the National Institute on Drug Abuse's most recent Community Epidemiology Work Group reported its abuse, primarily among youth who crush and snort tablets. Ritalin is also being injected, sometimes with heroin or heroin and cocaine.[44]

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Community-Based Organizations Serving Children and Families

"Children exposed (to drug and alcohol problems), through no fault of their own...are thrust into families and environments that pose extraordinary risks to their immediate and future well-being and threaten the achievement of their fullest potential." [1]

It is a sad fact that one in every four children in the U.S. is exposed to alcohol abuse or dependence in the family.[2] Although the majority of children who grow up in homes where drugs and alcohol are a problem will eventually overcome the obstacles they face as a result, many of them carry life-long scars or go on to develop serious drug and alcohol problems of their own. Consider these disturbing facts:

Facts About Parents Who Have Drug and Alcohol Problems and Their Children

- Children of addicted parents are the highest risk group of children to become drug and alcohol abusers due to both genetic and family environment factors.[3]
- Families affected by alcoholism often exhibit increased family conflict, emotional or physical violence, decreased family cohesion, decreased family organization, increased family (and social) isolation, increased family stress (including work problems), illness, marital strain and financial problems, and frequent family moves.[4]
- Three of four (71.6 percent) child welfare professionals cite drug and alcohol problems as the top cause for the dramatic rise in child maltreatment since 1986.[5]
- In one study, 79 percent of adolescent runaways and homeless youth reported alcohol use in the home, 53 percent reported problem drinking in the home, and 54 percent reported drug use in the home.[6]
- Children of addicted parents exhibit depression and depressive symptoms more frequently than do children from non-addicted families.[7] They also are more likely to have anxiety disorders or to show anxiety symptoms.[8]

The good news is that family-focused treatment and recovery support programs can be very helpful in mitigating the damage done to the children of parents who have drug and alcohol problems. Community groups that serve families, particularly those that are interested in fostering the health and well-being of children and young adults, can be a resource for parents and children who are in need of these services. These groups also need to recognize the critical role they can play when it comes to timely intervention and prevention. Consider these important findings:

- There is evidence that social support from friends and outside influences can moderate the effects of a family history of drug and alcohol problems.[9]
- Children who coped effectively with the trauma of growing up in families affected by alcoholism often relied on the support of a non-alcoholic parent, step-parent, grandparent, teachers, and others.[10]
- Factors that have been cited in fostering student ability to resist drugs include positive peer affiliations, bonding/involvement in school activities, relationships with caring adults, opportunities for school success and responsible behavior, and the availability of drug-free activities.[11]

- Children of addicted parents who rely on or who receive support from other adults have increased autonomy and independence, stronger social skills, better ability to cope with difficult emotional experiences, and better day-to-day coping strategies.[12]

Making a Difference: What Can I Do?

As a community-based organization that serves children and families, your staff members and volunteers are dedicated to finding creative ways to positively influence and assist them. Addiction to drugs or alcohol is one of the leading causes of family dysfunction and disintegration in the nation. Its repercussions are great, but so too is the influence each one of us can have on those families that are affected. Here are some things community-based groups can do to have a positive impact on the effort to reduce drug and alcohol addiction and its negative effects — one family, one parent, one child at a time.

1. Learn all you can. Make an effort to learn all that you can about drug and alcohol addiction and its effects on families, particularly children. There is a host of materials available to assist you in your efforts. Start by contacting the Substance Abuse and Mental Health Services Administration's National Clearinghouse on Alcohol and Drug Information (NCADI) toll-free at 1-800-729-6686 or 301-468-2600. Any one of NCADI's trained information specialists can assist you in identifying and obtaining the materials you need. You may also access NCADI via the Internet at www.health.org or e-mail at info@health.org.

2. Know the signs. One of the first things it is important to know is what to look for in a family or child who may be struggling with drug or alcohol problems in the home. Some common signs to look for include mood changes, increased aggression, and detachment from activities and/or people that were at one time important to the individual. Create and take every opportunity you can to learn more about how to identify these families and children, and then, how to inquire and intervene in a productive and helpful way.

3. Be aware of available resources. Find out what local support groups, treatment centers, family-oriented community action groups, and self-help recovery programs are available in your area to assist families and children of various ages who are dealing with drug and alcohol problems. Reach out to the families and young people you serve who are living with drug and alcohol problems at home by providing them with information on where they can go for help.

4. Build networks of support. Work in concert with other community groups, schools, faith organizations, and local treatment providers to create an integrated support network for families and young people who are dealing with drug and alcohol problems. Working together, you can ensure a comprehensive, community-wide network exists to intervene as appropriate in families where drugs or alcohol addiction is a problem, as well as to prevent the problem from becoming a family legacy wherever possible.

5. Become an integral part of a child's life. Encourage your staff members and volunteers to make an extra effort to mentor those children they suspect or know are dealing with a drug or alcohol problem at home. Positive adult role models do not come to children just in the form of their parents or guardians. In the case of children who live with parents or other adults who have drug

or alcohol problems, it is quite the contrary. Oftentimes, the only guide these young people have on their road to living productive and fulfilling lives is an adult at school, in a community or religious group, or after-school program of some sort. Understand the role you do and can play, then play it to the fullest.

6. Be an advocate. Be a loud and credible voice in your community for family-centered treatment services. Parents and adults who have drug and alcohol problems are not the only ones in need of treatment and support. Their loved ones, especially children, are very much affected by the dysfunctional environment in which they live. It almost goes without saying that if only 60 percent of individuals in need of treatment for their own addictions receive it,[13] those whose lives they affect are even less likely to get the help they need. Become an advocate in your community for a full continuum of services to meet the needs of families who are living with addiction or who are in recovery.

Making a Difference: How Can I Focus My Efforts During *Recovery Month?*

As it is every year, *Recovery Month* will be celebrated during the month of September 2001. This year's theme is, *"We Recover Together: Family, Friends, and Community."* It is a time for all of us not only to give thought to how we can better contribute to the effort to stop substance abuse and its effects, but to take some action. Here are some activities your organization can undertake during the month to initiate and further the recovery of those that you serve who are dealing with addiction.

1. Commit to quality. If your staff members and volunteers have already been trained in how to identify families and children who are dealing with drug or alcohol problems in the home, congratulations! September 2001 is a time to hold a refresher in-service training session just to make sure all of their skills and facts are up-to-date. If they have not been trained in this area, use this year's *Recovery Month* as an opportunity to get them started. Ask a local treatment provider or counseling expert from a state or county rehabilitation program to join you for a brown-bag lunch or a half-day workshop to talk about drug and alcohol addiction and its effects at home, how to identify families and children in crisis as a result of it, and what you can do to intervene where appropriate or prevent similar behavior.

2. Offer a support program for children. Group programs for children who are dealing with drug or alcohol problems in the home reduce feelings of isolation, shame, and guilt, while capitalizing on the importance to adolescents of peer influence and mutual support.[14] Use September as a "jumping-off point" to offer a program aimed at assisting kids who are dealing with adults in their daily lives who have drug or alcohol problems. Or, at the very least, make or renew your organization's commitment to working closely with already established programs and services in the community that support children or other family members and friends who are living with addiction in their daily lives.

   There are a number of resources available to assist you in creating and running programs of this kind. In particular, the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention have developed materials that you may find helpful. These materials can be obtained by contacting NCADI, as mentioned above.