TALK AND TRUST

IDENTIFYING SUBSTANCE ABUSE AMONG COLORADO WORKS FAMILIES

A report of the

Colorado Works Program
&
The Alcohol and Drug Abuse Division

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Chapter One
Introduction and Overview

We live with substance abuse every day. Our leaders, athletes, movie stars, prominent officials, and probably someone you know--no group is spared from the tragedy of addiction. Some people, like former First Lady Betty Ford and former Governor of Texas Ann Richards have recovered from addiction and refused to give in to the shame and stigma that accompany it. Rather, they have shown courage in helping the rest of us understand and appreciate their struggles and triumphs. They have become role models for us all.

Substance Abuse Affects People From All Walks of Life

Betty Ford
Ann Richards
Mickey Mantle
Darryl Strawberry
Marilyn Monroe
Robert Downey, Jr.
Noelle Bush

Others, like Mickey Mantle, one of the nation's greatest baseball players, and Marilyn Monroe, perhaps our greatest movie icon, died before their time after years of abusing alcohol or drugs. Darryl Strawberry, Robert Downey, Jr., and Noelle Bush move in and out of substance abuse, sobriety, treatment, and prison. We, and they, do not know whether ultimately they will succeed or succumb.

Substance abuse is one of the nation's most pressing social problems, and it rarely comes alone. Substance abuse can drive the way people live, including how they work, how they function in their communities, and how they parent their children.

Welfare Reform Is Not Just A Change In Rules

Welfare reform changed the way our society considers poverty and economic independence. These changes provide important new opportunities for families to redirect their lives and for public agencies to guide and support those families on their journeys. Welfare reform holds out the possibility of two different futures for our society. On the one hand, it offers an opportunity to address long-standing problems. State and county officials are free to set policies that respond to the strengths and needs of communities, and to use TANF funds for a variety of purposes, including many kinds of substance abuse treatment. On the other hand, with provisions that set time limits for benefits and impose strict work rules, welfare reform may weaken the safety net for vulnerable families.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) puts forth a radically changed view of our country's values regarding poverty, dependence, personal responsibility, and the role of government in addressing social problems. These values emphasize individual rather than public responsibility for personal well being. In some ways, welfare reform has succeeded beyond expectations. As of September 2002, there were nearly 5 million people (or 2 million families) receiving Temporary Assistance to Needy Families (TANF), down from 12.2 million people (4.4 million families)

who were receiving benefits in August 1996 when PRWORA was signed. In September 2002 there were 12,444 Colorado families, or 32,458 people, receiving benefits under Colorado Works, Colorado's TANF program. (USDHHS and CODHS, 2002).

Substance Abuse and Welfare Dependence: Problems and Possibilities

Substance abuse can be a chronic relapsing disease, frequently associated with co-occurring mental disorders, family breakdown, criminal activity and poverty. It is further characterized by denial and stigma, making it difficult for people to talk about their substance abuse or to seek help. TANF recipients may be especially reluctant to disclose substance abuse problems because they fear they will lose their children and will be penalized by the individuals and systems that purport to help them. At times these fears are justified.

However, substance abuse can be addressed and substance abuse treatment does work. Many people who suffer from substance abuse, including many former welfare recipients, end up leading productive and stable lives. As described in Chapter Two, treatment helps improve work outcomes and reduces dependence on TANF. This means that substance abuse treatment can be an important work-related service for people who need it.

Most heavy drinkers and illicit drug users are employed. According to the 2001 National Household Survey on Drug Abuse, about 9.8 million workers reported they were heavy alcohol users (meaning five or more drinks per occasion on five or more days in the past month). This represents 7.2% of full-time workers and 80% of all people who drink heavily. The NHSDA also found that 76% of people age 18 and over who reported current illicit drug use (meaning at least once in the past month) are employed full or part-time. This represents more than 10.2 million workers.

> *"The issues arrive at my door in an ambulance."*
>
> --A former TANF administrator

TANF officials and workers are charged with solving some of our society's most entrenched and challenging social problems. Many of these problems have been ignored or addressed only modestly in the past. TANF staff make difficult decisions about complex and controversial policies that affect the lives of their most vulnerable families. They have to set priorities in an environment in which everything is a priority, and they have to allocate limited time and resources to meet almost limitless demands.

Development and Organization of this Guidebook

Talk and Trust is a product of The Colorado Works Substance Abuse/TANF State/County Work Group. The Work Group includes representatives from state Colorado Works and Alcohol and Drug Abuse Division offices, staff from county Departments of Human Services, treatment providers and behavioral health care companies. Early in 2002, the Work Group prepared and released the TANF Survey Addressing Substance Abuse Treatment in the Colorado Works Program. Findings from that survey led members of

the Work Group to commission this guidebook for state and county TANF workers, supervisors, and managers. These are the people who have final responsibility for meeting the goals and requirements of PRWORA. *Talk and Trust* has the following goals:

To provide CO state officials and county TANF staff with tools and strategies for identifying substance abuse among Colorado Works recipients;

To provide an inventory of short substance abuse screening instruments that have been evaluated for reliability and validity in some settings;

To suggest combinations of screening and other strategies that will help TANF staff identify substance abuse as early as possible in a family's TANF experience;

To provide Colorado Works staff with practical suggestions regarding how to serve families with substance abuse problems;

To help TANF staff understand the nature of addiction and treatment.

Information for this book was drawn from a variety of sources. First, several types of literature were reviewed. This review included studies regarding the extent of substance abuse among TANF recipients, reports describing problems that generally accompany substance abuse among TANF recipients, evaluation studies of screening instruments, and studies regarding how substance abuse treatment affects work and dependence on TANF benefits.

Second, interviews were conducted with TANF and substance abuse treatment officials inside and outside of Colorado, to learn about what others were doing to identify substance abuse, and to gain insights from them about their successes and challenges. A list of people who were interviewed for this guidebook or who offered comments on a draft version is included in Appendix A.

Finally, it is critical to learn from and give voice to people receiving TANF who live with substance abuse and poverty, and to front line staff whose jobs have been so changed by welfare reform. Therefore, three focus groups were conducted: two with TANF workers and supervisors in Denver and Jefferson County; and one with TANF recipients attending substance abuse treatment at New Directions Arapahoe House.

Talk and Trust includes six chapters and appendices. **Chapter Two: Substance Abuse, TANF, and Work** briefly describes the extent of substance abuse and addiction in Colorado and in the country as a whole. It provides information about the connections between substance abuse treatment and work outcomes. It includes current data about the extent of substance abuse among TANF recipients and the array of problems that accompany substance abuse for these women.

Chapter Three: Screening Instruments and Techniques for TANF Staff describes how screening is supposed to work. It offers suggestions regarding how workers can introduce screening tools to recipients. It also reviews the benefits and limitations of

screening instruments and drug testing, and presents some widely used screening instruments.

Chapter Four: Beyond Screening: Other Ways to Identify Substance Abuse describes methods some Colorado counties and other states use to better identify substance abuse. In some cases, these methods do not involve workers at all. These strategies may be as important as the screening instruments themselves, and they can enhance the effectiveness of those instruments.

Chapter Five: Four Dimensions of Trust describes trust as a concept involving not only recipients, but also workers and agencies, and it suggests ways for TANF administrators to "operationalize" trust.

Chapter Six: Implications, Steps to Take, and Pitfalls to Avoid lays out some of the issues that administrators should consider when developing strategies for TANF families with substance abuse. It offers feasible steps to guide administrators through the process of establishing these strategies, and shares some lessons based on ideas that did not work.

Colorado is a diverse state that includes urban, suburban, rural, and frontier communities. Counties differ not only in the size of their TANF caseloads, but in their geography, their racial and ethnic composition, the health of their economies, and resources available to help people in need. The ideas put forth in this book will work better in some areas than in others. Hopefully, the range of observations and suggestions will give counties enough options for them to find some that are helpful in their environment.

Acknowledgements

Talk and Trust owes its existence to the work and commitment of the members of The Colorado Works Substance Abuse/TANF State/County Work Group, particularly co-chairs Janet Wood and Danelle Young. Marykay Cook and Karen Mooney were especially forthcoming in responding to many questions and providing ongoing guidance and perspective.

Amy Mennerich unearthed important articles, reports, and data for the literature review. Jane Carlson managed the formatting, design, and presentation of the information.

The Center for Substance Abuse Treatment (CSAT) at the US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) and the State of Colorado provided funding that allowed this guidebook to be developed. Johnson, Bassin, Shaw, Inc. provided administrative guidance and oversight.

Workers, supervisors, and managers in and outside of Colorado gave generously and thoughtfully of their time responding to interview questions and providing information about practices in their states and counties.

The workers and supervisors who participated in the focus groups offered important, unique, and often-overlooked perspectives that have enriched this document. Colorado is fortunate to have such a talented, competent, and caring workforce.

Finally, the deepest of thanks go to the women at New Directions Arapahoe House who spoke about their personal experiences with TANF, substance abuse treatment, and recovery. Their dedication to their recovery, their love for their children, and their sincere interest in helping the system work is inspirational.

Chapter Two
Substance Abuse, TANF and Work

This chapter presents information about the extent of substance abuse in America and in Colorado, and describes what is known about substance abuse among TANF recipients. It also includes a short description of problems accompanying substance abuse among TANF recipients. It concludes with some data describing how substance abuse treatment affects work, dependence on TANF, and recovery. This is not a chapter with recommendations—it provides background information about the problem.

Many Americans use or abuse alcohol or other drugs. The National Household Survey on Drug Abuse (NHSDA) is an annual survey of the non-institutionalized civilian population of the United States who are 12-years old or older. Findings from the 2001 NHSDA are summarized below:

2001 The National Household Survey on Drug Abuse (NHSDA)

Number of Americans who:		
Used an illicit substance in the past month	15.9	million
Were current drinkers (age 12 and over)	109.0	million
Abused/dependent on alcohol or drugs in 2001	16.6	million
Abused/dependent on alcohol in 2001	11.0	million
Abused/dependent on illicit drugs in 2001	3.2	million
Abused/dependent on both in 2001	2.4	million

Alcohol and Drug Abuse in Colorado*

Despite its beautiful scenery and expansive open spaces, Colorado has at least its share of the country's substance abuse problems. According to a December 2002 report from the Alcohol and Drug Abuse Division (ADAD) of the Colorado Department of Human Services (DHS) (An Analysis of Substance Abuse Prevalence, Treatment Resources, and Treatment Gaps in Colorado) there are nearly 250,000 Coloradans age 12 or over with current substance abuse problems. Of these, 85% are current abusers of alcohol, 8.75% are current abusers of both alcohol and other drugs, and 6.25% are current abusers of other drugs alone. Moreover, Colorado has one of the highest rates of alcohol and marijuana use in the country.

* Substance abuse is defined according to criteria established in the DSM-IV. Indications of abuse include failure to meet role obligations, substance related legal problems, and continued use in the fact if interpersonal problems. Substance dependence includes abuse and is further defined by such factors as tolerance, withdrawal symptoms, more use than intended, inability to reduce use, reduction in important activities, and continued use in spite of known adverse consequences.

For example, in 1999 Coloradans drank 2.1 gallons per person of absolute alcohol, versus 1.77 gallons per person nationally. Moreover, Colorado had 20,750 alcohol related hospital discharges in 1993 and 29,076 discharges in 1999, a 40% increase in five years. Finally, alcohol-related deaths in Colorado rose from 997 in 1990 to 1,234 in 1998, an increase of 24%.

> There are an estimated 250,000 substance abusers in Colorado, age 12 or over. That is about 7% of Colorado's population. (ADAD, 2002)

A report prepared for the State of Colorado by the National Technical Center for Substance Abuse Needs Assessments in March 2001 notes, "Colorado had one of the most severe substance abuse problems in the country in the period between 1994 and 1996. The State ranked second in the country with regard to combined alcohol and drug problems, and the primary substance of abuse was alcohol."

A recent study of substance abuse and addiction in Denver reported that about 15% of Colorado adults binge drink (five or more drinks on one occasion at least once during the past month). The state's 1995-1998 average alcohol consumption amounted to the equivalent of two six-packs of beer per person every week (Drug Strategies, 2002).

According to the 1999 NHSDA, Colorado ranked first among the 50 states in past month use of marijuana, and 4th in past month use of any illicit drugs. A December 2002 report prepared by ADAD notes that marijuana continues to be a major problem in Colorado. For example, people who used marijuana constituted the largest percent of drug-related treatment admissions in the first half of 2002, and marijuana-related hospital admissions rose to their highest level in the period spanning 1995-2001.

Substance Use and Abuse Among TANF Recipients (Nationally and in Colorado)

Reliable data regarding the extent of substance abuse among TANF recipients is hard to come by. Problems in establishing estimates arise because researchers define "abuse" differently, most studies rely on self-reports, and respondents (and perhaps particularly TANF recipients) may be fearful of disclosing abuse. Therefore, the true extent of substance abuse and the extent to which patterns of abuse pose barriers to work, are not known.

Nonetheless, studies have found that illicit drug use and dependence are more common among women receiving TANF than among women who do not receive TANF (Pollack, et.al. 2002). Illicit drug use is associated with TANF even after factors such as race, educational attainment, and region have been considered. An analysis of the 1998 NHSDA found that 21.3% of TANF recipients had used an illicit drug during the prior 12 months, compared to 12.5% of non-recipients who had used illicit drugs. This analysis also found that illicit drug *dependence* was about twice as common among TANF recipients as among non-recipients, 4.5% compared with 2.1%. The same survey found that 7.5% of TANF recipients were *dependent* on alcohol, compared to 4.6% of non-recipients. (Pollack, et.al. 2002).

Other studies conducted in individual states find the prevalence of alcohol and illicit drug abuse among TANF recipients as a whole to range between 12% and 20%. When examining subgroups of recipients, however, the numbers can be much higher. For example, a study of sanctioned TANF recipients in New Jersey found that 49% of sanctioned families had alcohol or other substance abuse problems. (Morgenstern, et.al. 2001)

Several Colorado agencies collaborated on a project in which staff surveyed 2,311 of the approximately 65,000 Medicaid recipients in the period between February 2000 and June 2001. More than 80% of these recipients were also receiving TANF benefits at the time of the survey. The report, "Alcohol and Drug Use and Abuse Among Selected Medicaid Recipients: Colorado 2001" was released in April 2002. The survey yielded several important findings:

Highlights of Results from Survey of Colorado Medicaid Recipients (based on a sample of 2,311 recipients out of a total caseload of 65,000)

14.1 % were dependent on or abused substances at some time in their lives
Of these:
- 6.1 % were dependent on or abused alcohol alone
- 3.4 % were dependent on or abused both alcohol and drugs
- 4.6 % were dependent on or abused drugs alone

5.5 % were dependent on or abused substances in the year prior to the interview
Of these:
- 2.5 % were dependent on or abused alcohol alone
- 1.1 % were dependent on or abused both alcohol and drugs
- 1.9 % were dependent on or abused drugs alone

Among all respondents, alcohol was more than twice as likely to be a source of problems:
- 9.6 % had alcohol problems
- 4.4 % had marijuana problems
- 2.5 % had cocaine problems
- 2.3 % had stimulant problems
- 1.2 % had hallucinogen problems

The report also found that only 26% of respondents to the survey who had an identified substance use problem in the past year had received any type of treatment during that period. Among those who had a recent substance abuse problem and who had not received treatment, 6.3 % said they would have sought treatment had it been available.

When we extrapolate from the survey sample to the Medicaid and Colorado Works population as a whole, several conclusions can be drawn:

- About 3,610 Medicaid recipients (5.5%) have current substance abuse problems.
- About 2,700 of these recipients with problems are women with children, or those most likely to be receiving Colorado Works benefits.
- Of the 2,700 Colorado Works recipients with substance abuse problems, only about 660 (24.5%) received treatment. This means that about 2,040 Colorado Works recipients said they had substance abuse problems but did not want or receive treatment.
- About 6.3% of those 2,040 recipients, or 129 Colorado Works recipients would have accepted treatment had it been available to them.

These are conservative estimates because they rely on self-reports from recipients, who are more likely to understate their substance use than to overstate it.

In response to a 2000-2001 survey of states (Capitani & Hercik, 2001), Colorado reported that addressing the needs of clients with multiple barriers to work was one of the State's top challenges over the coming year. The women at New Directions Arapahoe House said they believed about 75% of Colorado Works participants have alcohol or substance abuse problems. Estimates by staff who participated in the focus groups and interviews conducted as part of preparing this book ranged from 30% to more than 80%. These estimates reflect perceptions of recipients and staff, however, and are not based on research or quantifiable data.

For county-by-county information about substance abuse prevention and treatment in Colorado, visit these ADAD websites: http://www.omni.org/SIReports/siindex.htm (for prevention) or http://www.cdhs.state.co.us/ohr/adad/presentations.htm (for treatment).

Substance Abuse Rarely Occurs Alone

Two recent studies shed some light on the problems faced by TANF recipients as a whole, and in particular by recipients who have substance abuse problems.

First, a study of welfare recipients in Utah found that 42 percent were clinically depressed, seven percent had generalized anxiety disorders, 15 percent suffered from post-traumatic stress disorders, 12 percent had experienced severe domestic violence within the past 12 months, 23 percent had learning disabilities, 35 percent had physical health problems that prevented them from working, 30 percent had poor work histories, and 23 percent had children with severe behavior problems. This study also found that 92 percent of families faced at least one of these barriers, 26 percent faced three of them, and 37 percent faced four or more barriers. (Barusch, et.al. 1999)

Second, CASAWORKS for Families is a national demonstration program whose motto is "Work is treatment and treatment is work." CASAWORKS served 673 substance-abusing women receiving TANF in nine states.

The CASAWORKS evaluation, conducted by the Treatment Research Institute at the University of Pennsylvania, found that 75 percent of CASAWORKS participants had not worked in the three prior years, and only 17 percent had worked full time as their usual pattern. Almost half had received welfare for six years or more during their lives, and the average lifetime receipt was 5.6 years. Moreover, participants reported that alcohol and drugs had been a major problem in their lives for approximately eight years. Despite these histories, most women reported they had not received alcohol treatment and just over half had received drug treatment. (TRI, 2001).

CASAWORKS for Families
Substance Abuse Characteristics
(of 673 participants at time of admission)

Avg. Lifetime Years of Heavy Alcohol Use	8.2 years
Avg. Days Heavy Alcohol Use--Past 30 Days	10.5 days
Avg. Lifetime Years of Illegal Drug Use	8.1 years
Avg. Days Illegal Drug Use in Past 30 Days	9.1 days
Drugs of Choice among	*Percent*
Participants Who Used Within Past 30 Days	
Heroin	13
Other opiates/analgesics	7
Barbiturates	1
Sedatives	5
Cocaine	35
Amphetamines	8
Cannabis	31
Hallucinogens	1
Inhalants	1
Percent Who Ever Received Treatment	
Either alcohol or illegal drugs	58
Alcohol	26
Illegal drug	53

As shown in the following chart, CASAWORKS participants suffered from several serious problems in addition to their substance abuse. In particular, they had high levels of victimization, psychiatric problems and symptoms, legal, and child problems. Most had been physically abused and half had been sexually abused during their lives. Nearly half had received treatment for psychiatric problems, 75% had been arrested and 25 %

had been incarcerated. More than 20% were currently under investigation for child maltreatment by child protective services. (TRI 2001).

Health and Social Problems of CASAWORKS Participants (of the 673 enrolled)

	Lifetime (by Percent)	Past 30 Days (by Percent)
Abused By Anyone		
Emotionally	79	32
Physically	69	8
Sexually	51	1
Psychiatric Problems		
Ever treated	45	8
Hospital/inpatient	21	2
Outpatient	35	7
*Symptoms**		
Depression	68	42
Hallucinations	12	5
Problems concentrating	45	35
Anger problems	40	15
Serious suicide thoughts	40	7
Suicide attempts	31	2
Legal Problems		
Ever convicted of crime	76	
Ever incarcerated	26	
Recent parole/probation		20
Awaiting charges, trial or sentencing		14
Child Problems		
Ever lost custody to CPS	16.9	
Ever try to regain custody	14.4	
Currently under investigation		22
Child with serious medical, learning, behavior problems		34.7

* Symptoms experienced for at least two weeks in duration and not caused by alcohol or drug abuse.

Substance-Abusing Women Have Many Strengths and They Can Succeed in Treatment and as Workers

Substance-abusing women have repeatedly demonstrated the courage and dedication it takes to overcome addiction, leave violent relationships, parent their children, and maintain jobs. Many studies show that treatment reduces addiction, saves money, prevents criminal activity, and improves work outcomes. One study of TANF recipients in California (Gerstein, et. al. 1997) found that comparing the year before and the year after treatment:

- The percentage of women who engaged in illegal activities dropped by about 67%; the percent who sold or helped to sell drugs dropped by about 60%; and the percent arrested, booked, or taken into custody dropped by about 54%;
- The percentage hospitalized over one year dropped by about 58%;
- The percentage homeless for two or more days dropped by about 61%; and
- The benefits to taxpayers were 2.5 times the cost of treatment.

The 1997 National Treatment Improvement Evaluation Study (NTIES) examined outcomes for 1,374 women in federally funded substance abuse treatment programs. While total income for these women increased by 6%, there was a decrease of 11% in the number receiving welfare. This study also reported a 19% increase in employment among 5,700 participants in the year after treatment. (CSAT 1997).

Participants in the CASAWORKS for Families program realized significant improvements in work outcomes and significant reductions in substance abuse. After 12 months in CASAWORKS, 46% of participants reported they had not used alcohol or drugs in the past six months, 68% said they had not used any alcohol, and 90% said they had not used any illicit drugs during that time. (TRI 2001)

CASAWORKS for Families
Changes in Patterns of Substance Use

Substance Use	Admission	6 Months Later	12 Months Later
Avg. # Days Problem Alcohol Use in Past 30 Days	3.5	1.5	1.3
Avg. # Days Any Drug Use in Past 30 Days	14.2	8.4	4.6

Moreover, CASAWORKS participants increased their work activity, income, and attendance at school or training. Only 16% of CASAWORKS participants had worked at all within the month prior to enrolling, but 41% were working at least half time by the end of 12 months in the program. (TRI 2001)

CASAWORKS for Families
Changes in Patterns of Employment and TANF

Employment	Admission	6 Months Lat	12 Months Later
% Working at Least ½ Time in Past 30 Days	16	21	41

Chapter Three
Screening Instruments and Techniques for TANF Staff

This chapter defines "screening" and "assessment" and presents several short screening forms that are used to identify substance abuse. It discusses ways in which these screening forms may be useful aspects of TANF interviews, but cautions about the limitations of screening tools even when used in the best of circumstances. It concludes with a discussion of drug testing as a particular type of screening.

When welfare reform first passed, officials in some states realized they would have to develop ways to help workers identify and serve families with substance abuse problems if their welfare reform efforts were to succeed. In response to a 1997 needs assessment, TANF agencies reported substance abuse to be one of their top three challenges in implementing welfare reform (Hercik & Hoguin-Pena, 1998). These officials introduced the use of short screening instruments, provided training to workers about substance abuse and addiction, and developed working relationships with substance abuse treatment agencies and programs.

These screening tools yielded few results, however, and TANF officials realized that screening for barriers such as substance abuse is different than screening for barriers such as childcare or lack of work experience, in which short questionnaires are more likely to yield accurate information. Therefore, many states and counties expanded their practices to go beyond simple screening, adding strategies such as co-locating staff from treatment agencies on-site at the TANF office, training staff to note recipient characteristics or patterns of behavior that indicate substance abuse, and using indicators from case records or management information systems. These strategies are described in the next two chapters. Some states also use drug testing in limited and specified situations.

However, even states that have expanded their strategies continue to use screening instruments. A 2002 survey conducted by the Legal Action Center found that 26 States said they currently screened TANF families for substance abuse problems; seven said that screening decisions were left to counties, and 11 reported they were not conducting alcohol and drug screenings. It is likely that screening will continue to play an important role in TANF agencies' attempts to identify substance abuse among recipients.

Screening vs. Assessment

In general, ***screening*** is the use of a simple set of questions that can indicate the need for a thorough assessment. The outcome of a "positive screen" is a referral to a specialist for an assessment (Chandler, California Institute for Mental Health). The goal of screening, therefore, is to determine whether a person should receive a more thorough evaluation. Screening is frequently used in health or treatment settings such as hospital emergency rooms or prenatal clinics. Some screening forms can be administered by people who are not trained substance abuse counselors, such as TANF

staff. In some locations, recipients themselves administer the screening, which is then scored by a TANF worker or substance abuse counselor. Other instruments require training in administration and interpretation. (Nakashian & Moore, 2001).

Assessment is the process of establishing the extent and severity of a limitation once it is known. Assessment instruments are used to determine how substance abuse affects various aspects of life (health, work, legal, etc.). They are used for therapeutic intervention, to develop plans of treatment once substance abuse problems have been established. Assessment instruments generally require extensive training to administer and interpret, and are not appropriate for use by staff who are not skilled in using them. A common assessment tool is the Addiction Severity Index (ASI).

Both screening and assessment instruments require some self-disclosure on the part of people responding to the questions.

How Screening Works

Screening is an attempt to use objective standards to determine whether someone has a substance abuse problem. Several approaches have been developed to do this. One approach starts with established psychological or psychiatric criteria for substance abuse and relies on clinician interviews to determine whether a person meets those criteria. This approach uses standard and objective criteria, but relies on subjective information given by clients and subjective conclusions by the interviewer in deciding whether a person meets those criteria (Wanberg, 2000).

Another approach uses standardized self-report questionnaires that always ask the same questions to all people being evaluated. There is often a cut-off level for responses, above which there is enough indication of substance abuse that the person should be referred for a more complete assessment. This approach, similar to the strategy used in many TANF offices in and outside of Colorado, cuts down on some subjectivity, but it does not eliminate it.

- Screening gives TANF workers and recipients perspectives in five areas:
- It gives recipients a chance to disclose substance abuse problems
- It gives workers a chance to gather collateral information
- It gives workers a chance to discern whether the recipient appears defensive
- It gives workers a chance to weigh client responses, collateral information and level of defensiveness to estimate whether substance abuse might be a problem
- It gives the worker a chance to match services to where the client is in her/his readiness to consider treatment or other kinds of help (Wanberg, 2000).

Uses and Limitations of Screening Instruments

Despite the relatively low level of identification obtained when using short screening instruments with TANF recipients, there are justifiable reasons for using these instruments in helping staff explore substance abuse with recipients. However, there are also

reasons why TANF officials and workers should have only modest expectations about the use of instruments as part of TANF eligibility or case management.

In Deciding Whether and How To Use Screening Instruments, Consider the Following:	
Advantages	**Limitations**
Instruments work in some cases. For each recipient who is able to disclose substance abuse when asked about it as part of a standard interview, that instrument has succeeded. Even if only a small number of recipients disclose substance abuse in this way, each disclosure represents a person, and a family, that can be helped.	Instruments were not designed for use in TANF offices. One study conducted by the California Institute for Mental Health tested instruments by using researchers to screen 703 female TANF recipients in two California TANF offices. The researchers used three screening tools for alcohol problems and one for drug problems (see chart, TWEAK and CAGE). The screening instruments listed in the next section have been tested and found valid in some settings, but except for one study, they have not been tested in TANF offices.
Instruments are widely available and accessible. Many instruments are free and training curricula for their use has been developed and tested. They take little time to administer and score.	Even the best instruments administered under optimal circumstances will yield valid information only to the extent that recipients believe they will be helped rather than punished by disclosing problems. TANF recipients who participated in the focus group conducted in preparing this guide said they would talk about their substance use if they knew in advance that they would be referred to treatment programs where they could bring their children.
Instruments provide a consistent structure for workers to use in interviewing. If instruments are used, at least agency managers know the questions have been asked. Instruments provide written documentation that may be required for fair hearings or in subsequent interviews.	Substance abuse screenings are often conducted as one element of complex TANF eligibility or case planning interviews. These often take place in areas where there is not enough privacy or time to explore sensitive problems. It is best not to view substance abuse screening as a one-time event. TANF workers interview recipients at several different times and screenings do not need to be limited to any particular schedule.
Information from instruments can help workers and recipients make realistic plans for treatment and employment.	Positive responses to instruments do not automatically mean that substance abuse is a barrier to work. In-depth discussions about substance abuse should be handled by trained substance abuse treatment specialists and generally not by TANF workers.

Asking the Questions

Substance abuse screening tools are "blunt instruments." They pose direct questions and frequently call for Yes/No responses. It is not surprising that TANF offices have found low rates of disclosure when they rely on workers to administer these instruments. However, these tools are the best available in situations where there is little time and when staff asking the questions are not trained substance abuse clinicians.

Ultimately, the decision regarding whether to disclose substance abuse rests with the recipient and not with the screening tool or with the worker. But, workers can increase the effectiveness of these tools by framing the discussion so it is more comfortable for recipients. Following are two interview scenarios that workers might use to introduce screening forms, neither of which will add significant time to the interview. (What can accurately be said will vary by county, depending on what services are available and how the office is structured).

Scenario One. Tell the client why the questions are asked and what will happen as a result of the response:

> *I am required to ask some personal questions, and you can respond in any way you want. But, it might help if I explain why I have to ask these questions and what will happen as a result of your responses.*
>
> *We have to ask Colorado Works families about any problems that might prevent them from working. Some problems are obvious, such as lack of childcare or work experience. Others are less obvious and more personal, such as problems with alcohol or other kinds of drugs. The reason we ask these questions is to make sure all families get the help they need and that we do not push people into job activities if they are not ready.*
>
> *If you think you may have problems with alcohol or other kinds of drugs that would make it hard for you to work, here is what will happen. I will ask you to speak to a substance abuse counselor. The counselor will conduct a more complete and private interview and work with you to make a plan for treatment or other services. And, there are treatment programs where you can attend with your children. Saying that you have problems with alcohol or drugs does not mean that you will lose welfare benefits or get into trouble. It does mean that a trained counselor will speak with you, and that discussion will be private and confidential.*

Scenario Two. Explain the services available to help people *before* asking them to decide what to disclose.

> *Let me highlight some of the services our county has available for Colorado Works recipients. We can help families get job training, childcare, transportation and other services that make it easier to work. We also have services that provide counseling if you are having personal problems or if you are worried*

about how your children are doing, and we have trained counselors who will work with you to see if you need services such as substance abuse treatment. All the services we offer are confidential, and talking to the counselors about personal problems does not mean you will lose your benefits or get into trouble. It does mean that you will have another discussion with a trained counselor, and that discussion will be confidential.

Part of our process is an interview to see if you are eligible for Colorado Works (or whatever the purpose of the interview) and to talk with you about whether you would like any of the services we provide. The interview will include questions about general eligibility, your overall job interests, and personal aspects of your life.

Some Commonly Used Instruments

The substance abuse field has developed and tested several instruments, and TANF agencies have used or adapted some of them. The following Table provides a short description of the more commonly used instruments that have been found valid when used in appropriate settings. Copies of most of these instruments themselves are included in Appendix B. Many of these screening tools can be obtained from federal government websites, especially the National Institute on Alcohol Abuse and Alcoholism (www.niaaa.nih.gov) and the National Institute on Drug Abuse (www.nida.nih.gov). Some are available in Spanish.

It is essential to review materials accompanying instruments before using them. These materials provide practical guidance such as how many positive responses indicate that alcohol or drug use may be a problem, and they may suggest alternative wording of questions that might work better with TANF recipients.

For a more complete list of instruments used for screening, assessment, and diagnosis of a variety of populations, please see also the booklet prepared by the Alcohol and Drug Abuse Division (ADAD): "ADAD Approved Evaluation Instrumentation for Substance Using Adults."

Selected Substance Abuse Screening Instruments			
Instrument	*Purpose*	*Features*	*Reference*
Adult Substance Use Survey (ASUS) Used with the Self-Appraisal Survey (SAS) Used in Colorado for child protective services	A differential screening instrument designed to screen for an individual's perceived alcohol and drug use and abuse, mental health concerns, motivation for treatment, antisocial attitudes and behaviors, and level of defensiveness.	64 questions that can be self-administered or asked by another person. Available in Spanish. Takes 8-10 minutes to administer. Training is required and available. A Users Guide is available Free for use in Colorado but permission is required	Kenneth Wanberg, PhD Center for Addiction Research and Evaluation, Inc. 5460 Ward Road, Suite 140, Arvada, CO 80002 303-421-1261
Alcohol Use Disorders Identification Test (AUDIT)	A simple screening instrument designed to identify people whose alcohol use has become a danger to their health. Includes 3 subscales that assess amount and frequency of drinking, alcohol dependence and problems caused by alcohol.	10 questions that can be self-administered or asked by another person. Takes about one minute to complete. Targeted for adults. Free except for training materials.	Babor, T., de la Fuente, Saunders, J., & Grant, M. (1992). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary HealthCare*. The World Health Organization: Geneva, Switzerland. Babor. T.F. Alcohol Research Center University of Connecticut Farmington, CT 06030-1410

Instrument	*Purpose*	*Features*	*Reference*
CAGE (an acronym for four questions)	A simple screening in which questions pertain to lifetime drinking behaviors.	4 questions that can be self-administered or asked by another. Targeted for over 16. Questions can be incorporated into other questionnaires. Free.	Mayfield, D., McLeod, G. & Hall, P. (1974). The CAGE Questionnaire: Validation of a New Alcoholism Instrument. *American Journal of Psychiatry, 131*, 1121-1123.
CAGE-AID The CAGE or CAGE AID is used in Adams, Bent, Clear Creek Counties	A simple screening but expanded version of the CAGE that includes questions about the use of illicit drugs as well as alcohol.	9 questions that can be self-administered or asked by another person. Targeted for adults or teens over age 16. Questions can be incorporated into other questionnaires. Free	Brown, R.L. & Rounds, L.A. (1998). Conjoint Screening Questionnaires for Alcohol and Other Drug Abuse. Criterion Validity in Primary Care Practice. *Wisconsin Medical Journal, 94*, 135-140.
Drug-CAGE	Similar to CAGE but questions relate to illicit drug use in the past 12 months. The CIMH study found that only the first two of the 4 questions were necessary.	4 questions that can be self-administered or asked by another.	See CAGE
Drug Abuse Screening Test (DAST)	A simple screen designed to screen for the use of illegal drugs in the prior 12 months.	10 questions whose cumulative score indicates whether there is a drug problem, whether the person should be monitored, or whether the person should be further assessed.	The Addiction Research Foundation Center for Addiction and Mental Health 33 Russell Street Toronto, M5S2S1 Ontario, Canada 416-535-8501

Instrument	*Purpose*	*Features*	*Reference*
Michigan Alcoholism Screening Test (MAST)	Designed to screen for lifetime alcoholism related problems.	25 questions that can be self-administered or asked by another. Shorter version exists. Takes 5 minutes. Targeted for adults. Minor cost for original, then can be copied.	Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am. Jr. of Psychiatry, 127*, 1653-1658. Melvin L. Selzer, MD 6967 Paseo Laredo La Jolla, CA 92037 619-459-1035
Self-Appraisal Survey (SAS) Is a companion to the Adult Substance Use Survey (ASUS) Used in Colorado for child protective services	Designed to screen for alcohol and chemical dependency and to determine both extent of use and effects of use on aspects of life.	24 questions that can be self-administered by clients & 12 items for caseworkers using observation & other information. Client items take about 15 minutes. Free in Colorado but permission is required	Kenneth Wanberg, PhD Center for Addiction Research & Evaluation, Inc. 5460 Ward Road Suite 140 Arvada, CO 80002 303-421-1261
Substance Abuse Subtle Screening Inventory (SASSI) Used in Adams, Boulder, Clear Creek, Denver, Routt, Summit, Weld Counties	Designed to screen for chemical dependency and to resist efforts to fake or conceal problems. Has 8 subscales that can assess defensiveness and other dependency characteristics.	88 questions. Takes 10-15 minutes. Requires training to be administered but can be self-administered. Requires training to interpret and score. Must be purchased.	Miller, G. (1985). *The SASSI Manual.* Bloomington, IN Spencer Evening World. The SASSI Institute 201 Camelot Lane Springville, IN 47462 800-726-0526
Triage Assessment for Addictive Disorders (TAAD)	Designed for both drug and alcohol use in face to face interviews where time commitment is minimal.	30 questions. 12-13 minutes to administer & score. Can be administered by anyone with good interviewing skills; requires expertise to score. Must be purchased	Norman G. Hoffmann, PhD Evince Clinical Assessments PO Box 17305 Smithfield, RI 02917 800-755-6299

Instrument	*Purpose*	*Features*	*Reference*
TWEAK (an acronym for 5 questions regarding alcohol usage)	A simple screen developed and validated among women. Of alcohol tools tested by CIMH, this is the one they recommend.	5 questions that can be self-administered or asked by another. Takes 5 minutes to administer and score. No training is required. Free.	Marcia Russell, PhD Research Institute on Addictions 1021 Main Street Buffalo, NY 14203 716-887-2507
UNCOPE (an acronym for 6 questions)	A simple screen designed to detect alcohol or drug problems.	6 questions found in existing instruments and research reports. Can be self-administered or asked by another person. No training is required. Free.	Norman G. Hoffmann, PhD Evince Clinical Assessments PO Box 17305 Smithfield, RI 02917 800-755-6299

(This table was adapted from an earlier version included in A Look at State Welfare Systems Efforts to Address Substance Abuse, 2000.)

Perspectives on Drug Testing

Physical drug testing by analyzing the content of blood, hair, or urine to screen for substance abuse has been explored by some states. The State of Michigan implemented a program in which all applicants for TANF in three counties were required to undergo urine testing as a condition of eligibility. The federal court ordered a halt to this program, and in 2002 that court decision was upheld upon appeal.

Other states, such as Florida, Kansas, and Oregon have used drug tests in specific and limited circumstances.

Not surprisingly, use of drug tests as part of the TANF system is sensitive and controversial. The following discussion summarizes some of the issues that administrators should consider in deciding whether to test TANF recipients.

<u>Limitations of Drug Tests</u>

- Drug tests do not demonstrate patterns of use, and they do not demonstrate that a person is abusing substances. Test results indicate recent use (and sometimes, the amount) of a substance. They will not determine whether drug use has consequences for work.

- Because alcohol metabolizes quickly and is undetectable after about 8 hours, common drug tests do not provide accurate information about alcohol use.

- Whether a drug is detected depends not only on drug use but also on factors such as characteristics of the drug, individual metabolism, and cut-off levels specified by the agency requiring the test.

- Drug test results require specific decisions that determine the technology used, the types of drugs to be tested for, and cut-off levels.

- Drug tests are invasive procedures and raise questions about peoples' right to privacy. There are ethical questions to be asked if it appears that the only reason for testing is because a person is poor or receiving public assistance.

- People may be afraid to apply for benefits if they believe they will be tested. To the extent this happens, the testing policy masks substance abuse problems rather than unearth them, and in fact deters people from seeking treatment.

- Positive results from drug tests require that qualified and trained staff be available to initiate follow-up discussions with recipients.

- Drug tests are not always accurate. Some clients testing negative for substances may in fact have problems, and some testing positive may not have problems. Workers should not reach conclusions based on the result of a single test.

Possible Uses of Drug Tests

- Testing may be used for research purposes, to better understand the nature of substance use among TANF recipients within the state or county. For example, the State of New Jersey conducted a study in which drug tests were compared with client self-reports to workers and self-reports to researchers. It is important, however, that results be kept confidential, that anonymity is assured, and that participants are fully informed about the study.

- Drug testing may simulate work environments. Employers are increasingly drug testing job applicants and employees. According to a 1996 survey conducted by the American Management Association, 81% of major US companies reported having drug-testing programs, compared to 78% in 1995 and just 22% in 1987. Therefore, testing might be introduced towards the end of a job preparation program and accompanied by discussions about the reasons employers test for drugs. In this way, recipients are less likely to be surprised or disturbed if they are tested as part of job interviews.

- Testing could be used on a targeted basis; in situations where there are strong indicators that substance abuse might exist even if the recipient does not acknowledge it. Testing could be targeted to families in sanction, or for recipients who repeatedly fail to comply with program rules.

Chapter Four
Beyond Screening: Other Ways to Identify Substance Abuse

This chapter summarizes four strategies other than screening instruments that TANF offices can employ: observational checklists; case record indicators; marketing or public relations efforts; and targeted orientation strategies; and gives examples of states or counties that have used these strategies.

As TANF officials realized the limitations of paper and pencil screenings conducted by TANF workers, they turned to other methods that might yield better results. These ideas benefited from the lessons learned during the early years of welfare reform, and, importantly from the new relationships that some TANF administrators and staff formed with substance abuse treatment providers. The techniques featured here have not yet been evaluated rigorously, but they appear to show promise. They are feasible to implement, and they are well regarded by TANF staff who employ them.

Behavioral Observation Checklists

Substance abuse clinicians are skilled at picking up signs of substance abuse even when clients do not disclose it. In some states, TANF and treatment officials have collaborated in designing short checklists of common indicators of substance abuse that TANF workers can use after clients leave the interview. Workers scan the checklist and check-off attributes they noted. If more than a specified number of attributes are checked, the form is sent to a substance abuse specialist who calls the recipient in for a more complete assessment.

These checklists take almost no additional time to complete, and they provide workers with another avenue to refer recipients for help. Moreover, they help workers themselves become more knowledgeable about and sensitive to substance abuse in general.

At least two states--North Carolina and New York--use these checklists, and copies of both checklists are included in Appendix C. In North Carolina, the checklist is a stand-alone form that workers complete after the interview has ended. In New York, the checklist is one section of the CAGE-AID substance abuse screening tool.

Case Record Indicators

Often, there are indicators in client case records or management information systems that could point to possible substance abuse problems. Some states and counties have more complete and current case files than others, but in those places where case records are accurate and available, they provide information that helps workers talk to clients or make referrals for more thorough substance abuse assessments. Examples of these indicators include: experiences of homelessness or child welfare involvement (substance abuse is implicated in approximately 70% of families whose children are in

foster care, CASA, 1999); criminal charges or arrests for driving under the influence; multiple spells on and off TANF, etc.

New York State added a check-off section to its substance abuse screening instrument (the CAGE AID) that asked workers to look for indicators such as those listed above. A copy of the NY State Case Record Indicator Checklist is also included in Appendix C.

Social Marketing

Some TANF and substance abuse treatment agencies have collaborated to develop programs that "market" services to recipients and encourage them to follow-up by talking with workers. While these strategies may take time and money to design at the outset, they take some burden away from TANF staff who otherwise have to hold one-on-one discussions with recipients. They also provide another opportunity for recipients to think about their problems. Marketing strategies work to create an environment in which recipients come forward on their own terms, in a way that is the least threatening to them.

In the focus group with TANF recipients conducted in preparing this document, the women said they would have appreciated having brochures available and telephone numbers to call. They said they would pick up written material in TANF or other social services offices and they would watch videos about substance abuse while waiting to see their workers. Similarly, workers who participated in the focus groups said they would be interested in watching such videos and would like to have videos available for clients to view in waiting areas.

The State of New York prepared a 17-minute video featuring six TANF recipients in recovery from substance abuse. The women described what it was like to be addicted, how they got into treatment, what treatment was like for them, and how their lives were different as a result. The video is divided into four segments separated by a notice providing an 800-telephone number that people can call for help. The State prepared posters and brochures using the same logo as the video, and featuring the same 800-telephone number. Approximately 2,000 copies of the video were produced and sent to county TANF offices, community based organizations and substance abuse treatment providers. Release of the video was timed to coincide with the introduction of a new substance abuse screening form that included the behavioral observation and case record indicator checklists described above (for more information about the New York initiative, call Frances Shannon Akstull at 518-402-3219).

Alameda County Behavioral Health Care Services, CA (including the City of Oakland) collaborated with the county TANF agency to develop a comprehensive marketing campaign that featured several 30-second television spots, bus and subway posters, client brochures, and a client video. The video, running about 30 minutes, was sent to the homes of sanctioned CalWORKS (California's TANF program) recipients, who were encouraged to watch it and share it with others. The video used actors to depict ways in which the TANF agency could help people with substance abuse and mental health problems. The marketing campaign was launched at the same time as a countywide

outreach effort, in which pairs of outreach workers visited TANF recipients in their homes and in other community settings, helping them seek and accept services. (for more information about Alameda County's initiative, call Maxine Heiliger, 510-567-8102 or email at heiliger@bhcs.mail.co.alameda.ca.us).

In some places, it may be feasible to invite staff from substance abuse treatment agencies to make presentations in TANF waiting rooms. Presentations might cover an array of health related topics, such as prenatal care, child development, hygiene and nutrition, and substance abuse. Participants are encouraged to approach the presenters at the end of the session to ask for additional information. Because these presentations cover a range of health issues, recipients are less likely to feel ashamed by having others see them talking to a substance abuse counselor.

Orientation Sessions

Many states and many counties in Colorado hold group orientations for new TANF recipients. Generally, these orientation sessions last about two hours and include groups of from 10 to 20 people. Frequently, the goal of orientations is to provide recipients with an overview of TANF rules and services. Much time is devoted to explaining recipient rights and responsibilities and letting them know about the policies that are likely to affect them while they are receiving benefits.

It may be possible to revise orientation sessions in a way that creates opportunities for recipients to think about their lives differently, to explore their ambitions and goals, and to consider whether they need help with problems such as substance abuse. For example, each orientation session could start by asking recipients to brainstorm the question: "How would I like my life to be different one year from now?" Thinking along these lines helps recipients understand that TANF rules require them to make changes in their lives, it helps them express goals and dreams in their own terms, and it provides staff with insights regarding the interests, strengths, and priorities of clients.

Sometimes, the group environment, in which recipients are sitting with others who are in the same situation, prompts more open discussion and peer support than could be obtained in private interviews with workers.

In Portland, Oregon, all new TANF recipients attend an "Addictions Awareness Class" that runs for two hours and is held in the local TANF office. Classes are run by experienced substance abuse counselors who are already co-located inside the TANF office. There is no written curriculum for the classes, because they rely heavily on discussion and each one unfolds on its own. However, each session starts with a presentation about addiction that describes the physical aspects of addiction and introduces the concept of co-dependency. Then, recipients watch a video that portrays addiction in human and emotional terms. After some discussion, recipients complete the SASSI screening instrument on their own, and discuss their findings as a group, to they extent they are comfortable. (For information regarding the Oregon Orientations, call Christa Sprinkle, 503-256-0432, ext 519 or email at sprinklc@mhcc.cc.or.us).

Chapter Five
Four Dimensions of Trust

This chapter presents the notion that trust is the "make or break" ingredient that has to exist for any substance abuse screening or identification strategy to work. It describes four essential dimensions of trust, and gives examples of how each dimension can be developed.

Carl Sagan once noted "in order to bake an apple pie, you have to unravel the mysteries of the universe." Determining how to talk to TANF recipients about substance abuse problems feels much the same--in order to get a specific piece of information, you have to unravel all of the confusions and complexities embedded within recipients lives and within deeply entrenched TANF agencies and systems.

Laws change by legislative vote and executive signature, but people and systems don't change that easily, so that deciding what to do may be easier than doing it in the real world. The best screening tools and the most creative strategies will get results only to the extent that workers and recipients trust and respect each other. When they do, almost any instrument will succeed and when they don't, almost no instrument will succeed. Trust and respect start with agency visions, values, and missions that place priority on these attributes.

"An organization's effectiveness depends on the ability of its leaders to obtain the cooperation of its employees, on the acceptance of a common purpose and on a system of communication to tie it all together. . . The challenge for public agencies and employees is to manage diverse and conflicting expectations. The challenge for the political system is to design institutional mechanisms that help it achieve values it wants." (Ingraham, et.al.)

Changing cultures and systems is about the hardest work that people can do. It requires TANF officials to keep "one foot in the box and one foot out of the box." A basic function of TANF continues to be making timely and accurate eligibility decisions. At the same time, TANF staff are now charged with additional responsibilities to help people resolve their problems and become self-sufficient within a short period of time.

Trust is a concept that everyone believes is important. It sounds good. However, making trust real and meaningful within complex public systems that serve vulnerable families involves time-consuming, frustrating, and generally uncompensated (via salary or recognition) hard work. Moreover, many discussions about trust are limited to finding ways to help TANF workers build trusting relationships with recipients. This dimension is absolutely essential to achieving the goals of welfare reform, but it cannot be created in isolation, and other dimensions of trust are equally important but easily overlooked. Operationalizing trust is harder than thinking about it.

The effectiveness of screening tools, checklists, social marketing campaigns, and other innovative strategies hinges on developing trust along four dimensions:

Dimensions of Trust	
Trust Dimension	**Examples**
TANF worker have to earn the trust of their clients.	Workers have to: • Refrain from passing judgment. • Be comfortable in their knowledge of program rules and services. • Be forthcoming and clear in presenting options and consequences. • Explain why they need to know certain information and what will happen with information provided. • Not turnover to such an extent that recipients feel no one knows them. • Respect recipients. • Believe that recipients have strengths and potential. • Hold confidential information in confidence and explain to families when and how information may be shared.
TANF agencies have to earn the trust of their clients.	Agencies have to: • Create forms, brochures and letters that are user friendly. • Assure that services exist to help recipients. • Develop written and visual material to help recipients learn about what services they can get. • Create the most private and pleasant waiting areas and interviewing booths possible. • Seek feedback from recipients regarding services and procedures. • Create confidentiality, child welfare and work policies that support recipients in disclosing problems.
TANF workers have to trust their skills and capacities.	Workers need opportunities to: • Learn about addiction--its physical, psychological, and behavioral effects. • Understand why people become addicted. • Identify and explore their personal beliefs and values about addiction and dependence. • Visit substance abuse treatment programs. • Meet with people who are in recovery. • Work collaboratively with staff from treatment programs in making shared decisions about services and progress. • Achieve and be recognized for their achievements.
TANF agencies have to earn the trust of their staff.	Workers need to feel confident that: • If recipients seek help for substance abuse problems, the agency has resources to provide that help. • They will have ample opportunity for training that includes both conceptual and practical elements; and that they can practice and problem-solve what they have learned. • Their judgment, perspective, and autonomy is respected and valued by supervisors and managers. • The agency has appropriate employee assistance plans (EAPs) or other mechanisms for staff who have substance abuse problems themselves or within their families • They have opportunities for growth.

One of the most important steps TANF administrators can take in building trust is to develop clear statements of their agency's mission, vision, and principles. These statements should be discussed and debated during all new worker training programs, and they should be featured on agency letterhead, brochures, and notices to clients. Agency policy and procedure issuances should include a short paragraph describing how the policy contributes to the agency's mission.

Most of the ideas put forth in Chapters Three and Four are aimed at developing trust along these dimensions, and entire books could be written on each one. Moreover, these dimensions overlap, and strategies geared to address one dimension are likely to have positive consequences for other dimensions as well.

What follow here are one or two additional suggestions per dimension. There are several strategies that could be employed for each of the four dimensions. Some would be relatively inexpensive and require little additional time, while others would be more far-reaching, requiring higher levels of approval and more time to implement. The suggestions offered here are on the inexpensive and less time-consuming end of the continuum. Some of these concepts are also discussed in Chapter Six, Implications.

TANF Workers Have to Earn the Trust of Their Clients

- Workers should be given opportunities and encouragement to visit programs that serve their clients

Recipients are more likely to trust their workers if workers can speak confidently about agency rules, programs, and services. For example, recipients want to know what GED classes do, what happens when someone enters substance abuse treatment, whether childcare centers are licensed and monitored, etc.

In many, if not most cases, TANF workers know little about what goes on in programs they require clients to attend. It is not feasible for every worker to know every community service provider in depth, but it is feasible for every worker to visit and observe a few programs. It is also feasible for TANF agencies to invite staff and clients from service organizations to make presentations in TANF offices.

TANF Agencies Have to Earn the Trust of Their Clients

- TANF offices should develop both structured and informal systems to solicit and welcome feedback from clients.

Recipients have a view of public assistance that no one else can see and they are not often asked to share that view. While at times TANF recipients may have unrealistic perceptions and expectations, many times they have feasible and practical ideas for ways to improve programs and procedures. The recipients who participated in the focus group conducted for this report were pleased to be asked for their opinions and offered important insights. They also realized that some of their ideas were practical and others were better characterized as an ideal "wish list."

TANF offices can develop simple surveys for recipients, including closed-ended questions about topics of importance to the office. They could also conduct occasional focus groups of recipients, in which specific policies or office procedures could be explored. Welfare agency officials in Connecticut conducted public forums for recipients. Recipients were invited to attend a "town meeting" with welfare officials, held at a local school auditorium. Officials made short presentations regarding current welfare issues and then sought questions and comments from the recipients.

- Agencies have to create confidentiality policies that support recipients in disclosing problems.

TANF recipients have a legal and ethical right to trust that information about their problems will be kept in strict confidence. TANF agencies and substance abuse treatment providers operate within strict federal and state guidelines regarding how information about TANF recipients may be shared. The Center for Substance Abuse Treatment issued a publication entitled "*Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy.*" This report was prepared by the Legal Action Center and offers practical ways (including copies of federally approved confidentiality forms) for welfare and substance abuse treatment staff to protect recipient rights, promote inter-agency collaboration, and support case planning (the report is free and can be ordered by calling 800-729-6686 and requesting TAP#24).

Some principles that can help agencies establish appropriate confidentiality guidelines include:

> TANF recipients have rights about disclosing information to third parties. They can allow or refuse disclosure, determine the limits of disclosure, and revoke permission to disclose.
>
> TANF recipients have a right to be completely and accurately informed about why welfare or substance abuse information is requested, how it will be used, with whom it may be shared, and for what purposes.
>
> TANF staff needs to understand the purposes of substance abuse confidentiality as well as their technical aspects.

At times, confidentiality is presented as a reason for not collaborating with others. However, in offices where collaborative relationships have been established, confidentiality is seldom expressed as a barrier to effective communication.

TANF Workers Have To Trust Their Skills and Capacities

- Workers should be given opportunities for Professional Development that include but go beyond routine training sessions.

Workers will be more prepared to explore substance abuse problems with recipients if they feel comfortable and in control of their work, they understand their roles, and they feel secure enough in their understanding of addiction to open the topic. Because welfare reform has changed agency values and expectations, in many cases workers do not feel comfortable in their roles, and they know so little about addiction that they will not discuss it with recipients.

Traditionally, training for TANF workers has been focused on teaching them about new rules or procedures and preparing them to perform new tasks. These will continue to be important components of training curricula. However, to the extent that workers are expected to use their judgment, probe for hidden barriers to employment, and identify and build on client strengths, they require different kinds of training.

Training for staff needs to focus on building worker capacity in areas such as understanding how their values influence their relationships with recipients, developing good problem-solving skills, and knowing how to share decision-making with staff from other agencies.

Some counties in Colorado have developed systems that promote the Professional Development of staff along these lines. In particular, El Paso County provides extensive conceptual and practical training for new workers and offers a series of developmental experiences for workers throughout their employment. Training modules connect office policies and procedures to larger agency missions and values.

In some counties, including Denver and Weld Counties, co-located substance abuse counselors provide training sessions for TANF staff. New York State developed a one-day training curriculum for TANF workers specifically regarding substance abuse. The training introduced the revised substance abuse screening form, but placed usage of the form within the larger context of helping workers understand addiction in general and clarify their personal beliefs about addiction and addicts. An outline of the New York training curriculum is included as Appendix D.

TANF Agencies Have to Earn the Trust of Staff

- TANF and substance abuse treatment officials should assure that substance abuse assessments are provided shortly after screening and that entry into treatment is simple.

One fear expressed by some workers in and outside of Colorado is that if recipients do disclose substance abuse problems, there is no certainty that help will be forthcoming. If workers are not confident that their efforts will result in recipients getting timely assessments and referrals to treatment, they cannot reasonably be expected to encourage recipients to disclose those problems in the first place. When workers are unable to respond appropriately to recipients who request help, they lose faith in their own ability to perform their jobs and in their agency's ability to live up to its end of the mutual responsibility promoted by welfare reform.

Substance abuse treatment is not always readily available, although there are some places in Colorado in which gaining access to assessments and treatment is not a problem. In places where treatment is scarce, it should be a priority of both TANF and treatment providers to find ways to accommodate the needs of TANF recipients.

TANF administrators can begin by learning about what treatment programs exist in their county, and what programs in other counties will accept their clients. TANF funds can be used to cover treatment that is not purely medical in nature (such as in-hospital detoxification) and some counties and states have used TANF funds to purchase or reserve additional treatment. Moreover, to the extent that substance abusing TANF recipients are known to the child protective service system, they may receive higher priority for treatment. In response to a 2002 survey of Colorado counties, 18 reported they used Colorado Works funds for assessment and evaluation services, 10 used those funds for detoxification services, and 15 said they used Colorado Works funds to pay for outpatient drug treatment. (Colorado Department of Human Services, 2002).

If TANF funds are not available, agencies have other resources that encourage treatment providers to accept their clients. These include funding for childcare, job preparation services, and access to domestic violence or other services that substance abusing TANF recipients may need.

- Agency officials should ensure that there are appropriate and effective methods to identify and help staff who have problems with alcohol or other drugs.

As noted earlier, many people in the workforce use illicit drugs or drink heavily. There is no reason to believe that employees in TANF agencies are immune from these problems. TANF workers and managers may have substance abuse problems or have family members with these problems. It will be difficult for staff to help clients if they have not adequately addressed these issues in their personal lives.

All staff should be given information about Employee Assistance Programs (EAPs) or other counseling services available to them. They should be encouraged to seek help, and be assured that these services are confidential.

Chapter Six
Putting it Together: Implications, Steps to Take and Pitfalls to Avoid

This chapter presents factors that TANF administrators need to think about as they decide to implement screening and other strategies to help recipients discuss substance abuse. It also provides a list of actions to guide administrators in making and implementing these decisions and summarizes some strategies that have proven less helpful than anticipated.

First, do no harm.

This is a maxim cautioning medical students to think carefully before starting in on courses of treatment with vulnerable patients. The same philosophy should apply to TANF staff as they consider ways to encourage recipients to disclose and address sensitive personal problems such as substance abuse. As this guidebook suggests, the context within which screening takes place is at least as important as the instrument used to ask the questions. Context includes not only the environment of trust that must exist before discussions will be productive, but also the services, structures, and procedures that must in place to act upon information when it is received.

The following section summarizes some of the implications for managers to consider as they make decisions about changing the way they serve families with substance abuse problems. The implications fall into three categories: agency structure, staff development, and service delivery.

Implications for Agency Structures

Welfare reform has prompted many TANF offices, including some in Colorado, to create new operational structures. They realized that new structures would be important elements in making it feasible for TANF staff to talk to recipients about personal problems, and to provide timely and simple access to services when problems are disclosed.

Co-locating Staff

Several counties in Colorado--including Denver, El Paso, and Weld County--and several states across the country have outstationed substance abuse and other service staff on-site in TANF offices. In fact, the diverse constellation of people who show up for work at TANF offices has been one of the more significant effects of welfare reform. While co-location does not assure that collaboration will occur, it does seem to help. Both substance abuse and TANF staff in Colorado county offices where workers were co-located said they were pleased with this arrangement and had established systems for sharing information and coordinating work.

In most places, in addition to screening or assessing recipients, on site substance abuse counselors participate in TANF staff meetings and conduct trainings for TANF staff. At times, they attend client orientations and make short presentations to recipients. But, co-locating staff involves significant substantive and logistical challenges. The following table summarizes considerations that TANF offices have faced in co-locating other staff on site.

Factors to Consider in Co-Locating Staff

Program Factors

Are the goals for co-location clear, and do TANF and treatment staff have the same goals?
How do TANF staff feel about addiction, recovery, and treatment?
How do treatment staff feel about employment?
How will information be shared and privacy protected?
What functions will the co-located staff perform?

Logistics

Where will staff sit, what access will they have to computers, photocopiers, etc?
How will supervision be handled?
How will differences in work rules such as dress codes, signing-in, coming and going into the field, pay, and reward structures be resolved?

Lessons from Experience

Substance abuse staff have to be both a part of the TANF office environment, and they have to maintain their own identity.
Substance abuse training provided by on-site staff is often better received than training provided by TANF staff.
Expectations for what substance abuse counselors will do must be clear and agreed to by everyone (will they conduct screenings and/or assessments, will they provide ad hoc advice and will they participate in staff meetings)?
The relationships take time and work to develop and sustain.
Co-location provides opportunities for people to learn about other professions, understand other social problems, and generally broaden their professional horizons.

The State of Maryland has a county TANF system, much like Colorado's. In Maryland, substance abuse treatment counselors employed by local mental health and addiction agencies are based in TANF offices. The counselors screen all TANF families for substance abuse. If the screening indicates that substance abuse may be a problem, the counselor conducts a thorough assessment and makes referrals for treatment as appropriate. In some counties, the counselor may also monitor progress in treatment, while in other counties, this work is handled by TANF staff or the treatment program. (for information about the Maryland program, email Robin Lyles at rlyles@dhmh.state.md.us)

In North Carolina, a Qualified Substance Abuse Professional (QSAP) employed by the county mental health and addictions agency is stationed on-site at all local TANF offices (in rural areas one QSAP may serve more than one TANF office). The QSAPs conduct all screenings (they use a combination of the AUDIT and DAST instruments, both described in Chapter Three and included in Appendix B) and assessments, and make arrangements for treatment when it is needed. QSAPs also provide ongoing

training for TANF employees. North Carolina staff found that when workers screened recipients for substance abuse, they identified abuse in from 8 to 11% of cases, whereas when QSAPs conducted the screenings using the same screening instruments in the same welfare office, they identified substance abuse in from 28 to 33% of cases (Wolstenholme, personal communication 2002). For information about the North Carolina initiative, call Helen Wolstenholme, 919-733-4671 or email at Helen.wolstenholme@ncmail.net.

Case assignment

Another structural implication for administrators to consider is how they assign cases to staff. For example, some offices have identified specific workers to specialize in certain types of cases, such as substance abuse, domestic violence, or cases subject to sanction. It is helpful if assignments to specialized caseloads can be made based on worker preference, so that workers who are handling complex cases are interested in doing this kind of work.

Specialized workers are able to develop expertise in their areas and they become familiar with local service providers and systems. These are TANF workers who oversee financial eligibility and compliance with TANF rules, they develop Individual Responsibility Contracts (IRCs) and monitor progress, and they secure the special services required to assure that the family can attend treatment.

Workers may spend part of their week at the treatment site to meet with families or resolve problems with benefits. Because they learn how treatment programs operate, these specialized workers can collaborate with treatment staff to ensure that families are not confused or frustrated trying to meet conflicting requirements of treatment or TANF agencies.

Implications for Staff Development

When TANF agencies expect staff to talk with recipients about substance abuse problems, that expectation has implications for the kind of staff that are hired and the professional development support they receive. TANF agencies in Colorado have provided training for workers in many aspects of welfare reform. These efforts have been helpful, but they have often been limited in scope and have not always been accompanied by ongoing reinforcement outside a formal classroom setting.

Training agendas

Helping recipients disclose and address their substance abuse problems has implications for the kinds of initial and ongoing training workers receive. Training should cover topics such as how and why people become addicted, and how addiction affects peoples' ability to function. It should also include information regarding different kinds of treatment that are available, how treatment works, the role of relapse in recovery, and the ways that treatment improves employment outcomes. Workers will better understand these issues if they have an opportunity to visit a treatment program

and meet with women who have recovered from addiction. Much of this training could be provided by staff from a local treatment provider, and some could take place at a treatment program.

Workers who are asked to discuss addiction with families need time and support to think about and understand their own values about poverty, addiction, dependence and the role of the public sector in addressing these problems. Workers are uncomfortable talking with recipients about substance use for a variety of reasons, some of which have to do with their own confused or unresolved feelings about addiction. As noted earlier, few people in our society are immune from the effects of alcohol or other drug abuse, and staff experiences with addiction will shade how they approach the subject with families. This type of training will rarely change peoples' personal beliefs or values, but it will clarify them, and then workers can be helped to separate their personal beliefs from the way they relate to clients.

These topics have rarely been featured as essential elements of worker training or staff development programs but they should be incorporated into all new-worker training programs for TANF staff.

Training approaches should model the behaviors that agencies expect from staff: collaboration, problem solving, negotiation, and judgment. Therefore, at least some of the training TANF workers receive should involve workers from both TANF and substance abuse treatment agencies, and should be conducted by trainers from both agencies. Training should include practical opportunities for TANF and treatment workers to discover their mutual interests and learn to respect their differences. It should allow time to work through practical problems that are likely to come up on the job. Topics that are especially relevant for joint training include how to share information (confidentiality) and implications of substance abuse on child protective services.

Multi-disciplinary teams

One way to address staff capacity is through the use of multi-disciplinary teams and case conferences (these are also called "staffings"). In these situations, a team of workers, generally including an eligibility worker, a case manager (or whoever is responsible for the IRC), and substance abuse counselor share responsibility for working with recipients. These teams meet periodically (ideally, including the families as well) to develop and monitor case plans and progress. Denver, El Paso, and Weld Counties, employ some form of multi-disciplinary teams and case conferences.

These arrangements are not easy to establish, but they can yield important benefits for both staff and recipients. Collectively, the teams have a lot of expertise, and each member can contribute based on his or her area of expertise. Team members end up learning about each other's services and rules, so that they are less likely to give out confusing or incorrect information to families. Workers also gain a broader understanding of each family, and are better able to match TANF services to recipient needs. Recipients benefit from working with staff who have expertise and who communicate with each other to coordinate and improve services.

Supervision

Agencies that encourage recipients to talk about substance abuse problems also have to consider the nature and style of supervision workers receive. TANF supervisors face the same challenges faced by workers in implementing welfare reform, and they are expected to guide the workers through relatively uncharted territory. As indicated by the points raised in this guidebook, welfare reform requires TANF workers to collaborate with people who come from backgrounds that differ from their own, and who work in agencies with priorities that differ from TANF priorities. Supervisors have to set the tone for workers by modeling collaborative and productive relationships with colleagues. TANF supervisors can start by inviting colleagues from other agencies to staff meetings or "brown bag" lunches or by holding TANF staff meetings at another agency.

Supervisors also must ensure that staff know how to and actually do translate lessons from training to changed behaviors on the job. Training alone may be adequate to inform TANF workers about new eligibility rules, but it is not adequate to make them skilled team members or comfortable discussing personal problems with recipients. In some ways, guiding TANF worker performance is harder than it used to be, when the tasks were more routine and the outcomes more quantifiable (number of case actions completed, timeliness, etc.) than they are now. Supervisors should check with staff to determine whether they are discussing substance abuse problems with recipients, how they feel about these discussions, and whether they need more support. At least some staff meetings should include agenda items that cover follow-up to prior training and feedback from on-the-job practice of training concepts.

Implications for Services

Most decisions about locating and funding substance treatment programs fall outside the jurisdiction of TANF officials. Therefore, even when TANF administrators design agency structures and professional development systems that create environments conducive to discussions about substance abuse, they may find it hard to assure that their communities offer appropriate substance abuse treatment services. However, if treatment is not available or if women have to choose between entering treatment or retaining their children, it is not likely that TANF workers will ask recipients about substance abuse problems and it is not likely that recipients will be forthcoming about them. In fact, it may not be appropriate for administrators to expect those discussions to take place.

There is a simple way for Colorado county TANF administrators to learn about available treatment services. Log on to *www.cdhs.state.co.us*. Then click on "Adult Services" and then on "Alcohol and Drug Abuse", and then on "Treatment Directory." From there, it is easy to locate ADAD-approved substance abuse treatment programs based on name of city, judicial district, or type of program (residential, outpatient, etc.) ADAD also licenses providers for specialized services for women; this is a good place to start looking for substance abuse treatment programs. In addition, ADAD has assigned Treatment Field Managers to oversee ADAD-approved treatment programs.

To learn about which treatment programs receive public funding or will accept TANF families, call the managed service organization (MSO) for your region. Funding for substance abuse treatment In Colorado is very limited. According to a study conducted by the North Charles Research Group at Harvard University and reported in a 2001 ADAD report to the Colorado General Assembly (the "HEWI" report), Colorado ranks second in severity nationwide on the overall substance abuse problem index. However, another study, conducted by The National Center on Addiction and Substance Abuse (CASA) at Columbia University, found that Colorado ranked last in the nation in prevention, treatment and research. For every $100 Colorado spent on cleaning up the damage caused by substance, the state spent only six cents on prevention, treatment, and research, compared to $3.70 that other states spent on these aspects of the problem.

Email Karen Mooney, ADAD's Coordinator of Women's Treatment Services at Karen.mooney@state.co.us regarding specialized services for women, and to learn the name of the Field Manager for your area.

TANF funds can be used to pay for substance abuse treatment services that are not medical, and many states have used TANF funds in this way. Some Colorado counties, including Denver, Adams, Arapahoe, and Douglas Counties have used TANF funds to purchase "slots" in residential treatment programs, and, as noted earlier, others have used Colorado Works funds to pay for assessments, evaluation, and outpatient services. These arrangements assure that TANF families can get treatment as soon as they are ready. It also makes workers more comfortable discussing substance abuse with recipients, because they know they can offer help if recipients ask for it.

Steps to Take

Substance abuse is only one of the many challenges TANF staff confront every day. Given all of the challenges related to substance abuse among TANF families, it is easy to feel overwhelmed and conclude that this is a topic beyond the scope and capacity of a TANF agency. But, there are practical steps that can help administrators decide what is feasible within the context of their overall responsibilities. In addition, while the principles presented in this guidebook are targeted towards substance abuse, most are likely to be useful in other situations in which families have complex barriers to work.

What follows is a series of more or less sequential steps that TANF administrators can take in determining which strategies will work best for their clients and their staff. Colorado counties are quite different, and a strategy that makes sense in one place will not necessarily work so well in another.

Baseline Quiz

Before jumping into action, it is helpful to find your starting point. To do that, first, read this guidebook. Second, find the answers to the following simple questions. These can help focus your thinking about alternatives.

Can I name the 3 substance abuse treatment programs closest to my office?

Can I name the ADAD Field Manager who serves my area?

Is there anyone on my staff who is a certified addictions counselor or who has worked in substance abuse treatment programs?

How serious a problem is substance abuse among TANF families in my county and what information do I have about the prevalence?

How well do my workers know the families on their caseload? (Do they see families with enough frequency to know something about their lives)

Is the physical set-up of my office such that I can show videos to families who are waiting to see their workers?

Do I or could I display brochures about other agencies or programs in my county?

Is there any way I could find space to accommodate someone from another agency; or do I have the capacity to outpost a TANF worker on-site at another agency, either full or part-time?

Action Steps

After getting information from the Baseline Quiz, here are action steps to deciding upon and implementing a strategy. If you are located near a university, consider seeking a college student who could coordinate this initiative as a field placement. It would be an exciting and important project.

1. Check out the substance abuse treatment programs---
   - Log onto the ADAD Web site (instructions are described above).
   - Call the Field Manager and inquire about the programs you locate.
   - Look for programs that are licensed to provide specialized women's services.

2. Call the treatment program and arrange for a visit
   - Tour the program and ask to meet with clients as well as staff.
   - Bring some TANF staff with you.
   - Invite the treatment agency to visit your office and/or offer to do a TANF briefing for treatment staff.

3. *During these visits, discuss areas for potential collaboration.*
   Treatment programs will be interested in
   - Knowing what kinds of child care, transportation and other tangible
   - services that TANF can fund.

- Learning about eligibility rules that affect their clients, and how treatment. programs can communicate effectively with clients' TANF workers.

TANF agencies will be interested in

- Knowing how to make referrals to the treatment program.
- Learning about options to pay for the treatment.
- Finding out whether there is a waiting list.
- Knowing about arrangements for children while mothers are in treatment.

4. Don't try to figure everything out by yourself. Model the strength-based and empowering approaches you ask your workers to use with TANF families. Therefore, convene an office Work Group to develop one or more recommendations for better identifying and serving TANF families with substance abuse problems, <u>but:</u>
   - Set parameters for the Work Group, especially in areas such as whether additional resources are available, whether you want both short-term incremental ideas and long-term changes.
   - Tell members to read this guidebook and consider the recommendations included in it.
   - Ask for some ideas that can be implemented without large commitments of time or resources. This will assure that the Work Group focuses on what can be done rather than only on what would be great in an ideal world. Give a reasonable but relatively short deadline for the report.
   - Chair the task force yourself or nominate someone who commands respect of staff and who has credibility with them.
   - Assure that the membership reflects all affected areas of the office (clerical, professional, civil service union or association representatives).
   - Invite one or more substance abuse treatment programs to participate.

5. Talk to your staff
   - Identify staff who have experience or interest in working with substance abuse.
   - Review the screening forms in this guidebook with staff and determine with which ones they feel most comfortable.
   - Discuss with them where in the case process screening should take place—at initial interview, during development of the IRC, at orientations, etc.
   - Develop a TANF worker needs assessment that identifies the kind of training, information, forms, and procedures that workers are interested in having.

6. Talk to families about factors that would make them comfortable in discussing substance abuse
   - Prepare a short, anonymous, written survey for clients to complete.
   - Conduct two focus groups with clients (these could be short additions to the Orientations).

- Draw from your emerging relationship with substance abuse treatment. providers, and ask if the treatment program would allow you to speak with families in treatment.

7. As you begin to narrow your options, talk to counterparts in other counties that are using approaches similar to the ones that are of most interest to you
   - Review the Chart of Screening Instruments in this guidebook. It includes information about counties that are using each form.

8. Log onto the Web sites of the organizations listed in the Resource List(See Appendix E)
   - Many feature information about co-location, multi-disciplinary teams and other options that you will be considering.
   - Find out what screening instruments other states are using.

9. Get a formal written report from the Work Group and accept as many of the recommendations as you can (we have all been demoralized by preparing recommendations that no one acts on)
   - Keep the momentum of the Work Group by respecting and responding to its ideas wherever possible.
   - Create an implementation plan that starts quickly with items that are feasible, and that follows a schedule that includes longer-range options.
   - Refer to relevant sections of this guidebook for help in implementing recommendations.

10. Be as bold and creative as you can in testing new ideas
    - Try something as a pilot test if it seems too daunting to implement in full.
    - Ask for and accept volunteers for new assignments where possible.
    - Continue the Work Group to monitor implementation.
    - Keep track of what is happening and make changes as necessary.

11. Celebrate and share your successes!

Pitfalls to Avoid

State and county TANF agencies have learned a lot since 1996. Many have been bold and creative in trying new ideas and in making adjustments as they understood more about what works and what doesn't. Following are five insights based on early efforts that didn't work as well as anticipated.

<u>Insight 1: Screening instruments will not yield the results you need.</u>

Much of the work of TANF agencies is based on using structured interviews that involve completing forms. When welfare reform first started, therefore, many agencies followed established practices for policy changes and added new forms—for substance abuse, domestic violence, mental health, and learning disabilities. In most places, however, little substance abuse was identified through this mechanism.

State and county officials have come to realize that disclosing substance abuse is a personal matter, and that no one approach will work for all recipients. It would be wonderful to find there is a magic solution, but we have learned enough to know that there is no such solution. TANF officials have not abandoned screening forms, but now understand those forms to be just one of several strategies that they employ.

Insight 2: Don't assume that TANF workers will unearth most of the substance abuse problems

States started implementing welfare reform by training TANF workers, changing TANF rules, and introducing substance abuse screening instruments such as the ones presented in this guidebook. All of these activities are necessary, but they are limited in that they place virtually the entire burden on TANF workers.

Even in ideal situations, when TANF workers are effective interviewers and have time to talk about difficult personal problems with recipients, recipients fear negative consequences if they disclose substance abuse. And, often, situations are not ideal—TANF workers may not have enough time to open sensitive areas of discussion, they may not have private interviewing space where recipients can speak openly, or they are inexperienced workers, and still trying to learn the basic rules about welfare.

As TANF administrators have learned what they can reasonably expect from workers regarding helping recipients talk about substance abuse, they have added strategies along the lines suggested in this guidebook. But, in most jurisdictions TANF workers still have important roles to play in helping recipients disclose substance abuse.

Insight 3: Don't conduct training that is either only "feel good" or only "do it this way."

Training is often the first solution proposed to address problems within agencies, and it is usually an important element of implementing change. But, it is easy for TANF officials to embark on training solutions without understanding how the training should include both new concepts and new skills. When workers hear only concepts, it is easy for them to feel the training is not relevant. When they hear only skills and tasks, they are prone to completing forms by rote instead of using forms as guides to get at the kind of information they need.

For example, in preparing workers to discuss substance abuse with families, training should not be limited to teaching workers how to complete screening forms. Similarly, training should not be limited to general presentations about substance abuse that do not connect to expectations for workers on their jobs. Training has to include information about addiction and recovery, and it has to allow workers an opportunity to think about and understand their personal beliefs about addiction. Then, the training should provide concrete information, examples, and practice opportunities to help workers understand how addiction affects behavior and may cloud client responses to worker questions, and it should provide options for workers to use in posing questions that might yield more complete responses.

Insight 4: Don't start unless you can finish

Some jurisdictions in the country have developed innovative strategies to identify substance abuse among TANF recipients, only to find that there were long waiting lists before clients could be assessed, that there were no openings in treatment programs, or that there was not enough transportation or child care for women to enter treatment. It is unfair to ask TANF workers and recipients to discuss substance abuse if nothing can be done to address it. Workers will soon stop asking about substance abuse and recipients will soon stop disclosing it unless there are feasible options for treatment and other services required for recovery.

The list of Action Steps presented above suggests that TANF officials meet with treatment programs before implementing any changes in the way their offices approach substance abuse.

Insight 5: Don't assume that co-location will guarantee cooperation

Many states have used co-location to promote collaboration and service integration. When agencies have been able to work through their philosophical, logistical, and management differences, co-location has worked very well. However, co-location itself does not automatically create good relationships. Many TANF agencies underestimated the challenges involved in overcoming differences between agencies, and mistakenly assumed that so long as staff sit in the same office, the differences will work themselves out.

Managers express the following problems encountered in co-locating substance abuse treatment counselors on-site in TANF offices: conflicting goals for families (whether the emphasis is on recovery or work); wide differences in pay levels; competition for access to office supplies and equipment that are often in short supply; unwillingness to share information about families; refusal to share decision-making authority; different attendance requirements; and unclear supervisory chains of command. For example, in one jurisdiction, co-location was undermined because TANF workers were required to sign in each morning and substance abuse treatment workers were not.

Conflicts over logistical issues such as access to equipment or office space are problems in their own right, but they may also be proxies for more fundamental disagreements. Substance abuse treatment staff may feel that TANF rules and workers are rigid and insensitive to problems that women face; and TANF staff may feel that substance abuse treatment workers do not take work requirements seriously and that they inappropriately shield families from the realities of what is expected of them. TANF and substance abuse treatment managers alike need to be prepared to tackle these issues when they decide to co-locate staff.

Despite problems, however, over time it appears that more agencies have turned to co-location, suggesting that the benefits outweigh the challenges. The counties in Colorado who have co-located staff all reported that the arrangements were working well and were of great value in helping TANF staff achieve their goals.

Postscript

Working in welfare is one of the hardest jobs conceivable. It is also one of the most important jobs and one of the most rewarding. It is even harder to be a welfare recipient, and harder yet to be a welfare recipient struggling with substance abuse. It is easy to understand how staff become exhausted, emotionally drained, or burned out. It is also easy to understand why recipients become angry, hostile, despondent, or defeated.

Perhaps the best way to avoid these negative outcomes is to know the people you deal with, and learn what is important to them.

In conducting the focus group of TANF recipients at New Directions Arapahoe House, I asked them what they would like TANF agencies across Colorado to know about them, and I promised to share their answer.

They said:

> *All drug users are not bad moms and bad people. They are just people who have problems.*

Appendix A
People Interviewed and People Who Reviewed the Report

Phyllis Arrington
Department of Human Resources
Baltimore, MD

David Berns
Director
Department of Human Services
El Paso County, CO

Terri Carlson
Evaluation Specialist/Clinical Case Manager
Island Grove Treatment Center
Greeley, CO

Glenna Campagnaro
Work Program Consultant
Wyoming Department of Family Services
Cheyenne, WY

Daniel Chandler
Project Research Director
CalWORKS Project
California Institute for Mental Health
Sacramento, CA

Marykay Cook
Colorado Works
Workforce Development Section Manager
Colorado Department of Human Services
Denver, CO

Susan Diaz
Division Director
Department of Human Services
Grand Junction, CO

Mitzi Eckenroth
Supervisor, Assessment Unit
Colorado Works
Adams County DHS

Nancy Fjeldheim
Acting Operations Section Manager
Social Caseworker Supervisor
Department of Human Services
Denver, CO

Steven Harrison
Research Chemist
Longmont, CO

Jeanette Hercik
Managing Associate
Caliber Associates
Fairfax, VA

Norman Hoffman
President
Evince Instruments, Inc.
Smithfield, RI

Krisanne Johnson
On Site Counselor
Denver TANF Program
Denver, CO

Levetta Love
TANF Manager
Department of Human Services
El Paso County, CO

Kevin Loveland
Director of Family Assistance Programs
Connecticut Department of Social Services
Hartford, CT

Robin Lyles
Coordinator of Special Programs
MD Alcohol and Drug Abuse Administration
Baltimore, MD

A. Thomas McLellan
Founder and Director
Treatment Research Institute
Philadelphia, PA

Marilyn Mestas
Senior Case Manager
Department of Human Services
Grand Junction, CO

Karen Mooney
Women's Treatment Coordinator
Alcohol and Drug Abuse Division
Department of Human Services
Denver, CO

E. Ann Moore
Chief Operating Officer
Arapahoe House
Thornton, CO

Jon Morgenstern, Vice President
Treatment & Evaluation Research
The National Center on Addiction and
Substance Abuse at Columbia University
New York, NY

Mary Price
Former President and CEO
Marriott Employees Federal Credit Union
Boulder, CO

Safa Sulemain
Women's Treatment Coordinator
Substance Abuse Division
Wyoming Department of Health
Cheyenne, WY

Dan Thomas
Delta County Department of Health and
Human Services
Colorado Works Program Manager
Delta, CO

Cynthia Urenda
Branch Manager
Adams County Department of Human Services
Commerce City, CO

Frederick Wolf
Deputy Director
Adams County Department of Social Services
Brighton, CO

Helen Wolstenholme
Women's Treatment Coordinator
Division of MH, DD, SA
Substance Abuse Services Section
Department of Health and Human Services
Raleigh-Durham, NC

Janet Wood
Director
Alcohol and Drug Abuse Division
Colorado Department of Human Services
Denver, CO

Ramona Yarnell
Income Maintenance Technician Manager II
Weld County Department of Social Services
Greeley, CO

Danelle Young
Manager
Office of Self-Sufficiency
Colorado Department of Human Services
Denver, CO

Appendix B
Screening Instruments

Following are copies of screening instruments mentioned in this guidebook. These are for information only. Before using any of these instruments, it is essential that you obtain information regarding how to score and interpret them. That information includes guidelines for using the instruments and information regarding cut-off levels where responses indicate there is a drug or alcohol problem. It will also describe settings in which the instrument has been tested and used.

Some of these instruments are available in Spanish as well as in English.

Only one study has tested short screening instruments in welfare offices, with welfare recipients (California Institute of Mental Health). That study recommended that TWEAK for alcohol usage, but the researchers urged caution in interpreting results because the instruments were administered by researchers and not by TANF staff, and that they were tested in only two counties within California.

THE ADULT SUBSTANCE USE SURVEY (ASUS)

The ASUS is a differential screening instrument designed to screen for an individual's perceived alcohol and drug use and abuse, mental health concerns, motivation for treatment, antisocial attitudes and behaviors, and level of defensiveness. It is often used with the Self-Appraisal Survey (SAS). The ASUS includes 64 questions and takes about 10 minutes to administer. Training is required. Training and a Users Guide are both available from the ASUS developer. The ASUS is free for use in Colorado, but permission is required.

The ASUS is widely used in Colorado for families involved with child protective services.

Kenneth Wanberg, PhD
Center for Addiction Research and Evaluation, Inc.
5460 Ward Road, Suite 140, Arvada, CO 80002
303-421-1261

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Circle the number that comes closest to the patient's answer. In determining the response categories it is assumed that one "drink" contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25% from 10 g, the response category should be modified accordingly.

1. How often do you have a drink containing alcohol?

Never	(0)
Monthly	(1)
2-4 times a month	(2)
2-3 times a week	(3)
4 or more times a week	(4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

One	(0)
Two	(1)
Three or Four	(2)
Five or Six	(3)
Seven to Nine	(4)
Ten or More	(5)

3. How often do you have six or more drinks on one occasion?

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

5. How often during the last year have you failed to do what was normally expected from you because of drinking:

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

AUDIT (continued)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	(0)
Less than Monthly	(1)
Monthly	(2)
Weekly	(3)
Daily or almost daily	(4)

9. Have you or someone else been injured as a result of your drinking?

No	(0)
Yes, but not in the last year	(1)
Yes, during the last year	(2)

10. Has a relative or friend or a doctor or other health worker, been concerned about your drinking?

No	(0)
Yes, but not in the last year	(1)
Yes, during the last year	(2)

THE CAGE QUESTIONNAIRE

1. Have you ever felt you should **C**ut down on your drinking?

2. Have people ever **A**nnoyed you by criticizing your drinking?

3. Have you ever felt bad or **G**uilty about your drinking?

4. Have you ever had a drink first thing in the morning to steady your nerves to get rid of a hangover ? (**E**ye opener)

THE CAGE AID QUESTIONNAIRE

1. Do you now or have you ever used drugs or alcohol?

2. Have you ever felt you should cut down on your drinking or drug use?

3. Have people annoyed you by criticizing your drinking or drug use?

4. Have you ever felt bad or guilty about your drinking or drug use?

5. Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover (an "eye opener")?

6. Do you use any drugs other than those prescribed by a physician?

7. Has a physician ever told you to cut down or quit use of alcohol or drugs?

8. Has your drinking/drug use caused family, job or legal problems?

9. When drinking or using drugs, have you ever had a memory loss (blackout)?

THE DRUG-CAGE

Sometimes people may not be sure if they need help with their drug use or not. Your honest answers to the following questions can help you decide whether you need to talk with someone about your drug use.

1. In the last 12 months have you felt you should cut down on your drug use? (Please circle yes or no.) YES NO

2. In the last 12 months have people annoyed you by criticizing your drug use? (Please circle yes or no.)

   YES NO

3. In the last 12 months have you felt bad or guilty about your drug use? (Please circle yes or no.)

   YES NO

4. Sometimes people feel bad when a drug wears off. Did that ever happen to you in the past year? (Please circle yes or no.)

   NO Stop here and figure out your score.

   YES Answer 4.a. below

   If "yes," 4a. Did you ever take another drug when that happened? (Please circle yes or no.)

   YES

   NO

DRUG ABUSE SCREENING TEST (DAST-10)

The DAST-10 is a 10 item questionnaire designed to assess the use of drugs, not including alcohol, in the 12 months preceding administration of the questionnaire. Questions refer to the use of over-the-counter drugs in excess of the directions, and any non-medical use of drugs. Each "yes" response is given a score of 1. Zero points indicates no drug problems, 1-2 points indicates the need to monitor the client and reassess at a later date, 3-5 points merits further investigation into the client's use of drugs, and 6-8 points requires further intense assessment.

These questions refer to the past 12 months.

	Circle Your Response
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Do you abuse more than one drug at a time?	Yes No
3. Are you always able to stop using drugs when you want to?	Yes No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes No
5. Do you ever feel bad or guilty about your drug use?	Yes No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
7. Have you neglected your family because of your use of drugs?	Ye s No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes No

Score: _____

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

Three points or less is considered non-alcoholic, four points is suggestive of alcoholism and five points or more indicates alcoholism

1. Do you feel you are a normal drinker?	Y/N	2 pts
2. Have you ever awakened the morning after some drinking & found you could not remember part of the evening before?	Y/N	2 pts
3. Does your wife, husband, parents, or partner ever worry or complain about your drinking?	Y/N	1 pt
4. Can you stop drinking without a struggle after one or two drinks?	Y/N	2 pts
5. Do you ever feel bad about your drinking?	Y/N	1 pt
6. Do friend or relatives think you are a normal drinker?	Y/N	2 pts
7. Do you ever try to limit your drinking to certain times of the day or to certain places?	Y/N	0 pts
8. Are you always able to stop drinking when you want to?	Y/N	2 pts
9. Have you ever attended a meeting of AA?	Y/N	5pts
10. Have you gotten into fights when drinking?	Y/N	1 pt
11. Has drinking ever created problems between you & your spouse/partner?	Y/N	2 pts
12. Has your spouse, partner or family members ever gone to anyone for help about your drinking?	Y/N	2 pts
13. Have you ever lost friends, girlfriends or boyfriends because of your drinking?	Y/N	2 pts
14. Have you ever gotten into trouble at work because of drinking?	Y/N	2 pts
15. Have you ever lost a job because of drinking?	Y/N	1 pt
16. Have you ever neglected your obligations, family or work for 2 or more days in a row because you were drinking?	Y/N	2 pts
17. Do you ever drink before noon?	Y/N	1 pt
18. Have you ever been told you have liver trouble?	Y/N	2 pts
19. Have you ever had delirium tremors, severe shaking, heard voices, or seen things that weren't really there after heavy drinking?	Y/N	2 pts
20. Have you ever gone to anyone for help about your drinking?	Y/N	5 pts
21. Have you ever been hospitalized because of your drinking?	Y/N	5 pts
22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward or a general hospital where drinking was part of the problem?	Y/N	2 pts

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

(continued)

23. Have you ever been seen at a mental health clinic or gone to a doctor, social worker, or clergyman for help with emotional problems in which drinking has played a part?	Y/N	2 pts
24. Have you ever been arrested, even for a few hours, because of drunk behavior?	Y/N	2 pts
25. Have you ever been arrested for drunk driving or driving after drinking?	Y/N	2 pts

SELF-APPRAISAL SURVEY (SAS)

The SAS was designed to screen for alcohol and chemical dependency and to determine both the extent of use and the effects of use on several aspects of life. It includes 24 questions that are self-administered by recipients, and 12 additional items for caseworkers to complete, based on their observations and other information.

The SAS is often used in advance of the Adult Substance Use Survey (ASUS) and it is widely used in Colorado for families involved with child protective services.

Kenneth Wanberg, PhD
Center for Addiction Research and Evaluation, Inc.
5460 Ward Road, Suite 140
Arvada, CO 80002
303-421-1261

SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY (SASSI)

The SASSI cannot be included here because it is copyrighted.

The SASSI is an 88 item, one-page questionnaire designed to screen for chemical dependency. It is targeted for use with both adolescents and adults. Scoring results in classification of individuals as either chemically dependent or non-chemically dependent. The SASSI is resistant to efforts at faking and/or trying to conceal chemical dependency problems. It has eight subscales that can be used to assess defensiveness and other chemical dependency characteristics. While the administration of the SASSI requires training, the questionnaire can be self-administered via computer or pencil and paper, and takes approximately 10 to 15 minutes to complete.

For information on training:

SASSI Training Office, 800-697-2774, or www.sassi.com

For more information on the SASSI:

The SASSI Institute
201 Camelot Lane
Springville, IN 47462
800-726-0526

Copyright 1985 by Glenn Miller.

THE TRIAGE ASSSESSMENT FOR ADDICTIVE DISORDERS (TAAD)

The TAAD cannot be included here because it is copyrighted.

The TAAD is a very brief, structured interview covering current alcohol and drug problems related to the DSM-IV criteria for abuse and dependence. As a triage interview it provides more definitive findings than a screen. The TAAD identifies obvious cases and provides substantial support for the diagnosis. In cases where a diagnosis is not indicated, the TAAD provides documentation of negative responses to some of the more prevalent abuse and dependence symptoms. For the remaining cases, where only a few problems are indicated, a comprehensive assessment will be required to make a definitive determination.

The TAAD is intended to be presented as an interview and not as a pencil-and-paper instrument. The instrument can be administered by any staff person with good interviewing skills, but interpretation is reserved for qualified licensed professionals.

Administering the TAAD will typically take no more than 10 minutes. Scoring will take 2 to 3 minutes.

Photocopying or adapting the TAAD is illegal. When first purchased, the TAAD comes with a manual and interview forms. Additional interview forms must be purchased as needed. TAAD is also available by site license arrangement for large volume users. Site licenses provide a substantial discount. Please call for additional information.

Norman Hoffman, PhD
Evince Clinical Assessments
PO Box 17305
Smithfield, RI 02917
Tel: 800-755-6299, 401-231-2993

THE TWEAK

1.	**T**olerance:	How many drinks can you hold?
2.	**W**orried:	Have close friends or relatives worried or complained about your drinking in the past year?
3.	**E**ye-openers:	Do you sometimes take a drink in the morning when you first get up?
4.	**A**mnesia(blackouts):	Has a friend or family member ever told you about things you said or did while your were drinking that you could not remember?
5.	**K**(cut down):	Do you sometimes feel the need to cut down on your drinking?

THE UNCOPE

Variations in wording are given for some of the items.

U In the past year, have you ever drank or **Used** drugs more than you meant to? (Or, Have you spent more time drinking or using than you intended to?)

N Have you ever **Neglected** some of your usual responsibilities because of using alcohol or drugs?

C Have you felt you wanted or needed to **Cut Down** on your drinking or drug use in the last year?

O Has anyone **Objected** to your drinking or drug use?

P Have you ever found yourself **Preoccupied** with wanting to use alcohol or drugs?

E Have you ever used alcohol or drugs to relieve **Emotional discomfort**, such as sadness, anger, or boredom?

Appendix C
Observational Checklists and Case Record Indicators

For information regarding the New York State video, training curricula, observational checklist or case record indicator forms:

Frances Shannon Akstull
New York State Office of Temporary and Disability Assistance
Bureau of Transitional Programs
40 North Pearl Street
Albany, NY 12243
518-402-3219

For information regarding the North Carolina Behavioral Indicator Checklist:

Helen Wolstenholme
Women's Treatment Coordinator
Division of MH, DD, SA
Substance Abuse Services Section
Department of Health and Human Services
325 N. Salisbury Street, Suite 1168
Raleigh, NC 27603
919-733-4671

New York State Behavioral Checklist

If one or more items is checked, refer for assessment:

_____ Appears intoxicated
_____ Alcohol on breath or body odor
_____ Drowsy appearance or nodding out, fatigue
_____ Impairment in attention or memory
_____ Lack of coordination, unsteady gait (staggering, off balance)
_____ Needle marks
_____ Unclear speech (slurred, incoherent, rapid)
_____ Runny nose, but not a cold
_____ Jittery, nervous, tremors (shaking and twitching hands and eyelids)
_____ Agitated, belligerent, argumentative
_____ Hyperactive, continuous talking or movement
_____ Visible abscesses
_____ Constricted or dilated pupils, glassy eyes

(Note: this is taken from the actual checklist, which appears as one of three sections on the NY state substance abuse screening form).

North Carolina

Behavioral Observation Checklist II

This form may be completed if there is reasonable suspicion that substance abuse issues may be present. When there is an observation of actions, appearance or conduct that may be associated with substance abuse issues refer the Work First client to a Qualified Substance Abuse Professional (WF/QSAP) for further assessment and/or referral.

Name of Client: _____
Name of Observer: _____ Date Observed: _____
Location: _____ Time of Observation: _____ a.m./p.m.

Check all appropriate items. Behavioral indicators require only one check for referral to a WF/QSAP.

APPEARANCE/PHYSICAL SYMPTOMS:
_____ odor of alcoholic beverage on breath
_____ extremely poor hygiene
_____ constricted pupils (pinpoint)
_____ dilated pupils (enlarged)
_____ glazed or glassy eyes
_____ stumbling/staggering
_____ body odor of alcoholic beverage
_____ lethargic/slow movement
_____ swaying gait

HISTORY OF SUBSTANCE ABUSE RELATED PROBLEMS:
_____ pending DWI court case or drug court case
_____ loss of license for DWI
_____ drug or alcohol arrest or conviction
_____history of/or current substance abuse treatment involvement
_____ reports from employer, probation/parole of positive drug screen/breathalyzer
_____ positive AUDIT or DAST and non-compliance with referral to QSAP
_____ prior SUDDS IV diagnosis and non-compliance with treatment recommendations

SPEECH:
_____ slurred speech
_____ rapid/accelerated speech
_____ incoherent speech

CONDUCT/BEHAVIOR:
_____failure to report for job interview (2 or more)
_____repeated missed scheduled appointments
_____loss of inhibitions with no apparent reason (i.e., yelling, screaming, cursing, assaultive)

If known, how is the Work First client's behavior different from that previously observed? Be specific and describe any other observations about behaviors or actions not listed above:

To the best of my knowledge, this report represents the appearance, behavior and/or conduct of the above named Work First client, observed by me and upon which I base my decision to refer the person to the WF/QSAP for further assessment and/or referral.

_____ Date: _____
Signature of Observer
To be completed by WF/QSAP:
Was SUDDS IV completed? Yes _____ No _____
Was Work First client referred to SA treatment? Yes _____ No _____
WF/QSAP Signature _____ Date: _____

NEW YORK STATE CASE RECORD INDICATORS OF SUBSTANCE ABUSE POTENTIAL

Case Record Indicators (if 2 or more boxes are checked, refer for assessment)

_____*Homeless*
_____Active child welfare case
_____On temporary assistance 48 months or more
_____Active employment sanction
_____On temporary assistance more than once in the past two (2) years

Information in case history (DWI, failing work assignment):

Other:

Other:

(note this is taken from a three-part NY State substance abuse screening instrument that include the CAGE-AID, the Observational Checklist, and this Case Record Indicator List)

Appendix D
New York State One Day Substance Abuse Awareness and Values Training Curriculum

This is a one-day training session covering basic information about substance abuse and addiction, exploring beliefs about addiction, and how to use the new screening tool.

New York State
Rockefeller College, University at Albany
Professional Development Program

In collaboration with
NYS Office of Temporary and Disability Assistance
Office of Transitional Supports and Policy
NYS Office of Alcoholism and Substance Abuse Services

Unit 1
Overview of Substance Related Disorders

Importance Substance related disorders pose a significant obstacle to your client's abilities to achieve financial self-sufficiency by getting and keeping a job.

This overview unit is designed to:

- Raise your level of awareness about the effects of substance related disorders on the individual and the family, especially on women who are single parents in the TANF population.
- Provide you information about the stages of abuse, dependence and recovery in order to help you understand the breadth and depth of the problem
- Show you the benefits of early identification and treatment not only for yourself but also for the community at large.

Overview This unit consists of four lessons:

- Introduction to Alcohol and Drug Abuse Identification Training
- Understanding Substance Abuse and Dependence
- Effects of Substance Abuse on the Family
- Recovery, Relapse, and Treatment

Objectives By the end of this unit, you will be able to:

- Recognize the breadth and depth of issues related to substance abuse and substance dependence as it relates to clients achieving self-sufficiency.
- Describe the disease model of addiction.
- Recognize behavioral and physiological signs of substance abuse and substance dependence.

- Define recovery and relapse.
- Recognize the continuum of treatment options for people who have substance related disorders.
- Have increased empathy for the problems faced by those in the TANF population who have substance related disorders.

Lessons & Topics Lessons and topics included in this unit can be referenced on the following pages in this manual:

Lesson 1: Introduction to Alcohol and Drug Abuse Identification Training

Quick Quiz
Welfare Reform and Substance Abuse
Substance Abuse Identification for the Welfare Population
Special Issues for Women
Substance Abuse Identification and Treatment Process
Activity: WIFU, What's in it for Us?

Lesson 2: Understanding Substance Abuse and Substance Dependence

Activity: Profile of an Addict
Substance Abuse Continuum
Activity: Determining the Level of Use
Disease Model of Addiction
Effects of Alcohol and Cocaine
Stages of Dependence
Progression of Alcohol Dependence
Progression of Cocaine Dependence
Behavioral and Physical Signs of Dependence
Defense Mechanisms and Substance Related Disorders
Activity: Defense Mechanisms

Lesson 3: Effects of Substance Abuse and Dependence on the Family

Substance Dependence as a Family Disease
Progression of the Family Dysfunction
Family Stories
Common Emotions in Families with Substance Abuse and Dependence
Activity: Rules of the Game
Family Roles
Effect of Substance Abuse and Dependence on Children
Children's Stories

Lesson 4: Recovery, Relapse, Treatment

Recovery
Relapse
Treatment Options
12 Step and Other Self-Help Options
Women's Recovery Issues
Case Study: A Woman's Story

Unit 2
Screening for Alcohol and Drug Abuse

Importance This unit will help you administer the screening tool more effectively.

The eligibility worker:

- Creates an atmosphere where clients feel comfortable enough to respond honestly to the questions.
- Sets the tone for how the client feels about a referral and possible treatment.
- Plays a critical role in helping clients and their families move along the road to recovery.

Overview This unit consists of two lessons:

- Analyzing Attitudes to Alcohol and Drug Abuse and Dependence
- Using the *Alcohol and Drug Abuse Screening Form*

Objectives By the end of this unit, you will:

- Develop awareness of your attitudes towards alcohol and drug abuse and dependence.
- Develop a strategy for managing your attitudes so you can work more effectively with clients who are alcohol and drug abusers.
- Demonstrate effective communication skills while asking the screening questions, including active listening, empathy, and effective questioning.
- Complete the screening and behavioral observation portions of the screening instrument.
- Make an effective referral for assessment.

Lessons & Topics Lessons and topics included in this unit can be referenced on the following pages in this manual:

Lesson 1: Analyzing Attitudes to Alcohol and Drug Dependence

Perception and Attitudes
Activity: Examining Attitudes Towards Substance Abuse
Common Feelings Towards Substance Abuse
Activity: A Worker's Story
Activity: Identifying the Sources of Your Attitudes
A Process for Managing Attitudes
Words of Wisdom on Attitude

Lesson 2: Using the Alcohol and Drug Addiction Screening Form

Eligibility Worker's Role in Screening for Substance Abuse
Purpose and Organization of the Form
Instructions for Completing the Form
Activity: Identifying Factors Affecting the Client Worker Interactions
Guidelines for Asking Questions
Activity: Working with the Questions
Guidelines for Making a Referral
Role Play: Administering the Screening Instrument

Appendix E
Resource Organizations

American Public Human Services Association (APHSA)
Suite 500 www.aphsa.org
810 First Street, NE
Washington, DC 20002-4267
202-682-0100
202-289-6555

California Institute for Mental Health
CalWORKS Project
2030 J Street
Sacramento, CA 95814-3120
916-556-3480 www.cimh.org

Center on Budget and Policy Priorities www.cbpp.org
820 First Street, NE
Suite 510
Washington, DC 20002
202-408-1080
202-408-1056 (fax)

Center for Law and Social Policy www.clasp.org
1616 P Street, NW
Suite 150
Washington, DC 20036
202-328-5140
202-328-5195 (fax)

Joint Center for Poverty Research www.ssw.umich.edu
University of Michigan
Poverty Research Training Center
School of Social Work
Ann Arbor, MI, 48109

Legal Action Center www.lac.org
236 Massachusetts Avenue, NE
Suite 505
Washington, DC 20002
202-544-5478
202-544-5712 (fax)
1-800-223-4044 (NY office)

National Association of State Alcohol and Drug Abuse Directors
808 17th Street, NW www.nasadad.org
Suite 410
Washington, DC 20006
202-293-0090

National Governors' Association Center for Best Practices
Hall of the States www.nga.org
444 North Capitol Street
Washington, DC, 20001-1512
202-624-5300

The National Center on Addiction and Substance Abuse at Columbia University
633 Third Avenue www.casacolumbia.org
19th floor
New York, NY 10017-6706
212-841-5200
212-986-2539

National Clearinghouse for Alcohol and Drug Information
1-800-729-6686

The National Partnership for Women and Families
1875 Connecticut Avenue NW www.nationalpartnership.org
Suite 710
Washington, DC 20009
202-986-2600
202-986-2539 (fax)

The Nelson A. Rockefeller Institute of Government www.rockinst.org
411 State Street
Albany, New York, 12203-1003
518-443-5522

Research Forum for Children, Families, and the New Federalism
154 Haven Avenue www.researchforum.org
New York, NY 10032
212-304-7111

U.S. Department of Health and Human Services www.acf.dhhs.gov

Administration for Children and Families
370 L'Enfant Promenade SW
Washington, DC 20447

U.S. Department of Health and Human Services www.aspe.hhs.gov/hsp/hspwelfare.htm
Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services www.samhsa.gov/csap/index.htm
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
301-443-0365

U.S. Department of Health and Human Services www.samhsa.gov/csat/csat.htm
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
301-443-5050

U.S. Department of Health and Human Services www.nida.nih.gov
National Institutes of Health
National Institute on Drug Abuse (NIDA)
6001 Executive Blvd.
Bethesda, MD 20892-9561
301-443-1724

U.S. Department of Health and Human Services www.niaaa.nih.gov
National Institutes of Health
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
6001 Executive Blvd.
Bethesda, MD 20892-9561

U.S. Department of Labor www.webwp@dol.gov
Working Partners for an Alcohol and Drug Free Workplace
200 Constitution Avenue, NW
Room S-2312
Washington, DC 20210
202-219-6001

U.S. General Accounting Office (GAO) www.gao.gov/index.html
441 G Street NW
Washington, DC, 20548

Welfare Information Network www.welfareinfo.org
1000 Vermont Avenue, NW
Suite 600
Washington, DC 20005
202-628-5790

Welfare Peer Technical Assistance Network www.calib.com
10530 Rosehaven Street, Suite 400
Fairfax, VA 22030
703-385-3200

Welfare to Work Partnership www.welfaretowork.org
1250 Connecticut Avenue, NW
Suite 610
Washington, DC 20036-2603
202-955-300
1-888-USA-Job-1

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