

# Healthy Families Program

## Building a Better Alcohol and Drug Treatment System For California Youth

The California Institute for Mental Health  
Implementing Healthy Families Project  
Healthy Families Alcohol and Other Drug Benefit Analysis

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## Executive Summary

This is the second in a series by the California Institute for Mental Health (CIMH) examining mental health and substance abuse treatment in the Healthy Families program. The project is made possible through funding from the David and Lucile Packard Foundation.

This report highlights research on the problem of youth substance abuse and the connection to troubling youth behavior. It reviews the current Healthy Families substance abuse benefit and outlines an alternative, and potentially more successful method of making substance abuse treatment available to children enrolled in Healthy Families.

### *The Problem*

While policy makers, the media and the general public focus significant time and attention on the perplexing issues of youth crime and poor performance in the public school system, much less attention is devoted to the impact of adolescent alcohol and other drug use on these problems. And yet, research has consistently demonstrated a strong correlation between adolescent alcohol and drug use, youth crime and violence and school-related academic and behavioral problems.

As many as 132,495 California youth may have substance abuse problems resulting in serious consequences at school and in the community. Adolescent drug use is strongly associated with other high-risk behaviors including school failure and dropout, suicide and homicide, and is one of the strongest predictors of lifetime drug dependence.

Untreated or inappropriate treatment can have long-lasting impact that extends far beyond the adolescent years. At least 81 percent of state inmates, 80 percent of federal inmates and 77 percent of local jail inmates have some serious substance abuse involvement. Between 48 and 61 percent have not finished school.

While the impact of substance abuse on youth behavior can be devastating, research has consistently shown that adolescent alcohol and other drug treatment can be effective in reducing alcohol and other drug use, and can also have a positive impact in other lifestyle areas negatively affected by substance abuse.

Unlike California's mental health system, *there is no planned and organized system of care for children and youth in need of alcohol and other drug treatment services*. Rather, there are a scattering of outpatient and residential providers who serve this population. As a result, many youth in need of these services do not have access to any type of alcohol and other drug treatment until they come into contact with some other child-serving agency such as probation, child protective services, or special education.

## **Healthy Families: An Opportunity**

California's version of the national Child Health Insurance Program (CHIP), the Healthy Families program, offers a unique opportunity to reach a significant number of California youth who may be in need of substance abuse treatment. An estimated 500,000 uninsured California children will be eligible for Healthy Families when recently adopted program expansions are fully implemented. More than 175,000 children are already enrolled. Based on known prevalence of serious substance abuse problems in youth, as many as 14,000 Healthy Families eligible youth between the ages of 13 and 18 may need substance abuse treatment services.

Researchers have found that uninsured youth are much more likely to be referred to alcohol and other drug treatment by the legal system and are more likely to have dropped out of school by middle-school. Among juveniles arrested in California, one study found that uninsured youth were more likely to have been arrested for a felony crime, more likely to have a previous record of arrests, and more likely to have been arrested in the previous 12 months. By making substance abuse treatment available through the Healthy Families program, California has a chance to reduce delinquency and poor school performance among uninsured children.

However, in its review of the current Healthy Families substance abuse treatment benefit, CIMH found that the current program falls far short of meeting the existing need. Healthy Families uses CALPERS as the benchmark plan, allowing for medically necessary inpatient detoxification and 20 outpatient visits per year. Participating plans may provide additional outpatient visits. This limited benefit is not consistent with outcome research or with standards set by professionals in the substance abuse treatment field. To date, utilization of this minimal alcohol and other drug treatment benefit is exceedingly low in the Healthy Families program.

## **A Proposal for Change**

CIMH recommends modifying the Healthy Families benefit to provide more comprehensive and intensive services for youth with serious impairments due to alcohol and other drug use. The CIMH proposal reflects the clearly accepted view in the substance abuse treatment field that for adolescents, the treatment process must incorporate the nuances of the adolescent's experience – including cognitive, emotional, moral, and social development.

***The Expanded Benefit.*** Under the proposed benefit revision, children and youth who are assessed and meet the criteria showing *serious* alcohol and other drug impairment would have access to an enhanced and expanded substance abuse benefit. Eligible youth would be placed in the most appropriate service modality – intensive outpatient, day treatment, residential treatment or continuing care –

depending on the assessed severity of their condition and response to treatment, rather than a predetermined number of sessions/days.

The proposal incorporates detailed criteria for assessing the level of impairment for individual youth. All children referred for treatment would be assessed, and those with severe impairment would receive the expanded benefit. The CIMH proposal would place responsibility for administration of the expanded Healthy Families benefit with the local county alcohol and other drug departments.

***Projected Costs.*** Based on CIMH estimates of eligibility and potential utilization, the total increased program costs would range from \$1.4 million to \$2.4 million in 2000-2001, with 65 percent paid for by federal funds under the Healthy Families federal cost-sharing ratio. State General Fund costs would only increase by an estimated \$500,000 to \$837,000 for six months in 2000-2001. These increased funds would provide intensive services to as many as 517-864 substance impaired youth.

The cost estimates included here do not take into account the substantial savings anticipated in law enforcement, juvenile justice costs, prison, school-related property and discipline costs, health services and avoided out-of-home placements.

## ***Conclusion***

California has taken several steps in recent years to develop and improve its substance abuse treatment services for young people. The Healthy Families program offers an excellent opportunity to build on those efforts. This report outlines a comprehensive, expanded benefit that can be implemented in the Healthy Families program.

An expanded array of treatment options will improve access and offer services at the most appropriate level(s) of care to youth who without such treatment are at increasing risk of failing in school and committing serious crimes. The proposed expanded benefit would also create a potential model to improve overall substance abuse treatment services for youth in California.

## Introduction

While policy makers, the media and the general public focus significant time and attention on the perplexing issues of poor performance in the public school system and youth crime, much less attention and time have been devoted to the impact of adolescent alcohol and drug use on youth behavior. And yet, research has consistently demonstrated a strong correlation between adolescent alcohol and drug use and both school-related academic and behavioral problems and youth crime and violence.

California's version of the national Child Health Insurance Program (CHIP), the Healthy Families program, offers a unique opportunity for California to provide significant numbers of low-income youth with substance abuse treatment services that may directly improve their school performance and reduce the chances they will engage in violent or criminal behavior.

An estimated 500,000 California children will be eligible for Healthy Families when recently adopted program expansions are fully implemented. More than 175,000 children are already enrolled. Based on known prevalence of serious substance abuse problems in children, as many as 14,000 Healthy Families eligible youth between the ages of 13 and 18 could benefit from substance abuse treatment services.

However, in its review of the current Healthy Families substance abuse treatment benefit, the California Institute for Mental Health (CIMH) found that the current program falls far short of meeting the need. Although Healthy Families includes coverage for substance abuse treatment, the benefit is not consistent with outcome research or with standards set by the American Society of Addiction Medicine (ASAM)<sup>1</sup> and the Center for Substance Abuse Treatment.<sup>2</sup> CIMH found that the current benefit under Healthy Families is not comprehensive and cannot be tailored to the specific needs of individual children and youth in need of alcohol and drug treatment, as recommended by professionals in the field.

This report highlights research on the problem of youth substance abuse and its connection to troubling youth behaviors. It reviews the current Healthy Families substance abuse benefit and outlines an alternative, and potentially more successful, method of making substance abuse treatment available to Healthy Families eligible children. The report includes the framework for a comprehensive benefit package, examination of the associated costs of the proposal, and suggests implementation strategies at both the state and local levels.

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<sup>1</sup> The American Society of Addiction Medicine is a national medical specialty society dedicated to educating physicians and improving the treatment of individuals with alcoholism and other addictions.

<sup>2</sup> The Center for Substance Abuse Treatment is a federal agency mandated by Congress to expand the availability of effective treatment and recovery services for those with alcohol and other drug problems.

## **Background**

The California Institute for Mental Health (CIMH), as part of a grant from the David and Lucile Packard Foundation, initiated the *Implementation of Healthy Families Project* to assess mental health and alcohol and other drug services for children covered under the Healthy Families program. In its initial report, *Healthy Families: The California State Child Health Insurance Program*, CIMH found a number of significant barriers to effective utilization of the Healthy Families mental health and substance abuse treatment benefits. These findings included the need for family-centered coverage, inadequacy of the benefit package under Healthy Families, and cultural and linguistic barriers to treatment services for special populations.

Upon completion of the first phase project, CIMH received additional funding from the Packard Foundation to specifically address some of the obstacles and challenges in implementing these Healthy Families benefits. The current project goals are to:

- 1) Increase utilization of mental health (MH) and alcohol and other drug (AOD) treatment in Healthy Families,
- 2) Help move toward a comprehensive system for MH and AOD services, and
- 3) Ensure that the MH and AOD systems are integrated into the Healthy Families service delivery system.

## Making the Connection: Substance Abuse and Youth Behavior

In order to develop preliminary estimates of the prevalence of substance abuse among California youth, WestEd, a Southern California research firm, reviewed both the 1997-98 Biennial California Student Survey on Substance Abuse, and data from the 1994 California Survey of Substance Use Among Dropouts.

These surveys revealed that among children at the ninth and eleventh grade age level, 5 percent and 12.5 percent, respectively, met criteria as either an Excessive Alcohol User (EAU) or High Risk User (HRU) and presented with two or more related problems (school, family, legal, peer, other). Using these figures, as many as 132,495 California youth may have substance abuse problems resulting in serious consequences in school and the community.

In the August 1998 Journal of the American Medical Association, Drs. Ann Bruner and Marc Fishman reported that adolescent drug use is strongly associated with other high-risk behaviors including school failure and dropout, suicide and homicide. They further report that drug use in adolescence is one of the strongest predictors of lifetime drug dependence.

The evidence regarding the impact of substance abuse on school performance and youth behavior is startling.

- Of high-risk users in the eleventh grade, 33.5 percent have been suspended from school and 33.6 percent have taken a weapon to school.
- An alarming 62.5 percent of ninth grade students identified as high-risk users report being “high” at school, and 26.4 percent of eleventh graders report having damaged school property.
- Thirty-six percent of ninth graders and 34 percent of eleventh grade, high-risk users have been arrested.
- The Center for Research on Child and Adolescent Mental Health Services reports preliminary data that of 1,084 San Diego County youth receiving some type of public sector services, those with a substance abuse/dependence diagnosis were significantly more likely than those with no substance abuse involvement to have been on probation (69.5 percent vs. 8.3 percent) or incarcerated (43.4 percent vs. 2.9 percent) within the past year.

Untreated or inappropriate treatment can have long lasting impact that extends far beyond the adolescent years. A comprehensive analysis of the U.S. prison system by the National Center on Addiction and Substance Abuse (CASA) revealed that at least 81 percent of state inmates, 80 percent of federal inmates and 77 percent of local jail inmates have some serious substance abuse involvement.<sup>3</sup> Between

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<sup>3</sup> California Center for Health Improvement.

48 and 61 percent did not finish school. Very often, adult substance abuse and criminal behavior begins in early adolescence and increases in severity in the late teens and twenties.

### ***Adolescent Treatments Shown to Be Effective***

While the impact of substance abuse on youth behavior can be devastating, research has consistently shown that adolescent alcohol and other drug treatment can be effective in reducing alcohol and other drug use, and can have a positive impact in other lifestyle areas.

In a study of 1,483 adolescents between the ages of 12 and 19 with extensive substance use histories and correlated legal and school problems, Bergmann, et. al. found that 70 percent of those who received inpatient and/or residential treatment reported no regular drug use one year following treatment. The study also found substantial improvement in school performance and delinquency incidents.

The state of Washington conducted a number of studies on the effects of adolescent alcohol and other drug treatment. The cohort of adolescents studied met criteria for substance abuse and/or dependency criteria. Researchers found significant reductions in felony arrests one year after both inpatient and outpatient treatment (from 41 percent to 18 percent). Youth who received inpatient care showed significant gains in academic performance, as well as reductions in school suspensions from 70 percent to 26 percent and expulsions from 37 percent to 9 percent.

In addition, the National Treatment Improvement Evaluation Study and the Treatment Outcome Prospective Study reported substantial reductions in substance abuse for adolescents receiving treatment services. Both studies found that while both outpatient and residential treatment yielded positive outcomes, residential treatment resulted in more substantial and consistent reductions in substance use and related problems.

Powers, et. al., in examining the changes in criminal activity among adolescents in the Drug Abuse Treatment Outcome Study (DATOS) found that drug dealing, property crime, and violent crime were reduced from intake to follow-up in all treatment modalities studied (long-term residential, short-term inpatient, and outpatient drug-free). For example, at intake, 53 percent of adolescents placed in long-term residential and criminal justice system supervision had committed a violent crime. At the 12-month follow-up, the rate of violent crime among the same adolescents had dropped to 13 percent.

Hser, et. al. reported improvements in a cohort of 1,066 adolescents who received community treatments for marijuana use as part of DATOS. After one year of treatment, weekly marijuana use dropped from 96.3 percent to 46.3 percent,

heavy drinking from 32.1 percent to 18.9 percent, and use of hard drugs from 58.6 percent to 36.9 percent. This same study found better psychological adjustment and improvement in school performance following treatment.

Weinberg, et. al., in their review of adolescent substance abuse treatment found effectiveness in family therapy when combined with interventions focusing on a broader network of social influences. Henggeler similarly reported that large and clinically significant reductions in criminal activity and incarceration for substance-using adolescents occurred when a multi-systemic treatment intervention approach was instituted.

### ***Focusing on the Needs of Youth***

Within the substance abuse treatment field there has been a growing recognition over the past 10 years that specialty populations with serious substance abuse problems require unique and specific treatment approaches. Treatment efforts that focus on young people simply as “little adults” are bound to fail. Understanding the relationship between substance use and adolescent development is crucial for designing effective interventions and treatment strategies. The treatment process must incorporate the nuances of the adolescent’s experience – including cognitive, emotional, moral, and social development.

Health care professionals agree that a “one-size-fits-all” model may only address a subset of the total youth in need of treatment. The National Institute on Drug Abuse reported that those patients who received services specifically matched to assessed level of needs showed statistically significant improvement in all assessed problem areas. Bruner and Fishman, et. al. conclude that treatment resources *which provide a multifaceted approach* designed specifically for adolescents, need to be increased.

The American Society of Addiction Medicine (ASAM), in recognition of the need to assess and differentiate levels of care, has developed the Adolescent Patient Placement Criteria. The criteria consists of six dimensions and five levels of service (early intervention, outpatient treatment, intensive outpatient treatment, medically-monitored intensive inpatient treatment, and medically-managed intensive inpatient treatment).

Based on the current literature and research, key issues in designing an effective continuum of treatment services for adolescents include:

- Multidimensional assessment (Center for Substance Abuse Treatment, CSAT and ASAM)
- Services and treatment settings matched to identified needs (ASAM)

- Youth-specific treatment incorporating developmental issues and needs, cognitive and social-emotional development, cultural backgrounds, gender, etc. (CSAT)
- Family therapy and participation in treatment planning (CSAT)
- A full continuum of services ranging from outpatient to day treatment to high-intensity residential treatment (CSAT and ASAM)
- Opportunities for remaining in treatment over an extended period of time by providing continuing care (CSAT and ASAM)

## Building a Better California Youth Treatment System

Unlike California's mental health system with its legislatively directed and designated funded children's system of mental health care, there is no planned and organized system of care for children and youth in need of alcohol and other drug treatment services. Rather, there are a scattering of outpatient and residential providers who serve this population. As a result, many youth in need of these services cannot access any type of alcohol and other drug treatment until they come into contact with some other child-serving agency such as probation, child protective services, or special education.

In fiscal year 1996-97, 11,298 treatment services for youth ages 12 through 18 were provided in California's publicly funded alcohol and other drug treatment system. This represented less than 4 percent of the total number of all persons served. Approximately 820 adolescents are placed on a waiting list during any given month. **Table 1** shows the percentages of youth served by specific treatment modalities.

**Table 1**

### Levels of Care Received by California Youth in Treatment, 1996 - 1997

Level of Care	Percentage of Youth
Outpatient Drug-Free	85%
Intensive Outpatient Drug-Free	5
Outpatient with Medication	1
Residential Treatment	8
Inpatient Detoxification	<.05
<i>Source: California Department of Alcohol and Drug Programs</i>	

### Legislative Initiatives

Recent legislative actions have moved the State forward toward meeting the need for greater access and treatment for youth with alcohol and other drug problems. Enactment of AB 1784, the Adolescent Alcohol and Drug Treatment and Recovery Program Act (Baca, Health and Safety Code Chapter 4, Section 11759, 1998) and implementation of the Early Periodic Screening, Assessment, and Treatment (EPSDT) (for Medi-Cal beneficiaries) program provided some of the earliest focus on adolescent-specific alcohol and other drug treatment services.

Under AB 1784, the Legislature found that "families are in desperate need for assistance in the management and treatment of this adolescent and youth problem [alcohol and other drug use/abuse]." The Legislature also concluded that

treatment is the most cost-effective way to combat drug abuse and other drug related crimes.

This Act directed the Department of Alcohol and Drug Programs (DADP), in collaboration with the counties, to “establish community-based nonresidential and residential recovery programs to intervene and treat problems of alcohol and drugs among youth.” Also in 1998, SB 2015 (Wright, Health and Safety Code, Chapter 389, Section 11756) directed the DADP to “develop and test a comprehensive system of care... [that] ... addresses the devastating costs of substance abuse to individuals, families, and communities.”

***LAO Recommendations.*** In July of this year, the California Legislative Analyst’s Office (LAO) released a report on the state’s substance abuse system, “*Substance Abuse in California: Services are Cost-Effective to Society.*” Among other findings, the LAO emphasized the need for additional treatment for adolescents. The LAO noted that only 10 percent of the estimated number of adolescents needing publicly funded treatment actually receive that treatment, and made specific recommendations regarding both youth and adult treatment services. Specifically, the LAO recommended development of a long-term plan to address the demand for treatment services, including:

- Identification and dissemination of effective modes of treatment;
- Review by the DADP of California statutes and regulations to identify changes that can improve access to services for [adults and] adolescents;
- Development of a plan to phase-in treatment expansion;
- Identification of funding options to help offset the General Fund cost; and
- Development of strategies to overcome the barriers to treatment of adolescents.

The LAO reported that over 11,000 treatment services for youth were provided in fiscal year 96-97 in the public sector. The LAO also noted, however, the significant number of youth currently on waiting lists for treatment on any given day, and the relative lack of treatment availability for adolescents.

In an April 1998 mandated report to the Legislature, the Managed Risk Medical Insurance Board (MRMIB), in consultation with the DADP, outlined improvements needed in adolescent treatment to reflect the best advice of professionals in the field. Among the recommendations in the report:

- Implementation of standardized tools and practices to ensure uniform assessment of service needs and *placement in appropriate levels of care*;
- *Improved client need and service matching* so that services and utilization reflect assessment findings and specialized needs are identified; and
- *Development of a continuum of care* for youth that ensures access to a broad range of services, including aftercare services.

***A Model for Doing it Right: A Treatment System Focused on Women.***

Beginning in the late 1980s and continuing into the early 1990s, California identified the growing need for substance abuse treatment for women. Prior to that time there was minimal attention given to the specific needs of women in substance abuse treatment. Services were fragmented and primarily designed for adult males. If prior treatment admissions and utilization rates had been used to determine need, the logical conclusion would have been that there was no need to direct specific focus toward women as a group.

However, in spite of the then low utilization levels, the Legislature and Administration recognized the need, initiated and funded the Perinatal Treatment Expansion Project. The Act responded to the goals of keeping mothers with their children, reducing domestic violence and the associated trauma, and overcoming barriers women face in accessing health care and substance abuse treatment. This initiative marked the beginning of a focus on policy, treatment and funding specific to women.

One of the primary findings from these efforts was the need to differentiate specific programs for women from the prevalent system, driven primarily by the needs of adult male addicts and alcoholics. From 1992-93 to 1997-98 there was an increase of 11,809 treatment admissions for women, of which 7,550 admissions were classified as perinatal. The percentage of treatment admissions for women has steadily increased throughout the decade from 30 percent to 38 percent (CADDs).

Based on the experiences of a number of pilot programs focused on pregnant women, the treatment system for women in California has evolved into a sophisticated array of services that are specialized for women. If state policy had been guided solely on prior utilization rates for women in the early 1990s rather than on the identification of the specific and multifaceted needs of women, the comprehensive continuum of care existing in counties throughout California would, in all probability, be far less responsive and effective than it is today.

The same targeted approach is required to address the unique and complex needs of California's youth involved in substance abuse.

## The Healthy Families Program

Estimates of the actual number of uninsured children in California range from 1.3 million to 1.8 million. These children are typically in families that do not qualify for Medi-Cal, and 80 percent of their parents are employed full-time or self-employed without job-based health coverage.

This large group of disenfranchised children receive minimal preventive and primary care and instead often rely on episodic and emergency room care. As a result, they are at increased risk of having undetected health problems and more serious health-related consequences. Low-income children are more than six times as likely to be classified in fair or poor health than higher income children, and their parents have low confidence in being able to secure proper medical care for their children. (LAO report June 2, 1999 “*A Model for Health Coverage of Low Income Families*”)

The UCLA Drug Abuse Research Center (DARC), in reviewing two studies of adolescent substance abuse, found that uninsured youth are much more likely to be referred to alcohol and other drug treatment by the legal system and are more likely to have dropped out of school by their middle-school years. DARC also found that among juvenile arrestees detained in 14 California counties between August 1995 and September 1996, uninsured youth were more likely to have been arrested for a felony crime, more likely to have had prior arrests, and more likely to have been arrested in the previous 12 months.

***A Case Example: Sean.*** Sean is a fifteen-year-old male with a history of academic performance problems. Recently, he has become involved in petty juvenile offenses, refuses to follow reasonable rules at home, has lost weight and complains of having little energy. In talking with his school counselor, Sean admits he has been drinking heavily for the past six months and is also using marijuana regularly. He is feeling rather hopeless about his situation because he has tried to stop on his own a number of times with no success. Sean thinks he needs to get away from his friends for awhile “to get straight.”

Sean’s parents both work and neither have health insurance. Unfortunately for Sean, he will not have access to any residential treatment or intensive outpatient services unless he continues to be involved in the criminal justice system.

In contrast, if Sean had serious emotional problems rather than a serious substance abuse problem, he would have access to a publicly-funded mental health system of care for children and youth which offers a full array of services including case management, intensive outpatient, day treatment and residential treatment.

Sean's story illuminates the dilemma for low-income children who neither qualify for Medi-Cal, nor have access to substance abuse treatment through an employer-based health plan. Importantly, even if Sean's parents enrolled him in Healthy Families, he would only have access to very limited outpatient benefits unless his health plan chose to provide services beyond the minimum 20 visits required by the Healthy Families program.

### ***The Healthy Families Substance Abuse Benefit***

Under the Healthy Families program, health care coverage is provided to enrolled children through existing health care plans and provider networks. In establishing the array of benefits for Healthy Families, California chose as its benchmark plan the California State Employees benefits package which includes medical, vision, dental, mental health and substance abuse treatment. The Healthy Families benchmark plan substance abuse benefit allows for medically necessary inpatient detoxification and 20 outpatient visits per year. Participating plans may provide additional outpatient visits.

Utilization of the current Healthy Families alcohol and other drug benefit for enrolled youth is exceedingly low. In September 1999, MRMIB provided to the Legislature data on substance abuse utilization voluntarily submitted by 14 (of 25) participating health plans. For plan year July 1, 1998 through June 30, 1999, there were 37,289 youth ages 12 through 18 enrolled in Healthy Families. A total of only 53 enrolled youth used at least one treatment visit during this period. Even the most conservative estimates of the need for alcohol and other drug treatment for this age group would exceed the current utilization patterns by considerable margins.

By contrast, under the Healthy Families mental health benefit, children who are assessed as having severe emotional or behavioral disorders have access through the county mental health systems to a full array of services including case management, intensive outpatient, day treatment and residential treatment. Youth with substance abuse problems do not have access to the same array of benefits regardless of the severity or their alcohol and other drug use.

The Center for Research on Child and Adolescent Mental Health Services found that a large proportion of youth are receiving services in settings that are less than optimal for addressing serious substance use disorders. This can explain low utilization levels and is the type of information that would be necessary to identify the real capacity needs and types of services required to respond to substance abuse in youth.

## Need in the Healthy Families Population

Using estimates of prevalence by age and grade-level applied to the total Healthy Families eligibles following program expansions, as many as 13,866 Healthy Families eligible youth could be in need of substance abuse treatment services.

**Table 2** below depicts related problem areas for ninth and eleventh grade Excessive Alcohol Users (E), High Risk Drug Users (H), Conventional Users (C), and Abstainers–no use in last 6 months (A).

**Table 2**

	Grade 9 Percentage				Grade 11 Percentage			
	E	H	C	A	E	H	C	A
<b>Drinking alcohol has caused the student to fight with others</b>	13	11	2	0	15	13	3	0
<b>Been suspended from school</b>	39	35	19	12	30	34	13	6
<b>Been high at school, alcohol or another drug</b>	57	63	14	1	67	77	21	2.3
<b>Has driven a car when s/he had been drinking, or been in a car with friends who were drinking and driving</b>	47	48	22	5	68	66	34	12
<b>Damaged school property</b>	41	40	26	4	22	26	7	8
<b>Been arrested</b>	33	45	13	4	30	37	12	6
<b>Taken a weapon to school</b>	30	36	14	2	28	34	12	6

**Table 3** below projects, based upon the prevalence percentages in Table 2, the number of Healthy Families eligible ninth and eleventh graders who may have serious alcohol and other drug problems with related school and criminal justice involvement. Although the same information is not available on related problems for tenth and twelfth graders, it is reasonable to assume that the totals in Table 3 would be increased significantly if tenth and twelfth graders were included.

**Table 3****Estimated Number of Healthy Families Eligible 9<sup>th</sup> and 11<sup>th</sup> Graders with Substance Abuse and Specific Related Problems**

	Grade 9		Grade 11		TOTAL
	E*	H*	E*	H*	
Drinking alcohol has caused the student to fight with others	505	435	448	399	1,787
Been suspended from school	1,513	1,359	885	976	4,733
Been high at school, alcohol or another drug	2,213	2,426	1,957	2,251	8,847
Has driven a car when s/he had been drinking, or been in a car with friends who were drinking and driving	1,840	1,849	1,983	1,910	7,582
Damaged school property	1,596	1,541	631	769	4,537
Been arrested	1,277	1,759	859	1,066	4,961
Taken a weapon to school	1,172	1,405	804	978	4,359

\*E = Excessive Alcohol User, H = High Risk User

**Coverage in Other States**

There are a number of states that provide a more comprehensive substance abuse benefit package in their State Children’s Health Insurance Program. Oregon, Kentucky, Connecticut, New York and North Carolina have included a more comprehensive benefit package, including residential treatment and greater numbers of outpatient visits. **Table 4** illustrates the different benefits provided in a select number of states.

**Table 4**

	Inpatient	Residential Treatment	Intensive Outpatient	Day Treatment	Case Management
<b>Connecticut</b>	60 days (alcohol) 45 days (drug)		60 visits		
<b>Oregon</b>	X	X	X	X	X
<b>Kentucky</b>	30 days		X	X	X
<b>New York</b>			60 visits		
<b>North Carolina</b>	X	X	X	X	X

## Proposed Healthy Families Benefit Package for Seriously Impaired Youth

Modifying the Healthy Family benefit to provide more comprehensive and intensive services for youth with serious impairments due to alcohol and other drug use would satisfy Legislative intent, LAO policy recommendations, and standards of care advocated by health professionals. An expanded array of treatment options will provide access and appropriate levels of care to a significant number of youth who without such treatment are at increasing risk of failing in school and committing serious crimes.

Placing youth in specific treatment modalities based on an assessed level of need would assist in *identifying the optimal modes of treatment and would help reduce barriers to treatment* (LAO report recommendation).

An expanded benefit would also provide a *funding option to help offset General Fund costs* spent on substance use treatment and related problems (LAO report recommendation) by utilizing the 65 percent Federal Financial Participation (FFP) for the provision of these CHIP services.

A modification in the Healthy Families benefit would provide the Department of Alcohol and Other Drug Programs with a prototype for determining *changes that would increase access to a range of services*. (LAO report recommendation)

According to the ASAM Adolescent Placement Criteria, some adolescents with substance use problems can be appropriately placed in a standard outpatient setting. Therefore, the current outpatient substance abuse treatment benefit in Healthy Families will be appropriate for a number of enrolled youth. However, there are cohorts of youth with serious substance use patterns for which outpatient therapy will not be sufficient.

### ***A New Treatment Benefit in Healthy Families***

Under the proposed benefit revision, children and youth who are assessed and meet the criteria for a serious alcohol and other drug impairment would have access to an enhanced and expanded substance abuse benefit. Placement in a particular service modality would be based on the acuity of the youth's problems and the availability of specific program resources. The duration of care in any modality would be based on the assessed level of severity of the individual's condition and his/her response to treatment, rather than a predetermined number of sessions/days.

All treatment services would be structured to incorporate the unique aspects of adolescence—including cognitive, emotional, physical, and social development. Wherever possible family participation in the planning and treatment would be emphasized.

To identify those youth who have more significant alcohol and other drug use patterns with related problems in community and personal functioning, and who require more comprehensive and intensive services, this proposal includes specific criteria (see **Table 5**). Youth who meet these criteria would be matched to the most appropriate and available service.

**Table 5**

**Criteria Establishing Enrollee’s Eligibility for Expanded Service for Children with Serious Alcohol and Other Drug Impairment**

<i>The enrollee must have a documented or self-reported current (within the past 12 months) history of alcohol and/or other drug use and as a result of their substance use the enrollee meets a minimum of 2 of the 4 criteria in Section A and a minimum of one of the criteria in either Section B or Section C.</i>		
<b>Section A</b>	<b>Section B</b>	<b>Section C</b>
Substantial impairment in at least two of the following areas: <ul style="list-style-type: none"> <li>◆ Self care—a reduction in interest and/or ability in activities of daily living and/or deterioration in managing personal hygiene and/or personal belongings</li> <li>◆ School functioning—a drop in academic performance, attendance, and/or an escalation of incidents (frequency and seriousness) of on-campus behavior problems</li> <li>◆ Family relationships—increasing estrangement from and difficulty with maintaining communication and involvement with family members</li> <li>◆ Ability to function in the community—a reduction of and/or withdrawal from previous social activities i.e. sports, clubs, work, etc. and/or maintaining social relationships with other substance using youth as their primary peer affiliation, any involvement in the criminal justice system</li> </ul>	One or more of the following: <ul style="list-style-type: none"> <li>◆ The child is at substantial or imminent risk of removal from his/her home</li> <li>◆ The child has been removed from his/her home</li> <li>◆ The substance use/impairments have been present for six months and persistently cause significant dysfunction and is likely to continue without treatment</li> <li>◆ The emotional, behavioral, cognitive problems are persistently and significantly distracting to recovery and treatment efforts</li> <li>◆ Continued exposure to current school and/or living environments make recovery unlikely and the enrollee has insufficient or severely limited resources and skills needed to maintain an adequate level of functioning</li> </ul>	One or more of the following: <ul style="list-style-type: none"> <li>◆ Enrollee is at moderate to severe risk of behaviors endangering self or others</li> <li>◆ The enrollee is unable to maintain behavioral stability for more than 48 hours</li> </ul>

As the Healthy Families alcohol and other drug treatment benefit is currently designed, detoxification and the 20 outpatient visits are managed by the health plan within the basic benefit package. This benefit would still apply to youth not meeting the criteria for serious impairment. All youth with potential substance abuse problems would receive an assessment to determine the benefit level most appropriate for their needs. For those youth who are seriously impaired, a revised and enhanced substance abuse benefit would be available as follows:

- **Assessment.** A comprehensive youth-specific assessment would be completed to determine the type and seriousness of the alcohol and other drug problem. The youth would either be referred back to the health plan as appropriate for the basic benefit or admitted for treatment services under the enhanced plan.
- **Intensive Outpatient.** A minimum of 5 hours of treatment services per week. In addition to addressing alcohol and other drug abuse, psychiatric, emotional, social and family issues would be addressed.
- **Day Treatment.** A minimum of 3 hours per day, 3 days per week of structured therapeutic activities including individual, group, family therapy, and alcohol and other drug education. May be included as part of a school program. Will also address psychiatric, emotional, and social concerns.
- **Residential Treatment.** A 24-hour live-in setting that provides alcohol and other drug education and treatment throughout the day and evening. Services would also include psychiatric, educational/vocational, and family relations. (At the present time, not all counties have certified alcohol and other drug residential treatment group home providers. Therefore, as part of the comprehensive benefit package, residential services would be accessed on a regional basis. Each county would have an agreement with those residential programs in closest proximity to their counties in order to ensure the greatest access to such services.)

Program staff may implement exceptions to the above frequency of services to achieve individual treatment goals.

- **Continuing Care.** Continuing care services would be available as long as there are treatment needs requiring professional interventions and monitoring, including access to the full continuum of care.
- **Case Management.** Assessment, linkage, advocacy and monitoring of individual youths' treatment coordinated with physical and mental health providers.

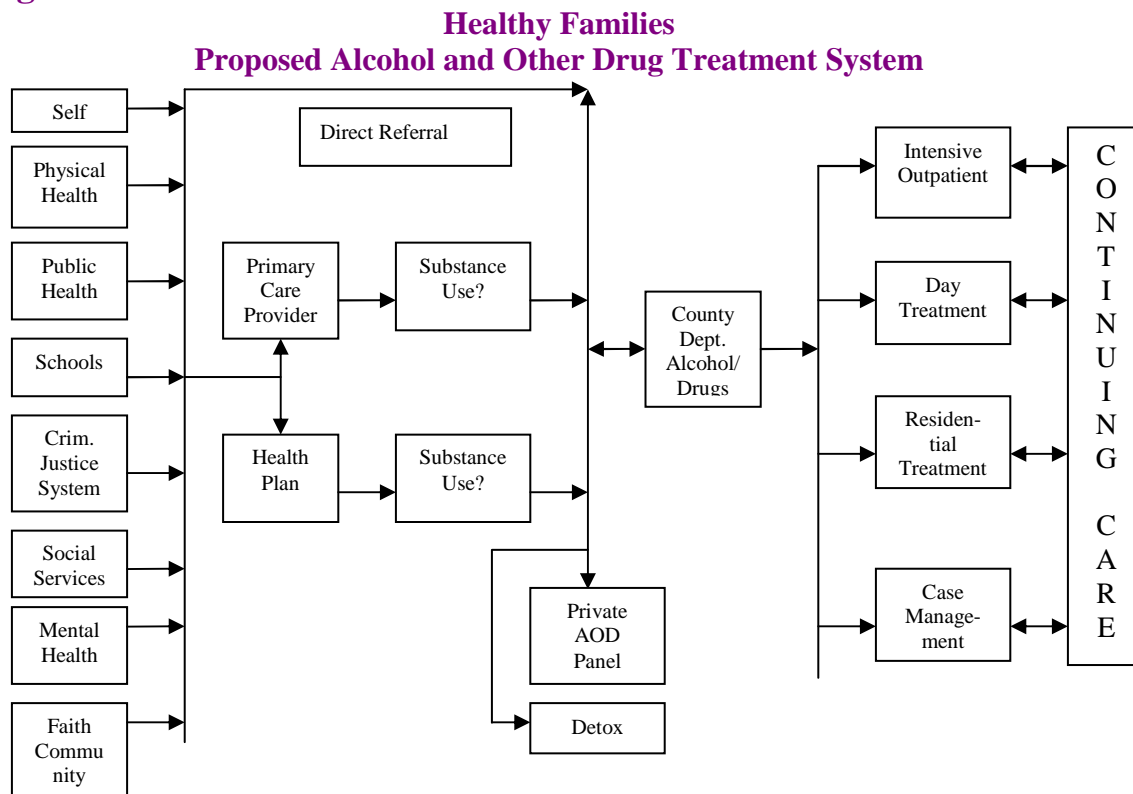
## Role of County Alcohol and Other Drug Programs

Under the Health and Safety Code (Sections 11755, 11756.7 and 11800.0), counties have responsibility for planning and implementation of local alcohol and other drug abuse programs, including the development of a comprehensive client-centered system of care. This proposal would place responsibility for administration of the expanded Healthy Families benefit with the local county alcohol and other drug departments (see **Figure 1** below).

Implementing the expanded Healthy Families alcohol and other drug benefit through county departments would bolster existing efforts to increase treatment capacity and better meet statutory responsibilities. In addition, this approach is consistent with the legislative intent regarding the Healthy Families program substance abuse benefit. The enabling legislation called for MRMIB to determine the feasibility of an expanded benefit and to work with health plans to implement the benefit through memorandums of understanding (MOU) between health plans and counties.

The MOUs would facilitate referral of children in need of treatment services to county alcohol and other drug programs. Finally, this role for county alcohol and other drug programs is consistent with AB 1784, which initiated the development of youth treatment services by funding new adolescent services in 20 counties. These programs include outpatient, day treatment, residential treatment, outreach and early intervention.

**Figure 1**



Specifically, counties would have the following responsibilities for administering the expanded benefit:

- Client assessments
- Coordination of care with health plans
- Development of the provider network for case management, intensive outpatient, day treatment, residential services, and continuing care
- Data management
- Billing

### ***Costs for an Expanded Benefit***

To evaluate the costs of an expanded alcohol and other drug treatment benefit, this section addresses overall estimated costs, strategies to maximize federal matching funds, the cost impacts of alcohol and other drug use on publicly funded service systems, and the cost benefits of providing treatment.

This report earlier identified an estimated 13,866 Healthy Families youth who would likely meet the criteria for expanded services (this number is based on full enrollment of approximately 500,000 children). In the 1998 report to the Legislature, MRMIB and the State Department of Alcohol and Other Drug Programs estimated that approximately 15 percent of youth with substance abuse problems would show up to treatment. This figure is based on studies of voluntary adult populations because there are no available (and reliable) data applicable to youth.

However, youth are less likely than adults to voluntarily seek treatment and are more likely to be required to participate by parents, probation officers, and or school officials in order to avoid some significant penalty or consequence(s).

To develop a meaningful estimate of the costs of the proposed expanded benefit, the following assumptions were used:

- Three different client treatment admission scenarios were considered – 15 percent, 20 percent and 25 percent.
- The total number of enrolled Healthy Families youth were estimated at 250,000 for fiscal year 2000, 300,000 for fiscal year 2001, and 350,000 for fiscal year 2002.
- The analysis assumes that 25 percent of youth in treatment will require residential treatment, 25 percent intensive outpatient, 25 percent day treatment, and 25 percent continuing care.

Based on these assumptions, the number of youth that might be entering treatment by fiscal year 2002 ranges from 1,448 to 2,416.

**Table 6**

**Projected Clients Entering Treatment**

Admission Projections	15%				20%				25%			
	OP	Day	Res	Cont Care	OP	Day	Res	Cont Care	OP	Day	Res	Cont Care
<b>Fy 2000 (6 months)</b>	129	129	129	129	173	173	173	173	216	216	216	216
<b>Total</b>				517				692				864
<b>Fy 2001</b>	311	311	311	311	414	414	414	414	517	517	517	517
<b>Total</b>				1244				1656				2068
<b>Fy 2002</b>	362	362	362	362	483	483	483	483	604	604	604	604
<b>Total</b>				1448				1932				2416

**Table 7** estimates the number of visits and the lengths of stay, using current Medi-Cal drug treatment rates plus an additional 25 percent for case management services.

**Table 7**

**Length of Stay/Costs per Treatment Episode**

Modality	Visits/Length of Stay	Costs per Episode
<b>Intensive Outpatient</b>	36 visits (12 weeks x 3 visits per week)	\$2,452
<b>Day Treatment</b>	48 days (16 weeks x 3 days per week)	\$3,257
<b>Residential</b>	90 days	\$6,688
<b>Continuing Care</b>	12 visits (12 weeks x 1 visit per week)	\$817

**Table 8** combines the estimated number of treatment admissions developed in Table 6 with cost calculations in Table 7. As established by Congress, the Children’s Health Insurance Program (CHIP) incorporates a 65 percent federal match for services rendered as part of the benefit plan, a higher percent than California’s 51 percent federal match under Medicaid. The Healthy Families program is therefore an excellent opportunity to leverage federal funds and maximize the efficiency of State General Fund expenditures. Table 8 also identifies State General Fund and federal matching fund contributions.

**Table 8****Total Costs per Fiscal Year**

Fiscal Yr	15% Treatment Admissions							
	Int. Outpt.	Day Tx.	Residential	Cont. Care	Case Mgt.	Total	SGF	Fed. Funds
2000	\$211,926	\$281,503	\$578,044	\$70,613	\$285,522	\$1,427,608	\$499,663	\$927,945
2001	\$762,572	\$1,012,927	\$2,079,968	\$254,087	\$1,027,389	\$5,136,943	\$1,797,930	\$3,339,013
2002	\$887,624	\$1,179,034	\$2,421,056	\$295,754	\$1,195,867	\$5,979,335	\$2,092,767	\$3,886,568
	20% Treatment Admissions							
2000	\$284,211	\$377,619	\$775,206	\$94,698	\$382,909	\$1,914,543	\$670,090	\$1,244,453
2001	\$1,015,128	\$1,348,398	\$2,768,832	\$338,238	\$1,367,649	\$6,838,245	\$2,393,386	\$4,444,859
2002	\$1,184,316	\$1,573,131	\$3,230,304	\$394,611	\$1,595,591	\$7,977,953	\$2,792,284	\$5,185,669
	25% Treatment Admissions							
2000	\$354,853	\$471,353	\$967,887	\$118,236	\$478,082	\$2,390,411	\$836,644	\$1,553,767
2001	\$1,267,684	\$1,683,869	\$3,457,696	\$422,389	\$1,707,910	\$8,539,548	\$2,988,842	\$5,550,706
2002	\$1,481,008	\$1,987,228	\$4,039,552	\$493,468	\$1,995,314	\$9,976,570	\$3,491,800	\$6,484,770

In 1997, when Congress passed and the President signed the enabling CHIP legislation, \$855 million dollars per year was earmarked for California. For state fiscal year 1999-00, the state budget includes \$76 million General Fund to draw down \$152 million in federal matching dollars, leaving \$703 million dollars of available matching funds unused. The Legislative Analyst's Office has consistently recommended maximizing federal matching funds to increase health coverage.

**Exploring Potential Cost Savings**

There are enormous costs associated with failure to provide young people with the substance abuse treatment services they need. Brook, et. al., in their study of young adult drug use and delinquency concluded "drug use and delinquency in adolescence cannot be taken lightly, since there is continuity of these behaviors into adulthood."

As identified earlier, school dropouts experience significantly higher rates of alcohol and other drug use and related problems. There are also a number of proxy measures that establish a correlation between dropping out and subsequent use of illicit substances. For example, dropouts comprise nearly half of the heads of households on welfare. Numerous studies reveal that half of the prison population is made up of dropouts with the majority reporting serious substance abuse problems.

**Table 9** highlights 1995 alcohol and other drug related costs to the criminal justice, health, and social services systems in California. The total cost is \$8.2 billion dollars, much of which is State General Fund supported.

**Table 9**

**Costs to California Service Systems Related to Alcohol and Other Drug Problems (1995)**

Law Enforcement	3.0 billion dollars (50% total expended)
Legal/Adjudication	1.1 billion dollars
Prison	1.2 billion dollars (50% total expended)
Health–Hospitalizations	2.8 billion dollars (6.4% of total)
Child Welfare–Out-of-Home Costs	62 million dollars
<b>Total All System Costs</b>	<b>8.162 billion dollars</b>

The cost benefits of treatment have been documented in a number of studies across the nation. Oregon researchers concluded that the savings benefits for those who completed treatment was \$5.60 for every treatment dollar spent. In addition, in a comparison between those who completed treatment and those untreated or minimally treated, researchers found that those without treatment continued to cost more than \$11,000 per person, per year.

In 1991-1992, California conducted a statewide cost impact analysis of substance abuse treatment. In summary, the study found that the average avoided costs per person treated – when considering areas of criminal justice, health care, public assistance, and victim and theft loss only – were \$8,034 per person in the 12 months following treatment. The benefit-to-cost ratio was approximately \$5.30 per every treatment dollar spent.

Expansion of the Healthy Families alcohol and other drug benefit affords the State a number of effective and efficient financial opportunities. For every dollar from the State General Fund an additional two federal dollars is secured. By investing those funds, the State would receive an estimated \$15.90 return for each \$3 investment.

***Expected Outcomes from an Expanded Benefit***

Based on the results of the studies on adolescent alcohol and other drug treatment cited previously in this report, there are a number of outcomes that would be expected from providing an age appropriate array of alcohol and other drug treatment services. Specifically, these studies found considerable gains made and sustained at the one-year post-treatment milestone including reductions in regular substance use, criminal activity, school suspensions, and school expulsions.

**Table 10** applies the anticipated rates of improvement noted in the research to the estimated number of Healthy Families eligible youth with a substance use problem who would participate in treatment.

**Table 10**

<b>Total Alcohol and Drug Population =13,866 (est)</b>	<b>2079 (15%)</b>	<b>2772 (20%)</b>	<b>3465 (25%)</b>
<b>Decrease in Regular Drug Use (from 100% to 30%)</b>	2,079 to 623	2,772 to 831	3,465 to 1039
<b>Reduction in Criminal Activity (from 53% to 13%)</b>	1,101 to 142	1,469 to 190	1,836 to 238
<b>Reduction in School Suspensions (from 70% to 26%)</b>	1,455 to 378	1,028 to 205	2,425 to 485
<b>Reduction in School Expulsions (from 37% to 9%)</b>	769 to 69	1,025 to 92	1,282 to 115

The significance of the expected treatment outcomes is increased when considering the possibility that youth alcohol and other drug use, criminal behavior, and poor school performance would otherwise continue into adulthood.

In a study of the state prison and jail systems conducted by the National Center on Addiction and Substance Abuse at Columbia University, 48 percent of the jail population and 61 percent of the state prison population had not completed high school. Sixty-two percent of the state prison population and 58 percent of the jail population used drugs regularly. Eighty percent of those in custody had violated drug and alcohol laws, were high at the time of committing a crime, stole property to buy drugs, had a history of substance abuse, or shared a combination of these characteristics.

Today’s youth with a history of poor school performance, involvement in the criminal justice system and heavily involved in substance use are the inmate population of the future. To the extent appropriate treatment is available and the expected outcomes are achieved, California will prevent potential negative consequences and avoid the associated costs.

## Recommendations

CIMH makes the following recommendations in an effort to improve access, quality of care and treatment outcomes for children and their families impacted by substance use. These recommendations will require the collective leadership of the Governor's office, the Health and Human Services Agency, the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, county Alcohol and Other Drug Program Administrators, providers, and parents.

- Enact legislation expanding the basic substance abuse benefit within Healthy Families to include a comprehensive array of services including case management, intensive outpatient, day treatment, residential treatment, and continuing care for youth with serious impairment due to substance abuse.
- Establish in statute the criteria, as outlined in this report, for identifying youth who are seriously impaired as a result of alcohol and other drug use and thus eligible for the expanded benefit.
- Require the State Department of Alcohol and Drug Programs (DADP) to (1) ensure compatibility with other state initiatives; (2) standardize data collection and evaluation; (3) provide direction on acceptable standardized assessment tools; and (4) formulate policy and procedures on billing.
- Require the DADP to convene a process for identifying adolescent-specific, empirically validated tools for use in the client assessment process.
- Assign county alcohol and other drug programs the administrative responsibility for developing a local provider network, conducting client assessments and case management, and monitoring quality.
- Require county alcohol and other drug programs and Healthy Families participating plans to develop and implement memorandums of understanding to coordinate care.
- Require MRMIB to convene a process with the state Department of Alcohol and Drug Programs, county alcohol and drug programs, health plans and alcohol and other drug treatment providers to develop a standard referral protocol and forms and qualitative outcome measures.
- Require county alcohol and other drug programs and county mental health departments to develop and sign a memorandum of understanding to coordinate dual diagnosis services.

- Increase State General Funds for Healthy Families to expand the benefit, the public sector treatment capacity and to maximize available federal dollars.
- Designate a portion of School Safety Block Grant Funds for an expanded, school-based alcohol and other drug treatment benefit.
- Future funding for AB 1784 should be comprised of State General Funds rather than federal substance abuse block grant funds in order to be used as part of the matching funds requirement of the Children's Health Insurance Program.

## Conclusion

Research consistently shows that youth with substance abuse problems are responsible for a disproportionate share of school academic and behavioral problems as well as crime and delinquency. Investing in developmentally appropriate substance abuse treatment is essential to help these youth succeed in school and become contributing members of their communities. The field of substance abuse treatment has documented success in treating adolescents, including reducing their substance abuse and related behavioral problems.

Untreated or inappropriate treatment can have long lasting impacts that extend far beyond the adolescent years. In California jails and prisons, 65 percent to 80 percent of prisoners have a history of serious substance abuse problems, and between 48 percent and 61 percent have not finished school. Typically, adult substance abuse and criminal behavior begins in early adolescence and increases in severity into the late teens and twenties.

California has taken several steps in recent years to develop and improve its substance abuse treatment services for young people. The Healthy Families program offers an excellent opportunity to build on those efforts and to provide effective and comprehensive treatment to youth who otherwise would not have access to the treatment services they need. However, the current benefit is insufficient for those youth having serious substance abuse-related impairments.

This project outlines a comprehensive, expanded benefit that can be implemented in the Healthy Families program improving access to treatment for children enrolled in the program and creating a potential model to improve overall substance abuse treatment services for youth in California. This report estimates the projected maximum costs for an expanded benefit at \$5.9 to \$9.9 million with 65 percent federal financial participation in the costs of the program.

In addition, the state can consider other potential funding sources such as the School Safety Block Grant. In part, School Safety Block Grant funds are for “conflict resolution counselors and certificated personnel trained in conflict resolution . . . or other programs to reduce the incidence of violence in the schools.” Given the strong correlation between alcohol and other drug use and school violence, School Safety Block Grant funding would be appropriately allocated to offset the costs of an expanded benefit and to facilitate a greater partnership between the schools, MRMIB, health plans and county alcohol and other drug programs.

An expanded alcohol and other drug treatment benefit, as part of Healthy Families would contribute dramatically to efforts by the Governor and the Legislature to improve school safety and academic performance as well as reduce juvenile and young adult crime. The proposal outlined here would meet the standards of care

set by the American Society for Addictions Medicine and the Center for Substance Abuse Treatment, and improve the lives of hundreds of California youth and their families.

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