



Increasing Access to Alcohol and Drug Treatment and Prevention Services for Pregnant and Postpartum Women and Women with Children

Introduction

Alcohol and drug treatment and prevention programs for women with children: (1) strengthen families, (2) reduce youth drug use, (3) reduce crime and violence, (4) reduce and contain health care costs, (5) support the effective implementation of welfare reform, and (6) enhance child safety.

Women with children, however, face many barriers to finding and paying for alcohol and drug treatment. Implementing policy changes to improve their access is critical to the health and safety of their children, as well as the success of recent welfare and child welfare reform initiatives. Policy changes that would improve access to treatment for women with children include:

- **Making alcohol and drug treatment required services under the Medicaid program (requires legislation).**
- **Lifting the “IMD exclusion” (could be accomplished through regulation or legislation).**
- **Creating a Targeted Capacity Expansion Program for Pregnant and Postpartum Women and Women with Children (requires legislation).**
- **Allowing Title IV-E (foster care) funds to follow children being reunited with their mothers in residential alcohol and drug treatment programs (requires legislation).**

Access to alcohol and drug treatment does not meet the current need for services. Only 50% of the individuals who need treatment receive it.¹ Waiting lists for alcohol and drug treatment are six months long in some regions. Funding from the Center for Substance Abuse Treatment (CSAT), which has supported residential programs for women with children and programs for pregnant and postpartum women and infants, has ended or will be ending this fiscal year for the majority of grantees. Without additional funding many programs for women with children will have to reduce or discontinue the services they offer, thus widening the treatment gap for these families.

¹ Woodward, A., Epstein, J., Gfroerer, J., Melnick, D., Thoreson, R., and Willson, D. “The Drug Abuse Treatment Gap: Recent Estimates.” **Health Care Financing Review**, Vol.18,Number 3. Spring, 1997.

Increasing alcohol and drug treatment for women with children will help the President achieve the important public policy goals of effectively reforming the welfare and child welfare systems.

Increasing access to appropriate alcohol and drug treatment and prevention services for welfare recipients will help them improve their chances at succeeding at job training, as well as finding and keeping a job. 1996 data for CSAT's Pregnant and Postpartum Women and Infants (PPWI) program demonstrated that after-treatment employment of women increased by 820%. Meta House in Wisconsin, a CSAT Residential Women with Children (RWC) program, found that after treatment 81.6% of its clients were either gainfully employed or engaged in Wisconsin's welfare-to-work program. Untreated alcohol and drug problems will keep welfare recipients from working, and as a result, welfare reform could fail.

Increasing access to appropriate alcohol and drug treatment and prevention services for families involved in the child welfare system will help reunify families, protect and enhance child safety, and reduce foster care caseloads. According to 1996 data for CSAT PPWI programs, after treatment 86.5% of children were living with their mothers. Almost all -- 95% -- of the children served by The Village's Families in Transition (FIT) program in Florida, a CSAT RWC program, were reunified with their mothers during treatment. Such results produce significant savings for the federal and state governments. Foster care costs in 1994 ranged from \$4,800 per year for placement in family foster care to \$36,500 per year for placement in group care,² which is two to 16 times the cost per person for federally funded drug treatment.

Treatment Needs in Welfare Reform

The 1996 federal welfare law³ has presented states and localities with many challenges and opportunities. One of the most pressing challenges is how to address the needs of welfare recipients with alcohol or drug problems and their families.

According to national data, 15 to 20 percent of adult welfare recipients have alcohol or drug problems.⁴ States that have collected their own data have found higher prevalence.⁵ Oregon has

² U.S. House of Representatives, *1996 Green Book: Background Materials and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1996, p. 707.

³ "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996," P.L. 104-193.

⁴ Entities that have published studies include: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; National Center on Addiction and Substance Abuse at Columbia University; and National Institute of Alcohol Abuse and Alcoholism, National Institutes of Health.

estimated that 50 to 60 percent of its welfare caseload has alcohol or drug problems. Kansas officials have reported – based on experience from an employment project with a state-based corporation -- that 20 to 50 percent of welfare clients there would fail a drug screen. Based on the national numbers, between 400,000 and 800,000 women could need treatment to move into recovery, off welfare, and into jobs. Yet, according to a 1997 Legal Action Center study, only nine states plan to increase their own appropriations for alcohol and drug treatment for welfare families.⁶

In addition, at least 20 states have passed or have reported that they will pass laws to deny welfare and food stamps to individuals with drug felony convictions, thus reducing funds that have been available for alcohol and drug treatment. Welfare and food stamps have helped to pay for room and board in residential treatment programs for women with children. The new law creates a lifetime ban on benefits, unless states “opt out” in whole or in part.⁷

Treatment programs serving women have, predictably, expressed concern about this provision, with many reporting that they expect welfare reform to decrease their revenue but increase their caseload. Many of these same programs are also facing the loss of categorical funding – through CSAT’s Residential Women With Children (RWC) and Pregnant and Postpartum Women and Infants Program – as a result of grants concluding and SAMHSA’s switch in program focus to Knowledge Development and Application (KDA) programs.

Treatment Needs in the Child Welfare System

According to national data, parental alcohol and drug abuse are among the most common reasons for any family’s involvement with the child welfare system. Almost 80 percent of children who entered foster care in 1991 in California, New York, and Pennsylvania had at least one parent who was abusing drugs or alcohol, compared to 52 percent in 1986.⁸ Nearly half of the women with cases open with the Department of Children and Family Services in Cook County, Illinois, in 1995 were assessed as in need of alcohol and drug treatment.⁹

⁵ Legal Action Center, **Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients**, September 1997.

⁶ *Ibid.*

⁷ Section 115.

⁸ General Accounting Office, *Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children*, 1994.

⁹ Illinois Department of Alcoholism and Substance Abuse, “Treatment and Prevention DO Work: A Survey of Illinois Alcohol and Other Drug Abuse Outcome Studies,” 1996.

In Washington State, babies born to a small number of women with alcohol and drug problems account for a large portion of out-of-home placements. In 1995, 41 percent of infants placed out-of-home had mothers who abused alcohol or drugs while pregnant.¹⁰

The increasing rate of foster care placements for children whose parents have alcohol or drug problems has escalated the cost of the program. Federal expenditures on foster care increased from \$438.45 million in 1984 to more than \$3.049 billion in 1995.¹¹ In Illinois, the added medical and related costs of caring for 2,500 cocaine-affected infants in child welfare custody was \$60 million in 1991.¹²

I. Increasing Treatment Through Medicaid

Nearly all women on welfare, as well as those in families involved in the child welfare system, are eligible for Medicaid, the main source of health care funding for low-income individuals without private health insurance. But Medicaid coverage for drug and alcohol treatment services for these women and families is unnecessarily limited.

Simply put, the national goal of reducing alcohol and drug use and their devastating consequences on individuals, families, and society requires better Medicaid coverage for treatment. Medicaid coverage for alcohol and drug treatment could be enhanced in at least two ways:

- **Make alcohol and drug treatment required services under the Medicaid program (requires legislation).**

Medicaid finances some drug and alcohol treatment, subject to state limits on amount, duration, and scope, but alcohol and drug treatment is not a required service under the program. States providing treatment to Medicaid clients can receive reimbursement if the treatment is provided under a Medicaid service category that qualifies for Federal matching funds.

For example, if alcohol or drug detoxification is provided as part of general inpatient hospital treatment, it is reimbursable under Medicaid in most states. Other aspects of treatment, such as prescription of methadone, may also be covered. At State option, clinic treatment services can also be covered.

The advantage of this policy change is that it would help establish a funding source for treatment that is not discretionary and subject to the annual appropriations process. The disadvantage is

¹⁰ Washington State Department of Social and Health Services, "Chemical Dependency Among DSHS Clients: A Departmental Problem," October 31, 1996, p. 6.

¹¹ Committee on Ways & Means, U.S. House of Representatives, *1996 Green Book*, p. 758.

¹² Child Welfare League of America, *Through the Eyes of a Child: A National Agenda for Addressing Chemical Dependency*, 1992.

that it would likely draw opposition by state representative organizations as an unfunded mandate even though states would draw down federal matching funds to support these services.

- **Lift the “IMD exclusion” (could be accomplished through regulation or legislation).**

One of the most serious roadblocks preventing low-income individuals from obtaining residential alcohol and drug treatment has been the “Institution for Mental Diseases (IMD) exclusion.” The IMD exclusion is a statutory provision that prohibits Medicaid from paying for institutional treatment for individuals between 22 and 64 who are diagnosed with mental diseases and receiving treatment in programs with more than 16 treatment beds. In addition, individuals who enter IMDs lose their Medicaid eligibility for all Medicaid reimbursable services, including prenatal and HIV care.

While Congress never explicitly defined mental diseases to include alcoholism and drug dependence, the Health Care Financing Administration (HCFA) has interpreted mental diseases to include addiction. Numerous organizations and advocates have spent years trying to change the IMD exclusion as it applies to alcohol and drug treatment, both through the courts and the legislative process.

The simplest way to change the IMD exclusion would be to amend the regulations by removing “substance abuse” from the definition of “mental diseases.” The advantage of a regulatory approach is that it would be easier to accomplish.

But legislative options, although probably more difficult to exercise, are also available. Last year, Senator Daschle introduced legislation, S. 147,¹³ which would lift the IMD exclusion for pregnant and postpartum women.¹⁴ The Congressional Budget Office scored a previous version of this legislation as costing \$145 million over five years.¹⁵

II. Increasing Treatment through Targeted Capacity Expansion for Pregnant and Postpartum Women and Women with Children

Alcohol and drug treatment programs designed to meet the needs of pregnant and postpartum women and women with children have been extremely successful in reducing drug use, criminal justice involvement, and health and welfare costs while simultaneously improving the employability and parenting skills of women. 1996 data for CSAT’s Pregnant and Postpartum Women and Infant’s Program found that after treatment:

¹³ The "Medicaid Substance Abuse Treatment Act of 1997" is also co-sponsored by Senators Chafee, Kennedy, Johnson, and Reid.

¹⁴ The bill would prohibit reimbursement for facilities with more than 60 beds (unless waived by the state alcohol and drug agency) or licensed as a hospital. It would also set a ceiling on the number of beds covered at 1,080 in 1998 up to 6,000 in 2002. After 2002, the Secretary would determine the number of beds covered.

¹⁵ The provision had been included in the Senate version of the 1993 budget reconciliation act but was dropped in conference committee.

- 67.4% of women were not using drugs or alcohol
 - 90.3% of women were not involved with the criminal justice system
 - 86.5% of children were living with their mothers
 - Employment of women increased by 820%
- **Create a Targeted Capacity Expansion Program for Pregnant and Postpartum Women and Women with Children (requires legislation).**

Targeted Capacity Expansion for Pregnant and Postpartum Women and Women with Children would directly fund programs providing alcohol and drug treatment services to pregnant and postpartum women and other women with children in order to continue and expand access to such services as the need for them grows. CSAT originally funded programs for pregnant and postpartum women and women with children to create a treatment system specifically designed to meet the needs of women with children. Since CSAT has been funding and evaluating programs for women with children for the last several years, it is in the best position to coordinate this Targeted Capacity Expansion initiative.

During the course of treatment women would have access to an array of critical services, including residential facilities for both women and their minor children; individual, group, and family counseling; relapse prevention services; prenatal and postpartum health care; referrals for necessary hospital services; supervision of children during therapy and other rehabilitative activities; parenting training; counseling about HIV/AIDS, domestic violence, and sexual abuse; counseling about obtaining employment and education; reasonable efforts to preserve and support the family units of women, including promoting the appropriate involvement of parents and others, and counseling the children of women engaged in treatment; and planning and counseling for the transition from treatment into society, both before and after discharge.

In addition to offering services for women, programs would provide essential services for the infants and children of the women engaged in treatment. These services would include pediatric health care, including treatment for any perinatal effects of maternal alcohol and drug use; screenings to evaluate the physical and mental development of the infants and children; counseling and other mental health services; and comprehensive social services.

Targeted Capacity Expansion would require three years of funding: \$50 million in FY 2000, \$100 million in FY 2001, and \$200 million in FY 2002. These funding levels would support alcohol and drug treatment services for pregnant and postpartum women and women with children during the height of welfare reform. As a result, these programs would play a critical role in moving women supporting families from welfare to work and their children from foster care to healthy, unified families.

III. Increasing Treatment Through Title IV-E of the Social Security Act

Some low-income women enter alcohol and drug treatment because they fear losing their children, and, for some women, the child welfare system makes treatment a condition of retaining their parental rights.

Women demonstrating progress in treatment can be – and often are – reunited with their children within the treatment program. Living together in a therapeutic environment helps the mother improve her chance of becoming a successful parent once treatment has ended, through parent training and other support services provided in programs serving women with children.

- **Allow Title IV-E (foster care) funds to follow children being reunited with their mothers in residential alcohol and drug treatment programs (requires legislation).**

Given the importance of protecting children and strengthening families, foster care payments should be allowed to support work toward those goals accomplished in residential alcohol and drug treatment programs. Recognizing this, an early Senate version of last year’s legislation to enhance safety within the child welfare system contained a provision that would have allowed Title IV-E foster care funds to accompany children into residential treatment with their mothers.¹⁶

Such a policy has three main advantages. First, it creates a funding stream for treatment that is not discretionary and subject to the appropriations process. Second, it is cost-neutral because it does not increase foster care payments; it simply redirects where they go (in most cases from the state to the treatment program). Third, it reimburses treatment programs for services they are already providing to these families.

Opposition to the provision last year was, unfortunately, based mostly on stigma. Criticism focused on the unfairness of giving addicted parents a chance (or multiple chances) to recover, given the potential risk for children.

Conclusion

The legislative and regulatory policy changes recommended in this paper will increase treatment and prevention services for women with children at a time when they are desperately needed to help maintain the core treatment system that effectively serves women with children. Without additional support for this system, welfare reform and the child welfare system will buckle and fail to serve our nation’s most vulnerable and valuable entities: families.

¹⁶ Section 203 of S. 511.