Substance Abuse–Challenges and Strategic Solutions

Final Report

Fargo, North Dakota
September 27–29, 2004

Welfare Peer Technical Assistance Network

SUBSTANCE ABUSE—CHALLENGES AND STRATEGIC SOLUTIONS

Final Report of Peer TA Activity

Conducted for the North Dakota Department of Human Services
Fargo, North Dakota
September 27–29, 2004

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This report describes the Administration for Children and Families Office of Family Assistance Welfare Peer Technical Assistance Network event that took place in Fargo, ND on September 27–29, 2004. The Agenda from the event is provided in Appendix A. Appendix B lists the event participants, and the Cass County Case Study is provided in Appendix C. The Action Planning Worksheet is presented in Appendix D, and Appendix E is the Evaluation Summary of the event.

The report is available for download at: http://peerta.acf.hhs.gov/taevents/chron.htm

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The Welfare Peer Technical Assistance (TA) Network is a federally funded initiative sponsored by the Administration for Children and Families Office of Family Assistance within the U.S. Department of Health and Human Services. The purpose of Welfare Peer TA is to provide peer-to-peer technical assistance to States, counties, and community-based organizations operating the Temporary Assistance to Needy Families (TANF) program. Welfare Peer TA facilitates the sharing of information between and among States and localities to establish linkages between organizations serving the needs of welfare recipients.

In response to a request for technical assistance from the State of North Dakota, Welfare Peer TA sponsored a statewide Roundtable event in Fargo, ND on September 27–29, 2004. Welfare Peer TA Roundtables are designed to bring together a cross-disciplinary group of professionals working in similar or complimentary disciplines in a workshop setting to foster peer-to-peer learning through interactive sessions. This particular event brought together teams of local representatives from the 8 service regions in North Dakota to address issues of substance abuse screening and identification and service integration. In addition to State staff, local regional representatives in attendance included TANF case managers, employment workers from the Jobs Services program, child welfare professionals, substance abuse staff, and mental health clinicians. The event included discussions on topics such as the impact of methamphetamine usage in rural North Dakota, substance abuse treatment and recovery, redefining treatment as a work experience, innovative ways to meet countable work requirements, the treatment/self-sufficiency continuum, and new approaches to client-focused services.

Outcomes observed by Roundtable participants included:

An improved ability of TANF workers to understand the impact of substance abuse

A clearer understanding of the impact of methamphetamine usage in rural areas

Creative strategies for operationalizing substance abuse treatment as a countable work activity

A renewed sense of the importance of customer-oriented service design and delivery

A comprehensive appreciation of the treatment/self-sufficiency continuum and the importance of system collaboration in serving customers involved with multiple service streams.

II. ROUNDTABLE BACKGROUND

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Since welfare reform passed in 1996, welfare offices nationwide have focused specific efforts on working with families that are difficult to move to self-sufficient employment, such as those presenting the multiple barriers of substance abuse, mental health issues, and/or disabilities.[1] Identification, assessment, and screening for these barriers at the time of intake as well as service integration among systems have helped TANF offices foster effective service delivery for their hard-to-serve caseloads. However, many factors hinder both identification and screening processes as well as service integration and collaboration. For example, clients with substance abuse issues may actively hide, or be unwilling to admit, their drug use for fear of the stigma associated with substance abuse, or involvement with the child welfare system. Further, systems change and service integration efforts are commonly stalled by differing mandates between agencies, conflicting philosophies, fixed habits, and attitudinal biases.

Substance abuse is recognized as one of the most prevalent barriers to employment among hard-to-serve TANF recipients. Research has indicated that substance abuse problems are more prevalent among welfare recipients as compared to the general population. For example, national estimates of TANF recipients with substance abuse issues range from 5 to 27 percent (and State and local estimates from 9 to 60 percent), compared to only 4 to 12 percent of the general non-welfare population.[2] Long-term TANF recipients are also found to be more likely to have substance abuse problems than short-term recipients.[3] In addition, substance abuse issues often exacerbate other sets of barriers to self-sufficiency for TANF customers such as low educational attainment, difficulty securing child care and transportation, poor work skills, and health issues.[4]

Both TANF and substance abuse treatment program administrators recognize that treatment in the absence of supplementary work activities does not fully meet the needs and work requirements of TANF clients facing substance abuse challenges.[5] In light of this recognition, many States are presently attempting to more effectively address the intricate processes of treatment, recovery, work, and self-sufficiency through innovative collaborations between agencies and a variety of integrated work/treatment models.[6]

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1 Hercik, J. & Jenkins, S. (2001). "Issue Brief: Co-Occurring Disorders." Fairfax, VA: Caliber Associates.

2 National Household Survey on Drug Abuse. (2000). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

3 Physician Leadership on National Drug Policy. (2001). Best Practice Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment.

4 Capitani, J., Hercik, J, & Kakuska, C. (2001). Pathways to Self-Sufficiency: Findings of the National Needs Assessment. Washington, DC: U.S. Department of Health and Human Services, Office of Family Assistance.

5 Kakuska, C. & Hercik, J. (2003). Addressing Treatment: Where We've Been. Fairfax, VA: Caliber Associates.

6 Ibid.

Specifically in North Dakota, methamphetamine (meth) use is making an increasingly prevalent emergence in the TANF caseload. According to the current State Attorney General, methamphetamines are the number one issue facing North Dakota law enforcement over the next four years. Meth use and production in North Dakota has exponentially grown in recent years from a total of 3 meth lab raids in 1995 to 297 lab raids in 2003. These statistics, combined with the reality that serious drug dependence is more common among TANF recipients than nonrecipients, underscores the concerns of meth use in rural North Dakota and its impacts on the TANF, JOBS, and child welfare systems.

The Welfare Peer TA Network has collaborated with TANF professionals in North Dakota to complete two different technical assistance interventions. First, in late 2003, TANF professionals from Cass County, North Dakota requested technical assistance from the Welfare Peer Technical Assistance Network regarding identification, screening, and assessment tools to assist local TANF caseworkers in devising strategies to assist substance-abusing customers find and maintain employment. Although the original TA request broadly addressed substance abuse screening in general, it also included specific concerns about methamphetamine use and identification among TANF clients in Cass County, North Dakota as well as concerns about systems change. This original TA request resulted from numerous factors, such as the need for better screening tools in rural areas, clients' unwillingness to divulge substance abuse for a variety of reasons, and the impact on children when there is methamphetamine and other substance abuse in the home.

To fulfill the scope of this TA Request from North Dakota, the Welfare Peer TA Network sponsored a site visit to Cass County, which was conducted from October 13-15, 2003. The site visit included a needs assessment, an analysis of current protocols, and recommendations for improvement. The full report from this site visit is made available on the Welfare Peer TA Web Site at: http://peerta.acf.hhs.gov/pdf/north_dakota_full.pdf

Building on the first technical assistance intervention, the State of North Dakota then made a follow-up request to the Welfare Peer Technical Assistance Network for a statewide technical assistance event. Specifically, this event addressed the topics of: service integration, substance abuse diagnosis and treatment, defining work activities for TANF clients with substance abuse issues, the effects of addiction (e.g., addiction to methamphetamines) on children, how to work with clients with co-occurring mental health and substance abuse concerns, and how to incorporate a family-focus into treatment.

III. ROUNDTABLE SESSIONS

III. ROUNDTABLE SESSIONS

The Welfare Peer TA Roundtable event entitled "Substance Abuse – Challenges and Strategic Solutions" took place in Fargo, North Dakota and was comprised of two intensive full days of workshop sessions, interactive discussions, breakout groups, and presentations. The North Dakota Department of Human Resources hosted the event. The following sections of this report summarize the content of the various event sessions.

1. WELCOME AND INTRODUCTIONS

During this brief introductory session, speakers welcomed the Roundtable participants and offered their initial thoughts on the purpose, goals, and anticipated outcomes of the event. Thomas Sullivan, the Regional Administrator for ACF Region VIII, discussed the unique service needs and challenges of rural States such as North Dakota and the critical importance of finding solutions to address substance abuse in our society.

Mr. Sullivan emphasized that despite the barriers of providing services to a widely dispersed population living in rural areas, Region VIII has a strong history of providing high-quality services. John Hougen, the TANF Administrator of the North Dakota Department of Human Services, gave credit to the individuals operating a successful pilot program in Cass County, ND for providing the impetus for this statewide event. He also reiterated that because resources in North Dakota are relatively scarce, TANF, JOBS, Human Services Centers, and child welfare staff need to devise strategies for service integration to maximize what resources are available. Kathy Hogan, the Director of Cass County Social Services, spoke briefly and warned against the dangers of falling into "service silos." She pledged to continue to work to break the silos to truly make a difference in how clients are treated. Finally, John Horejsi, the Federal Project Officer for the Welfare Peer TA Network provided a summary of the role and function of Welfare Peer TA and introduced the Roundtable's overall facilitator and Project Director Dr. Rivera.

During the introductions, the following themes emerged with respect to anticipated outcomes:

Recognizing symptoms of substance abuse in TANF clients during intake

Designing/accessing more effective tools and strategies for working with substance abusing clients

Determining how to address the confidentiality issues inherent in working with this population

Identifying more available resources in the community

Creating treatment plans, safety plans, and employment plans

Understanding the physical and psychological consequences of addiction

Helping substance abusing TANF clients find and maintain employment

Working with the children of addicted parents

Learning better ways to collaborate with other service agencies

Learning more about the "meth" epidemic and the unique impacts of this drug

Handling security issues for staff working with substance abusing clients.

2. SETTING THE CONTEXT

Dr. José Rivera, Project Director for the Welfare Peer TA Network and a national expert in welfare reform, opened the program by helping the audience to see the "big picture" related to substance abuse, TANF, child welfare and workforce development. The session outlined a broad framework of ideas and concepts relating to substance abuse, such as general notions of addiction, treatment, recovery, and the systems serving substance abusers. Three expert speakers offered their own big picture issues, which were designed to provide overarching considerations related to service delivery, systems change, collaboration, and policy.

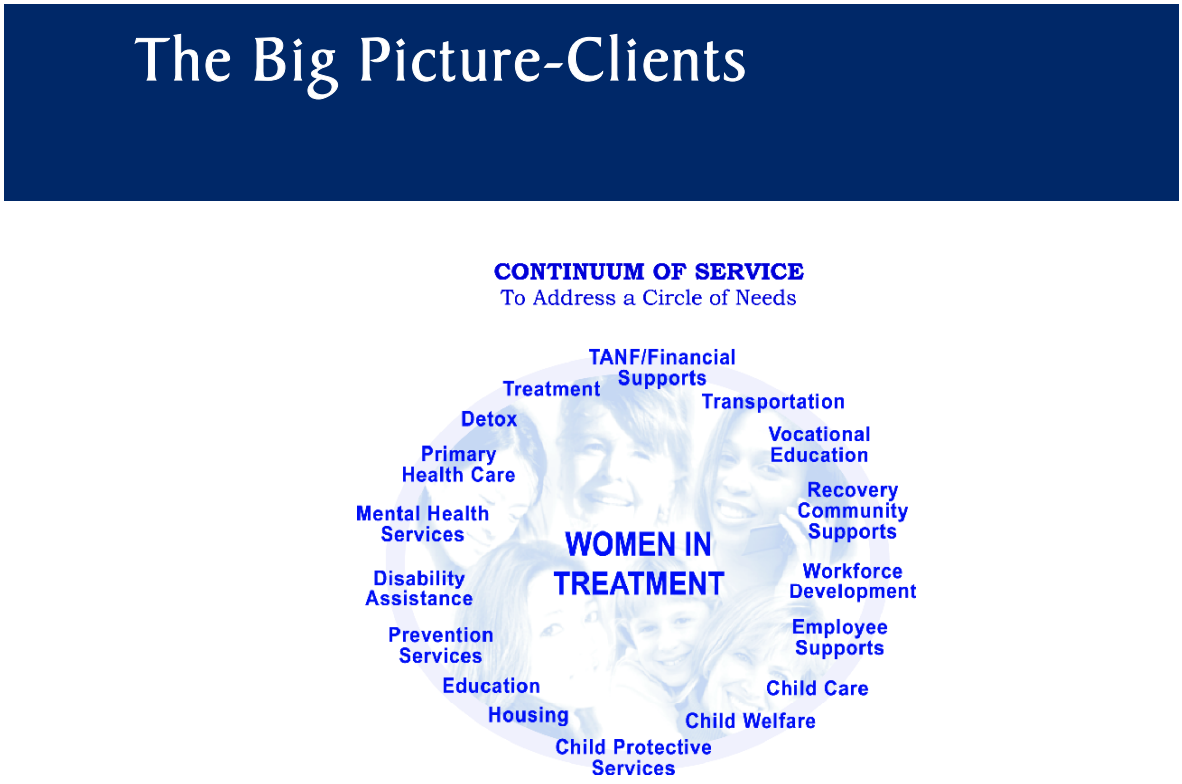
Dr. Jeanette Hercik, Deputy Project Director for Welfare Peer TA and a national expert in understanding public assistance services, opened the session by emphasizing the importance of cross-disciplinary collaboration. Collaborations, partnerships, and conversations across disciplines are all needed to move the field forward. Dr. Hercik underscored the value of the peer-to-peer learning that occurs at events like this one when States and counties can all sit in the same room and share ideas together. She highlighted the benefits of bringing together heterogeneous audiences. Dr. Hercik also offered a brief account of how the systems of social services, employment services, substance abuse services, and child welfare have all come together in recent years. Prior to welfare reform, the predominant focus of public assistance was income maintenance and providing monetary relief for those in poverty. After welfare reform in 1996, the focus of our national welfare program shifted to finding jobs and fostering self-sufficiency for those on welfare. Clients presenting with multiple barriers, such as of substance abuse addiction, mental health issues, or disabilities are often the hardest to serve and employ.[7]

[7] Morgenstern, J. R. A., McCrady, B., McVeigh, K., Blanchard, K., & Irwin, T. "Intensive Case Management Improves Welfare Clients' Rates of Entry and Retention in Substance Abuse Treatment." http://aspe.os.dhhs.gov/hsp/njsard00/retention-rn.htm. January 2001.

Dr. Hercik stated that one study[8] found 84 percent of women on TANF and in substance abuse treatment services also had an open child welfare case.

Dr. Hercik stressed the importance of shifting approaches from a systems perspective to a client-focused perspective. She also discussed the "circle of needs" of a TANF client with substance abuse issues and how the various systems can come together to wraparound these clients and work to meet all of their needs. Substance abuse rarely occurs in the absence of some preceding or subsequent problem or issue. Because of the interrelatedness of substance abuse and other issues, the systems that address substance abuse are related to and dependent upon the systems that address TANF, child welfare, and workforce development. See Exhibit III-1.

EXHIBIT III-1
CIRCLE OF NEEDS



Ms. Mary Nakashian, an expert in welfare systems and identifying substance abuse among TANF eligible clients, presented after Dr. Hercik. She framed her comments by relating the metaphor of "thinking outside the box" to the process of systems change. In this respect,

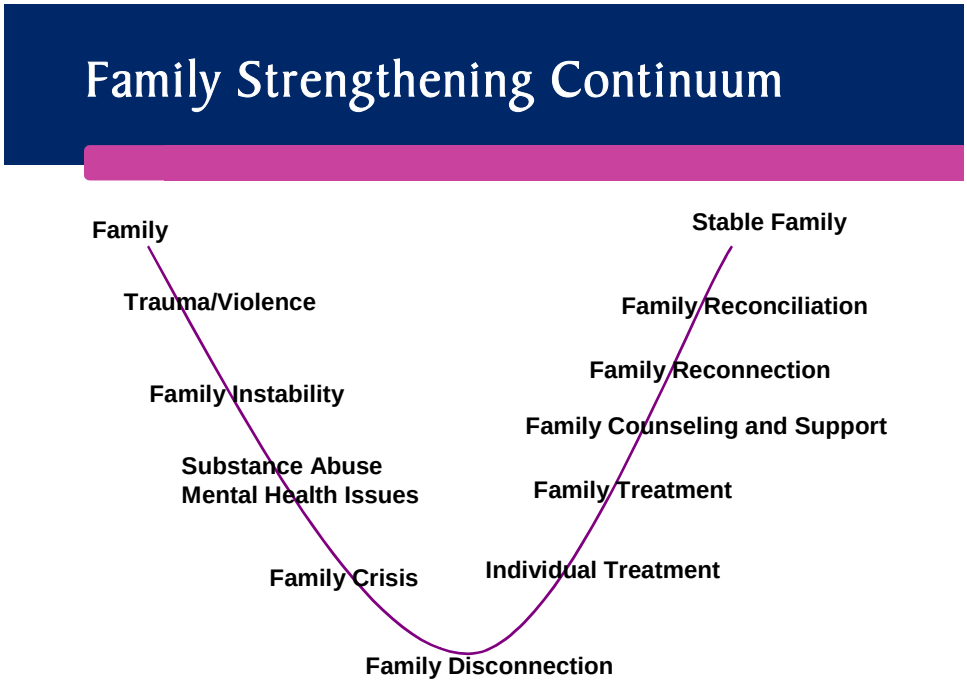
[8] Ibid.

"the box" represents any given established system, and "outside the box" would be the thought or action required to change or improve that system through new initiatives.

Reflecting on her years as an intake worker, the Deputy Executive Administrator of the New York City Human Resources Administration, and a Vice-President implementing CASAWorks, she recalled how many times people have mentioned the platitude to "think outside the box." For Ms. Nakashian, the challenge of thinking outside the box while working in and managing systems is that you need to keep one foot still in the box, metaphorically speaking, to continue to run the machine that you're responsible for. Workers and managers may not have the luxury of thinking outside the box if they're swamped with the responsibilities of maintaining the status quo and serving families. Ms. Nakashian then described some examples by applying this metaphor to the different systems represented in the audience. Regarding welfare, the box must ensure that eligibility systems are timely, accurate, and welfare checks must go out on time. Regarding child welfare, the box relates to protecting children, preserving safety, and placing children who've been removed from their homes. Ms. Nakashian reiterated that sometimes, the responsibilities of running and managing the current box do not allow the time to think about progress or grand improvements. Instead, individuals are simply too busy trying to meet the requirements of each day. Overall, Ms. Nakashian encouraged participants to embrace what she felt to be the ultimate challenge and also the greatest reward of public service: learning to balance keeping one foot in the box and one foot outside the box at the same time; that is, the balancing act of forming new initiatives while not allowing the current level of services to drop in quality.

Dr. José Rivera was the third to speak during this session and offer his big picture comments to outline the framework for the discussions over the next two days. Dr. Rivera first spoke about what he referred to as the "family-strengthening continuum." This concept refers to the reality that whenever we speak about substance abuse issues or an individual in substance abuse treatment, we are often speaking about family issues as well. See Exhibit III-2.

EXHIBIT III-2
FAMILY STRENGTHENING CONTINUUM

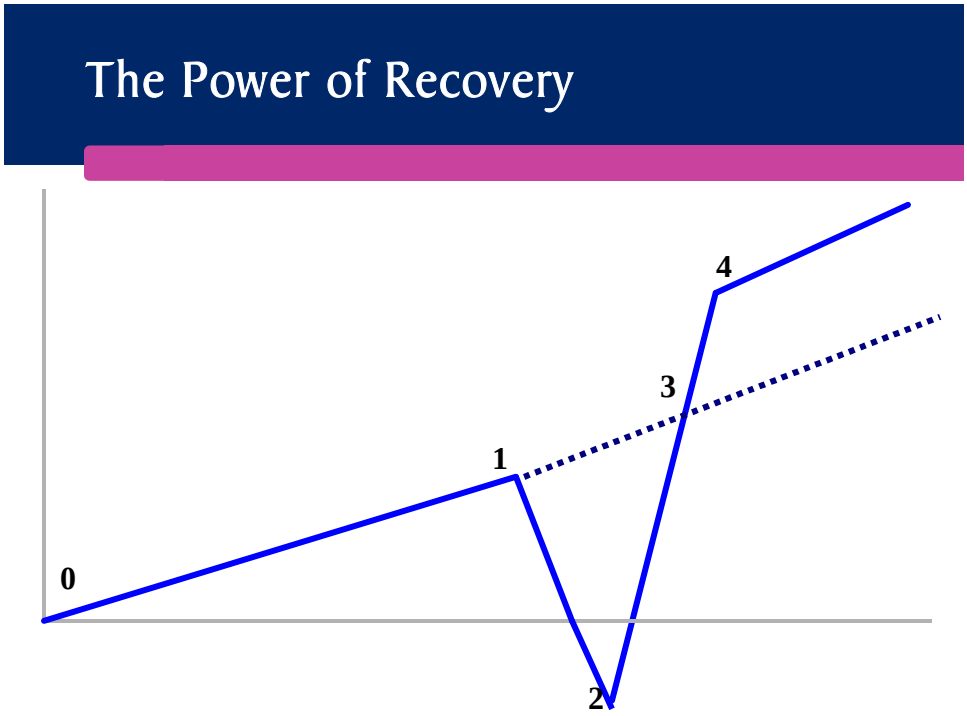


The notion also reflects an evolution of the system of substance abuse treatment. At first, professionals operated under the assumption that you could merely treat the individual for the individual disease. However, in recent years, it has increasingly become evident that substance abuse occurs within a broader context that includes a myriad of issues such as family stability, trauma, domestic violence, stress, or flux in relationships. The correlations are there. Dr. Rivera encouraged the audience to recognize that whether we work in TANF, child welfare, workforce development, or substance abuse and mental health services, we are all in the family-strengthening business together. Ultimately, the work of all providers is to create or advance the creation of a self-sufficient and stable family.

Dr. Rivera also discussed the process of recovery through a graphical depiction of an individual's life as a continuum. This continuum, pictured in Exhibit III-3, represents one person's life who has experienced issues of drug abuse. In this graph, Point 0 represents the starting point of this individual's life. This individual reaches a critical moment or event at Point 1, where circumstances lead to the initiation of drug use. Point 2 represents the "rock bottom" for this individual who has spiraled down from Point 1 and is now addicted to drugs. Point 3 represents the intersection of the person addicted to drugs after "spiraling up" and receiving treatment and the point at which they would have been had they never been addicted. Dr. Rivera referred to Point 3 as "the point of past expectations." However, the power and

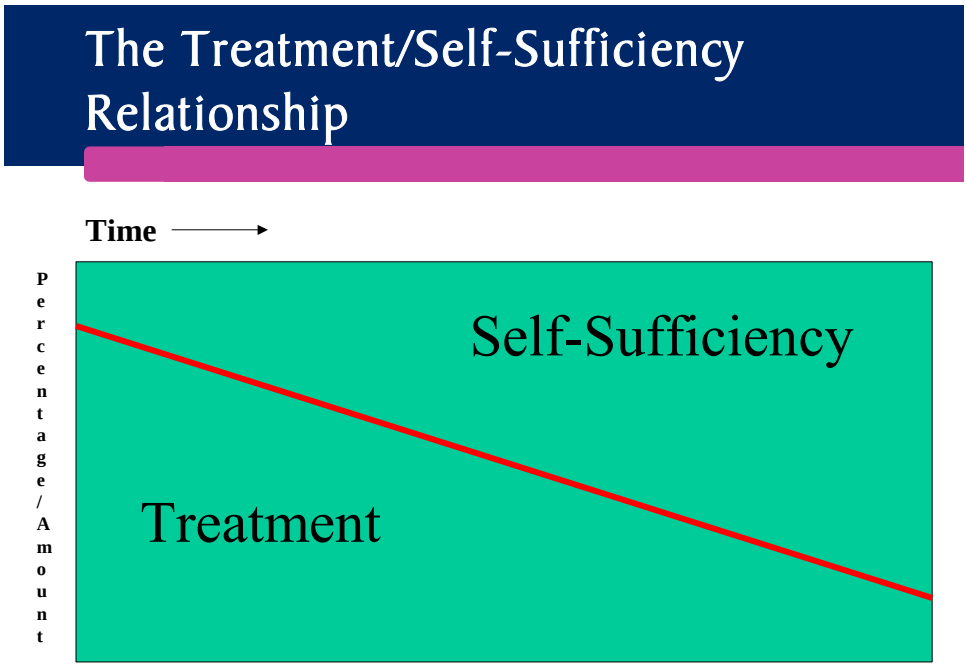
energy of the process of recovery brings this individual past Point 3 to Point 4. Dr. Rivera's primary point was to encourage participants to appreciate that the process of recovery has the power to bring an individual past Point 3. He also stated that it is good to keep in mind that TANF, child welfare, workforce development, and substance abuse professionals will see all different types of people at different points along their continuum.

EXHIBIT III-3
THE POWER OF RECOVERY



In closing, Dr. Rivera discussed the treatment/self-sufficiency continuum, pictured below in Exhibit III-4. This illustration demonstrates that treatment has a direct correlation to self-sufficiency. It also shows that treatment does not occur in a vacuum. When a person enters treatment, they may need 90 percent treatment and only 10 percent self-sufficiency services. As time moves forward and the treatment need decreases, the need for self-sufficiency services increases proportionately. The graph contradicts the commonly held notion that a person goes to treatment, disappears for a period of time, and then reemerges into society as "cured." Instead, the graph emphasizes that good treatment should be designed to prepare an individual for self-sufficiency from Day One. Dr. Rivera ended his presentation by highlighting that "good treatment, without a connection to self-sufficiency, is bad treatment."

EXHIBIT III-4
THE TREATMENT/SELF-SUFFICIENCY RELATIONSHIP



3. INVENTORY OF SUBSTANCE ABUSE CHALLENGES AND COMMUNITY AREAS

In this session, Dr. Rivera led the participants in an exercise designed to help them assess the current substance abuse challenges in their area. The local representatives from each region were asked to complete an environmental scan of their specific agencies and regions, looking particularly at strengths and weaknesses in combating substance abuse and serving substance abusers. Challenges were those that impacted the ability of local offices to help TANF customers find and maintain employment. After receiving introductory words and instructions from Dr. Rivera, the teams from the eight regions then worked on this exercise independently for approximately 20 minutes. Subsequently, a designated "reporter" from each region was asked to report their answers to the full group. The following sub-sections summarize the answers from each of the eight regions.

Region 1

Strengths:

We have a good treatment facility.

We have a pilot project in Williams County, similar to the mentoring program in Grand Forks, in which a para-professional conducts home visits. She carries a caseload of about 10.

Good communication between the systems of child welfare and TANF.

Some team case management is occurring.

Low-income housing is available and easy to access.

Our community nursing home has a child care facility.

Challenges:

We can't offer enough longer-term treatment.

Lack of understanding of the nuances of confidentiality requirements.

Still having trouble knowing what to do with indications of suspicions of drug usage among certain clients.

Medicaid doesn't pay the substance abuse evaluation fee.

We do not have an individual on the Human Services Center side who understands TANF; collaboration is impeded because they don't understand us and we don't understand them.

Transportation and far distances; lack of public transportation in Williston.

Available low-income housing.

Available child care.

Region 2

Strengths:

We have a good mentoring program.

We have para-professionals who conduct home visits.

New Hope program in Minot is intended to be long-term.

Agencies have a strong desire to collaborate and do not have turf issues; we now want to transform that desire into concrete strategies.

Challenges:

New Hope program only covers two children.

Still struggling with how to engage clients on a longer term and how to link systems.

Medicaid will not cover a substance abuse evaluation after a Driving Under the Influence (DUI) violation.

Region 3

Strengths:

Both in-patient and out-patient treatment centers.

Good collaboration between TANF, JOBS, and Safe House.

Good pilot projects underway.

Some team case management is occurring.

The SHARE Network is a great resource for finding other agencies in the area.

Challenges:

Client loads are high.

Transportation and far distances.

Clients not having driver's licenses or vehicles.

Shortage of addiction counselors and treatment centers; demand exceeds supply.

Confidentiality.

Physical and security issues for workers.

Region 4

Strengths:

We have a good mentoring program.

We have para-professionals who conduct home visits.

New Hope program in Minot is intended to be long-term.

Agencies have a strong desire to collaborate and do not have turf issues; we now want to transform that desire into concrete strategies.

Challenges:

New Hope program only covers two children.

Still struggling with how to engage clients on a longer term and how to link systems.

Medicaid will not cover a substance abuse evaluation after a Driving Under the Influence (DUI) violation.

Region 5

Strengths:

The collaborative pilot unit

Resource rich when compared to other places in North Dakota

Multiple providers of private and public treatment

Treatment providers are able to enact consequences for failure to engage in a plan

One solid residential treatment center, modeled after Grand Forks and Minot

Good public transportation.

Challenges:

Need for more residential treatment centers

Constant communication and exchanging information effectively

Maintaining the mechanism to allow funding (e.g., Medicaid) to continue after children leave a setting

No State Opt-Out Waiver: mandatory discontinuation of all TANF benefits for a person with a past drug felony.

Region 6

Strengths:

Current collaboration occurring between agencies

Good case management services in Fargo using the team case management approach between TANF, JOBS, and the Southeast Human Service Center

Good communication between TANF and HSC in terms of counseling

Cross-education, cross-training, and peer-to-peer site visits occurring between agencies.

Challenges:

Lack of residential treatment facilities

Lack of places for people to go and get care

Difficulty of collaboration with Child Protective Services due to confidentiality barriers

Need for gender-specific treatment

Staff shortages and resource constraints.

Region 7

Strengths:

There's a variety of treatment centers in Bismarck, including a number of private facilities connected with hospitals.

The faith-based community is a strength due to the number of churches.

Collaboration is growing between agencies who are learning to talk more and work together more frequently.

Strong sense of commitment among all service staff.

Challenges:

Due to a lack of transportation, people in Ft. Yates do not have access to the services in Bismarck; many people lack driver's licenses

Because towns are so small and tight-knit, everyone may know each other's business. This small size poses confidentiality concerns. Clients may be less willing to disclose substance abuse because they're afraid everyone in the town will learn.

Small town attitudes and biases of "that doesn't happen here."

Region 8

Strengths:

We have an interagency group where service agencies meet on a quarterly basis and share what's going on in our programs.

We're on the cusp of doing a TANF education program.

We have very self-sufficient communities. For example, if there's a family in need of support, someone in that community tries to help.

We have open case management between agencies.

We're always one phone call away from another source of support.

Challenges:

Distance—the time it takes for clients to get to services or for staff to get to clients

Biases, stigma, and public awareness issues about poor families

Very few private agencies in the area

Only one residential facility.

Between report-outs, Dr. Rivera, the discussion facilitator, offered his reflections and highlighted noteworthy points that were brought up. First, he stressed the importance of taking the time to visit each other's office in order to examine how other systems work and how those systems impact or interact with one's own. It is a no-cost item, but enables staff to learn so much and engage in cross-education and cross-training. Dr. Rivera also noted that "the treatment plan is very similar to the employment plan created under JOBS North Dakota." He emphasized the reality that these plans often overlap and can be collapsed and condensed into a more

comprehensive single plan. In response to transportation concerns, he suggested the creation of a regional transportation network that can be operated and subcontracted to TANF participants as a work activity. Dr. Rivera described how this is being done in Georgia. Encouraging participants in community- and faith-based organizations to become mentors for TANF participants is another option to serve TANF customers. In addition, Dr. Rivera also stressed the need to do, what he referred to as, "zero-based rethinking." In this sense, zero-based rethinking is a brainstorming session that cleans the slate and does not rely on established processes or commonly-held assumptions. Zero-based rethinking assumes nothing and starts from scratch. To end the session, Dr. Rivera closed with a final thought. He encouraged participants to consider Maslow's hierarchy of needs and how substance abusers have a similar hierarchy. All of us seek to self-actualize; however, some may not know how as well as others. For Dr. Rivera, if we remember that we all have the same needs and exist on the same hierarchy, we'll recognize that different circumstances are one of the only differentiators of a service provider from one seeking services.

4. CAUSES, SYMPTOMS, AND TREATMENT OF ADDICTION

In this session, Dr. Sushma Taylor, the CEO of Center Point, Inc. in San Rafael, CA, gave a thorough presentation on various aspects of drug addiction and the structure and philosophy of her treatment program. Her presentation can be broadly divided into two main parts, and the following sections of the report summarize her comments.

4.1 The Causes, Symptoms, and Physiology of Drug Addiction

Dr. Taylor began her presentation with the definition of addiction. Addiction is defined as "a progressive, chronic, primary disease that is characterized by compulsion, loss of control, continued use despite adverse consequences, and distortions in normal thinking." In short, addiction is a disease of the brain with significant impacts on the individual. Dr. Taylor also clarified the distinction between a "drug of abuse" and "drug use." She then delved into a detailed description of the reward pathway of addiction and outlined the physiology behind drug addiction. Dr. Taylor described how different parts of the brain govern different functions. For example, some of the functions of the prefrontal cortex include focusing attention, prioritization, suppressing primitive urges, and reducing impulsivity. Through a detailed summary of the functioning of nerve cells, synapses, and neurotransmitters, Dr. Taylor integrated the physiological effects of different drugs with her description of how the brain functions, making the basic point that addictive drugs activate a reward pathway in the brain. Consequently, drug addicts and non-addicts display clear differences of behavior as a result of frontal cortical functioning. For example, whereas many non-addicts are able to make healthy choices that abstain from immediate gratification, addicts tend to make choices without regard for

punishment, consequences, or harm. In the non-addict response, there is no pattern of repetitive use, whereas for an addict, habit and compulsion override the recognition of the harm associated with a repeated error. The addict response pattern becomes "got to have more" as they become psychologically and physically dependent on chronic use.

During her presentation, Dr. Taylor offered detailed lists of types of drugs, common methods of drug administration, and the risk factors associated with addiction. She also broke down the effects of addiction on physical, cognitive, psychological, emotional, social, and spiritual health. These effects are as follows:

Physical health – Physical health is the last aspect of health to deteriorate, but the first to return to normal after cessation of use. Some examples of physical health effects include increased tolerance for higher quantities of drugs, liver problems, headaches, fatigue, cravings, depression, agitation, intense hunger, and insomnia.

Cognitive health – Reasoning, judgment, intuition, memory, and perception are all affected by drug use.

Psychological health – Distortion of information, misinterpretation of cues, persistent suspiciousness, irritability, impatience, paranoia, restlessness, and delusion may result from drug use.

Emotional health – Emotions may be characterized by extremes, and the negative emotions of anger, hate, and resentment are frequent. Positive emotions such as love, joy, warmth, intimacy, and hope deteriorate.

Social health – Social interactions weaken as old friends are replaced by drug using acquaintances, legal and financial problems emerge, and problems at work or with family and friends may progressively worsen.

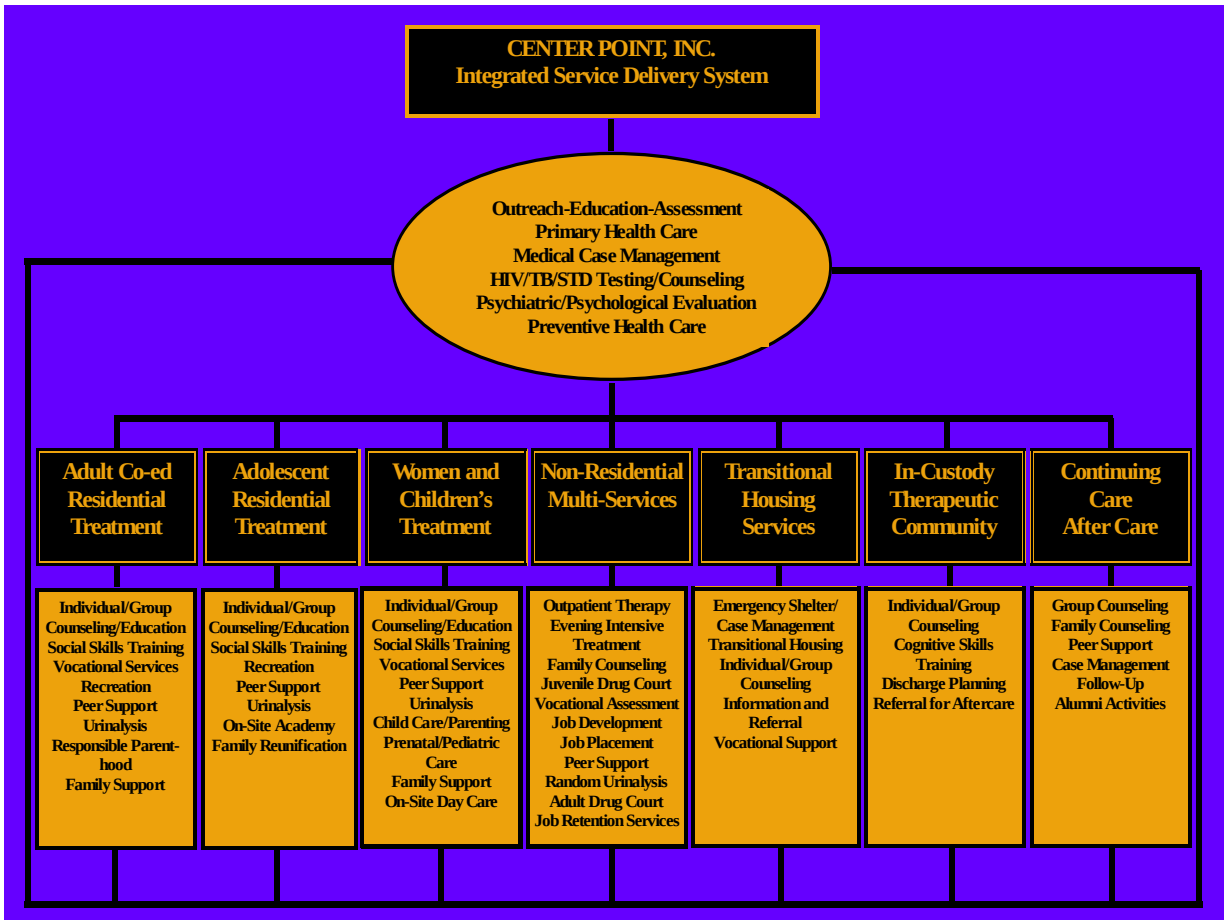
Spiritual health – Lives lack a higher meaning or spiritual purpose, users feel disconnected from life, and life begins to revolve around obtaining and using more and more drugs.

4.2 Gender-specific Substance Abuse Treatment – Center Point, Inc.

Center Point, Inc. began as an adult co-educational substance abuse treatment program in 1971. In 1981, Dr. Taylor assumed leadership over the program, and in 1989, the program added a gender-specific women and children's treatment program. Subsequently, Center Point was one of the original congressionally mandated demonstration projects for residential services for women and children. It is also one of only a few substance abuse programs to receive a competitive Welfare-to-Work grant. The program strives to offer an integrated and comprehensive set of services that include seven main components: adult co-ed residential

treatment, adolescent residential treatment, women and children's treatment, non-residential multi-services, transitional housing services, an in-custody therapeutic community, and continuing care/after care. Center Point uses a therapeutic community model. See Exhibit III-5.

EXHIBIT III-5
THERAPEUTIC COMMUNITY MODEL



Center Point's underlying service mentality focuses on the four phases of substance abuse treatment. Phase I requires crisis or medical emergency-oriented services. Most detoxification programs end at phase I. Phase II involves the addict's withdrawal from the drugs of dependence. During phase III, the previous user goes through psychological and physiological stabilization. Phase IV involves lifestyle restructuring. Dr. Taylor stated that most short-term substance abuse treatment programs span through phase III.

When Dr. Taylor became the Executive Director of Center Point in 1971, their initial treatment program length was 13 months. One of the first undertakings for Dr. Taylor was to cut the treatment program length down to six months. She restructured the treatment intervention so

that at least fifty percent of the client's time could be focused on vocational issues and aspects of community reentry. Currently, Center Point operates in three phases of service. Phase I lasts for 60-90 days and is treatment intensive. Phase II lasts for 30-60 days and is focused on re-entry and vocational issues. Phase III lasts for 30-60 days and focuses on the transition back into the community. Then, these three phases are followed by after-care and follow-up services.

To provide a snapshot of characteristics of drug users upon admittance into a substance abuse treatment program, Dr. Taylor outlined a profile of the women in her program. The profile of her program participants is as follows:

PROFILE OF CENTER POINT FEMALE CLIENTS	
Characteristic	**Percent**
Criminal justice involvement	67%
Childhood physical abuse/sexual abuse	36%
Adult physical abuse	48%
Domestic violence	53%
Parental substance abuse: Father	53%
Parental substance abuse: Mother	35%
Family substance abuse: Siblings	58%
Supporting children who are minors	35%
Loss of parental custody	65%

In addition, Dr. Taylor discussed in detail the vocational/employment services offered to Center Point residents. These services include:

Job readiness training

Addressing work stress issues

Job stability groups

Learning to respond to supervision and be held accountable

Punctuality and other vocational skills

Budgeting and money management

Tutoring for high school equivalence

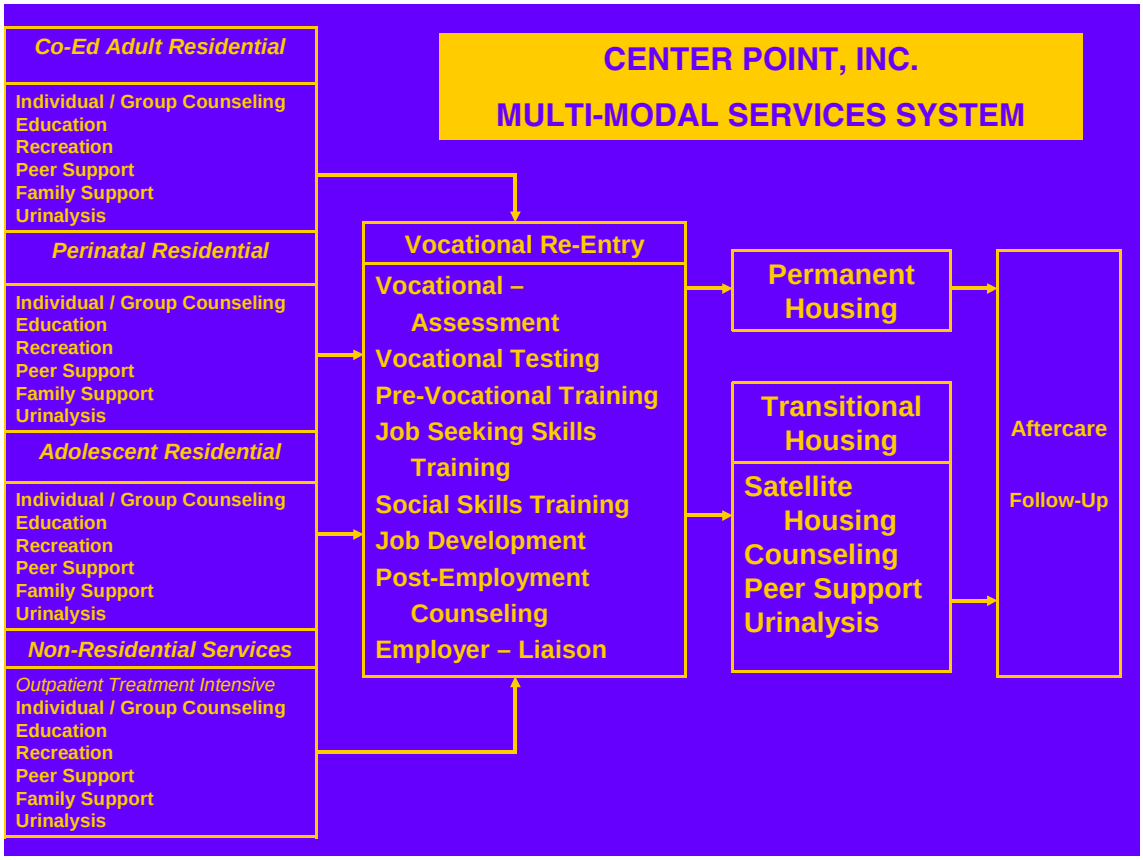
Job seeking skills

Vocational training

Job retention strategies.

Center Point also maintains a Job Databank for residents to use to search for jobs. Plus, Dr. Taylor stated that Center Point has relationships and partnerships with over 250 employers who work exclusively with her and the program. In 1982, she started the process of building relationships with local employers, and she "knocked on doors for over 20 years." Now, her program offers its residents a wide array of employment options after graduation. Center Point's employment/vocational services flow chart is displayed as Exhibit III-6.

EXHIBIT III-6
CENTER POINT, INC.
MULTI-MODAL SERVICES SYSTEM



4.3 Reflections on Presentation

One innovative strategy offered to participants during this Welfare Peer TA Roundtable was the presenter's reflections on each other's material. Following Dr. Taylor's presentation, Dr. Rivera asked Ms. Nakashian to provide her initial thoughts and reactions to spark an interactive discussion with the audience and a question and answer session. Ms. Nakashian's reflections are listed below, followed by a summary of the question-and-answer dialogue that resulted.

Most people who are substance abusers are employed – Based on data from the National Household Drug Survey, 80 percent of heavy drinkers reported being employed, and 7.2 percent of the overall workforce reported heavy drinking. In addition, 76 percent of those who reported using an illicit drug in the past month were employed either full or part time.

The definition of addiction reads quite differently than the definition of TANF – When most of us think of TANF, we think of concepts like "temporary" or "end in sight." However, when we read the definition of addiction, we hear concepts such as "progressive," "long-term," and "chronic." If you juxtapose these two definitions, you realize that many struggles may result because of how differently we define our two fields.

Children are both a motivator to get into treatment but also a trigger for relapse – In this sense, children can be a two-edged sword. Many parents are motivated to go into treatment for the sake of their children, but once out of treatment and reunified with family members, it can be very stressful when children start coming home.

It's interesting to note that there currently is no medical treatment specifically for "meth" – When we think about methadone clinics for heroine addicts, we realize that in addition to the behavioral therapy side of treatment, there are specific medical treatments for some drugs. The medical treatment for "meth" still hasn't been discovered.

It's very scary to change what you rely on every day – All of us have little habits and rituals that we rely on each day, such as a cup of coffee in the morning, or a daily run. Think, for a moment, about these safe little habits. It would be an interesting exercise to try to abstain from something you enjoy every day for the three days we're here in Fargo. An exercise like this might help you to empathize with an addict who relies on the ritual of drug use each day.

"Meth" use overlaps with issues of weight and body image – Some women smoke to stay thin. Other women also use meth to lose weight because meth suppresses appetite.

The current trend of incorporating work into substance abuse treatment is similar to the previous theme of incorporating education into work – The dynamic that is playing out now in the substance abuse and TANF communities has already played out before in the education and training communities.

Substance abuse is a disease with behavioral implications – Many other diseases don't have behavioral implications like substance abuse does. For example, if a diabetic lapses off taking insulin, we let them try again. However, if an addict relapses out of substance abuse treatment, we often blame them more harshly than those facing other medical conditions.

Long-term drug addiction causes brain damage and truly alters the way the brain functions – It changes the structure of the way people hear, think, see, and learn information. These brain changes have implications for the way we communicate with clients. It is valuable to think about the dosage and the medium through which we are communicating with our clients.

Intake interviewing is not the only way to learn about substance use from a client – It is a common assumption that improving intake interviewing is the only remedy to improve substance abuse screening and identification for TANF clients. However, there are other ways, such as health educators in waiting rooms.

Convey messages in as many ways as you can – Convey your requirements, your services, and the consequences of noncompliance in as many ways, in as small doses, and through as many different sources as you can.

Think about how current employment norms and protocols may affect drug users – It would be quite interesting to study how paychecks being given on Fridays may impact drug use. If paychecks were given on a day in the middle of the week, would it have an affect?

Screening questions as related to genetic predisposition for addiction – Due to the element of genetic predisposition for addiction, one safe question to include in an intake screening procedure might be, "Has anybody in your family history had substance abuse or alcohol addiction problems?"

4.4 Questions and Answers

Following Dr. Taylor's and Ms. Nakashian's presentations, the moderator opened up the floor of the event to transition into a dialogue of interactive questions and answers. The following section of the report recounts the question and answer session, which includes questions directed to Dr. Taylor as well as questions relating to previous presentations of the day. In addition to a few brief closing remarks and reflections on the day, this final discussion ended the first day of activities of the Roundtable event.

Q: Are there some people who will have a greater chance of becoming addicted to drugs because of the way that their brain works?

Dr. Taylor: The question is hard to answer given the current literature and research at the time. Currently, the only research we have suggests that there may be genetic risk factors for addiction. For example, the sons and daughters of alcoholic individuals are three to four times more likely to develop alcoholism.

Q: What might be the genetic cause of the risk factor?

Dr. Taylor: We still have a long way to go in learning about the genetic underpinnings of addiction. It's safe to say that something in the DNA that one inherits from their parents has an effect. But, a predisposition is not a certainty. The notion of a predisposition is that just because you're predisposed doesn't mean you'll necessarily become an addict. It means more that if in a certain behavioral context, one is exposed to certain cues, the predisposition puts you at a higher risk to become addicted than others.

Q: I read somewhere that many gamblers are also recovering addicts. Is there a correlation there?

Dr. Taylor: One similarity may be that gambling, like drug addiction, has elements of compulsion, impulsivity, a reward pathway, and lack of regard for consequences. It also provides a thrill of adrenaline that may fill some void in an addict's life, who missed the rush of getting high.

Q: Are there certain personality types that are more susceptible to addiction, like an obsessive personality?

Dr. Taylor: The research is still unclear on this question. But, we do know that it's not entirely causal. For example, every person who has obsessive compulsive disorder is not necessarily a drug addict. However, the patterns of use sometimes mirror certain personality traits. There may be other behavioral patterns as well, such as if depression, addiction, and risk-taking all go hand-in-hand. It is clear, though, that there is no cookie-cutter personality type to become an addict. It's a combination of factors that are very complex.

Q: Where is the line drawn between drug use and drug abuse?

Dr. Taylor: The use/abuse line is razor thin. The abuse/disorder line is also razor thin. There are many grey areas and many differentiating factors. What may be a tolerable level of use for one person may be addiction for another. When you think about it, dopamine can be produced naturally by something as simple as closing your eyes, thinking of a fond memory, and getting a rush from it. On the other end of the spectrum, the release of dopamine can be artificially induced from external drugs.

Q: What are some specific and unique differences about "meth" as compared to other drugs?

Dr. Taylor: Meth has a few unique features. One is its specific impact on women. During the heroine and cocaine epidemic, women were often recruited to carry drugs for dealers. In the meth world, women are now manufacturing the drug and often at the core of the distribution rings. We've even seen an increase in women admissions to prison for meth. Another unique feature of meth is how easy it is to manufacture. Up until recently, you could even find recipes for meth on the internet. Plus, it's not difficult to obtain the required ingredients. Third, meth can be produced with great flexibility and mobility. It can be produced in a suitcase. However, there are many waste products from meth distillation. In California, the area from Fresno to Sacramento has been referred to as the "interior corridor." Eighty percent of the country's meth production occurs in that corridor, but due to waste products leaking into the soil, the fruit orchards are being affected. Fifth, meth impacts the brain in very powerful and unique ways. The impact of meth on the brain is so strong and so severe the psychotic and paranoid behavior is routine. With women on meth, they'll even deny their children and lose that motherly restraint, which is unique. Lastly, the frequency of suicidal fantasies in users is also unique to meth.

Q: What is tweaking?

Dr. Taylor: The high on cocaine usually lasts about 20 minutes. The high on meth usually lasts 6-8 hours. There is a short period of time just at the end of a high which represents the few minutes or moments before the high is about to end and the user is about to crash. Over time, users learn to identify the precipice just before the crash. Tweaking refers to the process when users purposefully take a hit at the very moment before the crash to continue the high. The body can stand tweaking for up to about two weeks. After two weeks of extreme dehydration and deprivation of electrolytes, your body crashes and the user collapses.

Q: Do people use meth in conjunction with other drugs?

Dr. Taylor: Yes. Meth is known as a poly-drug, because users often use other drugs in addition to meth. You'll find meth users who are also alcoholics. Alcohol is one of the only drugs that isn't a poly-drug. Alcoholics may only drink alcohol.

Q: When does the physical withdrawal from meth start?

Dr. Taylor: We see both acute withdrawal and subacute withdrawal with meth. If a user stops using meth but you allow them to sleep heavily and frequently, occasionally the user can

sleep through the acute withdrawal. Then, the kindling effect takes place around the 55-60 day mark. If a user can get past the 90 day mark, you won't see much attrition after that.

Q: Dr. Taylor talked about the importance of creating a safe environment for healing and growth at her organization. How can we, as agencies, create that safe haven?

Dr. Rivera: A women who is a victim of domestic violence develops very resilient instincts of survival and self-protection. They can walk into a room, immediately assess how safe they feel in the room, and walk out if they feel at all unsafe or anything amiss. Some people may say, "I don't feel safe vibrations here." What we must do is learn to create the type of environments that people will walk in and choose to stay.

Dr. Taylor: I work to create that feeling of a safe haven by first working to engender a strong sense of empathy in my staff. When a new staff member gets hired, they live the life of a client for the first entire week. They have to follow the program as if they were a recipient of services for one week. Not only does this process give me feedback as to how to improve the program, it also breaks the new staff of preconceived notions they may have and develops empathy in them. I think what is in the heart of your staff really helps to create that safe environment.

Dr. Rivera: Another thing that erodes the safety and warmth of an agency is what I call "othering." Othering occurs when you look at another person and treat them as the "other." You think of them in terms of "they," "them," and "those" instead of "we" and "us." Our clients respond to othering very negatively. It's a vibration. People who've felt it before have a very acute sense of perception for it. We should all work to make our agencies a place where our clients do not feel like "others" or "they."

Q: Can you give an example of the treatment/self-sufficiency continuum and how activities that help a person to become self-sufficient can be incorporated into treatment?

Dr. Rivera: For example, anger management and time management can both be considered part of substance abuse treatment, but they can also both be considered job preparation. These are skills needed to function in the workforce.

Q: Do you think that an increase in transparency on the part of agencies would also work to create a safe environment for clients? I feel like we could be more explanatory about our protocols and decision-making criteria.

Dr. Taylor: At Center Point, we don't sugarcoat anything for our clients. We also don't cover up for our clients. We tell them exactly how decisions are made, and we explain all of our procedures to them, so they know what they're getting into.

Ms. Nakashian: It seems to me that many of the questions here today have focused this notion of creating a safe environment for clients in a public agency. To me, that question, at its essence, asks: how do public systems operationalize trust? Trust can be developed across four dimensions: 1) making workers more trustworthy for clients; 2) making agencies more trustworthy for clients; 3) making workers more trustworthy for themselves; and 4) making agencies more trustworthy for workers.

5. REFLECTIONS ON DAY 1

The second day of the Roundtable event began with a short discussion between the moderator and the participants covering reflections and reactions to the information from day one. Dr. Rivera offered each of the eight regions a chance to speak about any noteworthy or pressing comments they'd like to address with the group. The following sub-sections of the report summarize the topics that were discussed during the morning's reflections.

Worker Safety

Various regions in North Dakota are operating programs within which mentors or paraprofessionals make home visits to conduct outreach activities. However, worker safety becomes a concern due to some of the impacts of meth use on behavior and cognition. Meth can make people dangerous, paranoid, and potentially belligerent after a prolonged period of tweaking. The issue of danger for workers and home visitors is a very important one and something we should address when safety protocols are designed for these outreach programs.

Relapses, Slipping, and Setbacks During the Process of Treatment

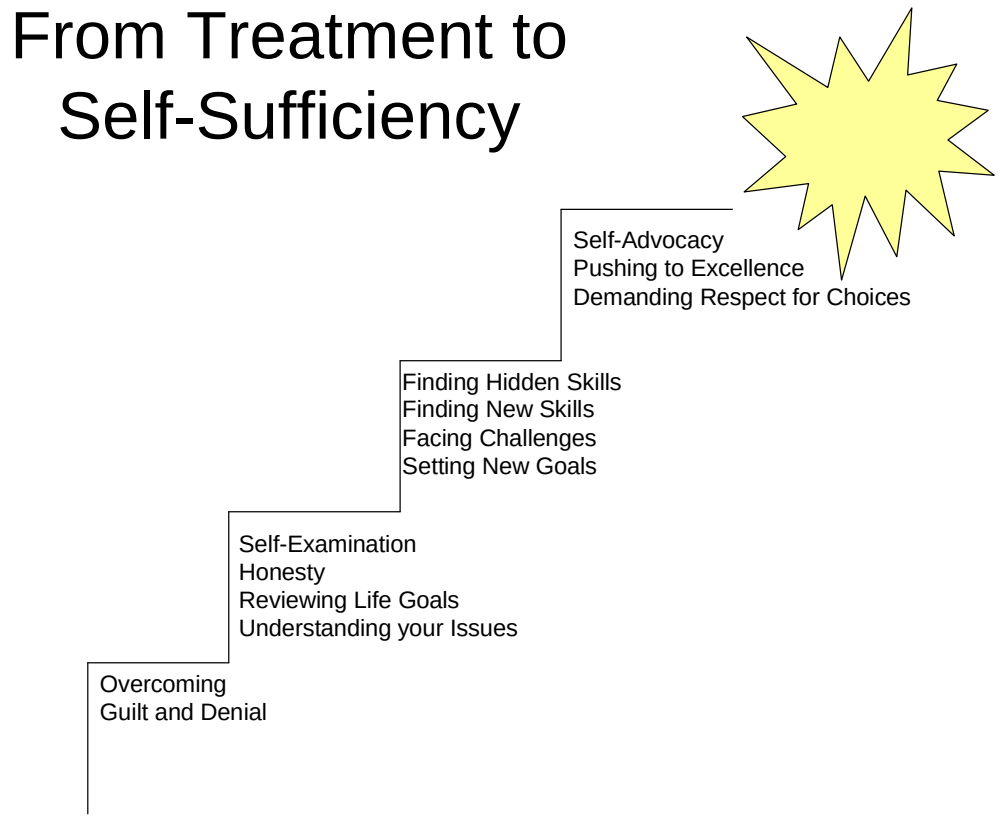
As part of TANF, there are consequences for noncompliance, and as part of Jobs Services, there are proof of performance requirements. Sanctions result when participants slip. However, it is important to brainstorm positive and persuasive strategies to keep participants engaged after a setback or relapse. As an addict tries to participate in treatment and find and maintain employment at the same time, if punitive measures for noncompliance are too strict, such measures may deter future engagement and push participants away. It is critical to ask the question: how do we help our people to perform at their best level, without allowing slipping or relapses to derail the entire pathway to self-sufficiency and process of recovery? The issue is further complicated when slippages and setbacks also have implications on family reunification, permanency, and child safety from a child welfare perspective. As relapses may be a part of the

treatment process, those relapses have implications on the ways that the TANF, workforce development, and child welfare systems will react.[9] Exhibit III-7 depicts the Staircase to Self-Sufficiency.

Tapping Community Resources

Many regions in North Dakota are facing resource constraints. These constraints require more imaginative thinking and new strategies to harness and maximize the use of other existing resources in the community. Public institutions may need to engage in proactive strategies to utilize more community resources. For example, a group of churches could band together and form a family crisis center. As an action step from this Roundtable, each region should assess all the resources available in their community and brainstorm new ways to tap those resources to serve families.

EXHIBIT III-7
STAIRCASE TO SELF-SUFFICIENCY



[9] Rivera, J. (2003). Defining and Operationalizing Work in the Substance Abuse Treatment Setting. Rockville, MD: Rivera, Sierra & Company, Inc.

Integrating the Child Welfare System

Work activities support family reunification. However, the systems of TANF and JOBS both tend to focus more on the participating adult. Children are affected very deeply by substance abuse in a family and by the process of recovery. While the adult may be going through treatment or receiving services, the child is often on a parallel path in the child welfare system, such as in foster care. These two parallel paths currently intersect with family visitation or with court appearances, but are there ways to bring the paths of the children and the adult deliberately closer and more aligned? As stated on day one, children are a motivator to go into treatment, but children are also a motivator to stay in treatment out of fear of being responsible to raise a family again. A critical element of this roundtable event involves thinking about how the child welfare system can be more effectively integrated with the systems of TANF and workforce development.

6. CASE MANAGEMENT STRATEGIES: SUPPORTING SUBSTANCE ABUSE TREATMENT

Ms. Mary Nakashian, the facilitator for this session of the roundtable, began the session with introductions of Sidney Schock, Carey Fry, and Kathleen Moraghan, the three representatives from Cass County giving the morning's presentation. During this session, Cass County staff presented their pilot project of systems integration for the benefit of the other regions in attendance. Ms. Nakashian concluded her opening remarks by reminding the audience that Fargo, ND is the biggest metropolitan area in the State, and as a result, replication of the Cass County model might play out differently in other regions with different resource constraints. The Cass County pilot project was presented as a springboard for ideas and as an example of how one county worked through some of the difficult issues of systems integration.

6.1 Putting the Pieces Together: A Case Study in Cass County, ND – The TANF Perspective

Cass County embarked on their pilot project in case management service integration as a result of numerous pressing concerns among systems in the year 2000. The fundamental problems that Cass County staff initially sought to address can be described by the following:

The discovery that up to 25-40 percent of TANF applicants failed to complete their initial JOBS enrollment, despite the fact that the local JOBS office is less than 2 miles from the TANF office

The recognition that TANF participants revealed problems and demonstrated behaviors which TANF staff were ill-equipped to understand or treat, resulting in a great deal of non-productive wasted time for case managers

The occurrence of frequent TANF case cycling due to case closures and sanctions, potentially resulting from North Dakota's cumulative progressive sanction policy combined with undiagnosed substance abuse or mental health issues

The consensus that prevailing policies fostered non-compliance and prevented TANF re-engagement.

To address these pressing concerns, the Cass County TANF program within the Department of Social Services embarked on a pilot project to restructure case management through systems integration with the local JOBS program and the mental health system. This project was entitled the Cass Pilot Demonstration Project and was initiated in 2000. In response to the enumerated problems, this demonstration project sought to make the following changes:

Co-locate JOBS counselors and TANF case managers on-site to allow for immediate JOBS enrollment and more comprehensive case planning and client staffings. Shared calendars on Lotus Notes help to facilitate appointment planning as well

Secure the services of a local mental health professional from the Human Services Center (HSC) to conduct mental health and substance abuse assessments for TANF participants and provide training to TANF and JOBS staff about issues relevant to their role

Effect TANF and JOBS program modifications and enhancements by defining system requirements and necessary modifications.

In describing the goals of the pilot project, Mr. Sidney Schock reflected on the importance of the modifications made in Cass County. Primarily, Mr. Schock emphasized the benefits of co-located offices and service integration. For Mr. Schock, co-located offices build team identification, promote ad-hoc case staffing, foster cross-training, enhance the availability of on-demand emergency services, and present a seamless interrelation of systems to TANF customers. As a result, clients in Cass County now understand that money, work, and mental health services are all a single integrated package.

Cass County staff are quite pleased with the outcomes thus far of the Cass County Pilot Demonstration Project. Some noteworthy impacts are as follows:

TANF applicant failures to enroll in JOBS reduced from the initial 25-40 percent to a rate less than 3 percent

Clients sanctioned for JOBS non-compliance increased 16 percent

TANF affiliation after sanction fell from an average of 9.4 months to an average of 2.5 months

Average amount of time that TANF participants spent in sanction decreased from 3 months to 1.7 months

TANF customers engagement in mental health and/or substance abuse treatment services increased by 28 percent

TANF customers exiting TANF within one year increased from 82 percent to 94.8 percent

The overall TANF caseload in Cass County decreased 40 percent throughout the pilot during the months from October 2000 to December 2002, thus saving approximately $545,000 per year.

6.2 The Impact of Methamphetamines on Cass County Service Provision

The impact of "meth" was one of the initial factors for Cass County's TA request to the Welfare Peer Technical Assistance Network. As described in section II of this report, the October 2003 site visit to Cass County assessed performance, analyzed protocols, and offered recommendations for service improvement. As part of their morning presentation, Cass County staff reviewed Peer TA's recommendations for the group and reported their progress related to implementation. This section of the report recounts the recommendations and the progress Cass County has made in implementing each.

1) **Recommendation** – Provide TANF Managers and JOBS Counselors with an observational checklist to assist in uncovering substance abuse.

   Current status: North Dakota adapted substance abuse inventories from New York and North Carolina to develop the North Dakota Behavioral Checklist. This checklist is currently in full use.

2) **Recommendation** – Provide TANF Managers and JOBS Counselors with guidance in asking questions about substance abuse.

   Current status: A Program Manager Script has been developed relating to frequently asked questions about substance abuse. This script is used by all TANF staff and is on everyone's desks. It addresses numerous topics and reasons for discussion of sensitive issues.

3) **Recommendation** – Provide staff with ongoing training and professional development experience.

Current status: An ongoing effort for professional development and continuing education has been initiated. TANF, JOBS, and mental health staff have attended in-service presentations from a number of providers in the community. More community presentations are also planned. It has been recognized that these cross-training events help to build trust, put faces on voices, break silos, and streamline services.

4) Recommendation – Create short, attractive brochures and fact sheets that describe services available to TANF families.

Current status: A Cass County TANF Greeting Letter was developed and included in the informational packet that all applicants receive. This letter describes available services. More efforts are underway to redesign current brochures.

5) Recommendation – Consider using videos and/or presentations in client waiting areas or in Job Service Orientations.

Current status: The North Dakota Department of Human Services is coordinating a State effort to develop a video presentation that will be shown in social services offices throughout the State. Modeled after a product made in New York State, this video will discuss substance abuse, addiction, and recovery. Until the video is employed, current efforts still offer brochures in waiting areas.

6) Recommendation – Urge the State to exercise the federal option to partially or fully opt out of the prohibition on providing TANF benefits to people convicted of drug-related felonies.

Current status: This recommendation is being reviewed and considered by the North Dakota Department of Human Services. North Dakota staff will also utilize the vehicle of Interactive Q&A offered through the Welfare Peer TA Network to learn about other States' relevant legislative efforts.

7) Recommendation – Develop county policies that attempt to reconcile or reduce conflicting time pressures that create confusion, inequity, or tensions across departments.

Current status: A new protocol was introduced and will soon be finalized that will allow the county's TANF and Children and Family Service Unit (child welfare) to conduct regular and ongoing staffings with families who receive services from both systems.

6.3 Putting the Pieces Together: A Case Study in Cass County, ND – The JOBS Perspective

Carey Fry, the Supervisor of Workforce Programs for Job Service North Dakota (JSND), continued the morning presentation by offering her thoughts about the impacts of the pilot program in Cass County from a workforce development perspective. For Ms. Fry, the pilot in Cass County changed the definition of the term "work ready." Whereas previously JSND did not serve all TANF participants, the new pilot project allows the JOBS program to serve everyone.

The role of JOBS in the pilot project is to conduct comprehensive assessments of employment-related issues for TANF participants, set goals for participants, and monitor progress. The Cass County pilot fostered the co-location of JOBS and mental health providers at the social services office. This co-location helps to achieve more comprehensive assessments with an increasingly detailed inventory of barriers. The pilot has also expanded the number and scope of countable work activities for TANF participants. Substance abuse treatment, mental health counseling, and cardiac rehabilitation are all examples of new activities counted towards participation rates. However, these new innovations have also resulted in new protocols to monitor progress and an increased demand for collaboration with a wider number of providers. Collecting doctor's notes, compiling medical documentation, and using medical attendance sheets are newly developed methods to monitor engagement and progress. Ms. Fry encourages JOBS participants to think of their JOBS Counselor as an employer and to think of a TANF check as a paycheck.

Another important development of the Cass County pilot is the use of shared electronic calendars among JOBS, TANF, and mental health staff to enhance scheduling appointments. Instead of making a referral by placing the burden on the participant to do all their scheduling, shared calendars allow staff from multiple agencies to schedule appointments for each other seamlessly. The protocol works when JOBS counselors and mental health clinicians set aside blocks of time when they will be available for appointments. As a result, other staff can view their calendar, assess those blocks of time, and proactively schedule referral appointments for the client. In addition, JOBS counselors hold workshops for participants every 15 days. Ms. Fry is actively engaged in planning and implementing these workshops. These workshops increase the opportunity for JOBS counselors to observe the behavior of clients over a consistent period of time. At the workshops, observers include JOBS counselors, worksite supervisors, TANF program managers, and workshop trainers.

Lastly, the Cass County pilot increased the quantity and quality of mental health assessments conducted for TANF and JOBS participants through the introduction of an on-site

mental health professional co-located part-time in the social services office. Mental health assessments are mandatory for all participants who:

Declare the need for an assessment through personal testimony

Have experienced incidents of domestic violence

Are engaged in Proof of Performance activities following JOBS sanction

Are suspected of or have addiction issues confirmed by a reputable third party, such as Child Protective Services, the receipt of a DUI citation, or arrest through criminal charges.

6.4 Putting the Pieces Together: A Case Study in Cass County, ND – The Mental Health Perspective

Ms. Kathleen Moraghan is the co-located mental health clinician involved in the implementation of the Cass County pilot model. She conducts the majority of mandatory mental health assessments for TANF and JOBS participants and has for the past three years. Ms. Moraghan completed the morning's presentation by providing some relevant statistics about methamphetamine use, describing the impacts of meth on clients that she sees, and reflecting on lessons learned.

According to the current State Attorney General, methamphetamines are the number one issue facing North Dakota law enforcement over the next four years. Meth use and production in North Dakota has exponentially grown in recent years from a total of 3 meth lab busts in 1995 to 297 lab busts in 2003. In addition, the United States Drug Enforcement Administration (DEA) estimates that young children (12-14 years old) who live in smaller towns are 104 percent more likely to use meth than their counterparts who live in larger cities. This statistic, combined with the reality that serious drug dependence is about twice as common among TANF recipients than nonrecipients, underscores the concerns of meth use in rural North Dakota and its impacts on the TANF, JOBS, and child welfare systems.

For Ms. Moraghan, some lessons learned in her work with meth-addicted clients include:

Clients do not come to TANF offices and JOBS services intending to disclose substance abuse

The North Dakota Behavioral Checklist helps intake workers identify objective symptoms that may indicate substance abuse

Detection of meth use in TANF participants is difficult due to a number of contributing factors, such as the half-life of the drug (testing takes 48-72 hours before testing positive), clients leaving TANF for periods of time, clients fearing disclosure will lead to loss of children, and clients tampering with lab specimens

Meth affects the brain in such a way that leads to a variety of psychiatric symptoms, moods, and behaviors that may vary from day to day

Co-occurring issues of substance abuse and mental health challenges often complicate an accurate diagnosis

The presentation of a drug user may depend on amount used, the timing and history of usage, and route of administration of the drug

Clients are best assessed by accumulating information on behavior, mood, and thoughts in a variety of settings and across a number of days on a regular basis

Techniques such as motivational interviewing, providing empathy, and discussing decisional balance may create an environment where precontemplation can move to active contemplation of recovery.

6.5 Questions and Answers

Q: How valuable has it been to require mandatory assessment during the period of proof of performance? How open are clients to discuss issues, and are there other ways to bring in other sources for collateral information?

Ms. Moraghan: In terms of the provider, it is a tough interview. However, that interview also leads to the establishment of a longer-term relationship. It also educates about the availability of mental health services. If the person is unwilling to talk, it is at least educational. As a provider, I've learned to focus on the parts of the interview that can be of value. I try to speak more calmly and informally. Clients clearly do not like to come though. It is not easy. We range between a 33-50 percent attendance rate.

Ms. Fry: I'd also like to add that you never know which effort will cause that light bulb to finally turn on in the client's mind. It may be effort number one, or it may be effort number ten. You have to keep trying, and eventually, it really makes a difference.

Q: What collateral sources do you use to add to the mental health assessment?

Ms. Moraghan: I really depend on the TANF and JOBS workers to help out with the assessment. Those are my sources. If I tried to leverage other sources, I'd have to deal with issues of confidentiality and releasing information.

Q: Can you elaborate about the 15-day workshop?

Ms. Fry: It occurs over a 15-day period, and a new one starts every 15 days. We pattern it just like work. Participants must be on time, and must be active participants. During the workshop, we do career assessments, we fill out job applications, and we do a range of other employment-related activities. During the workshop, we bring in Ms. Moraghan to talk about substance abuse and mental health. We also bring in a local rape and abuse center to talk about domestic violence. The workshop also allows us to see them every day at a consistent time, so we can observe patterns of behavior. At the workshop, we can see if they are consistently late, or if they smell like alcohol, or if they look like they just rolled out of bed.

Q: How did you get this pilot started?

Mr. Schock: The challenges you all are experiencing now are no different than the challenges we were up against when we first started. The key is just to start to work together. Learn about the organizations in your community and learn their dynamics. Once you understand it, you can begin to navigate the services in your community. Making those overtures to the service providers in the community sends such a strong message. Even if you can't co-locate like we did, you can still do a better job of forging stronger relationships with community agencies.

Q: Knowing that TANF eligibility is based on having kids in the family, if the children become removed and eligibility is lost, how do the partners work together in that arena?

Mr. Schock: We have hospital living arrangements for up to three months to maintain the TANF grant. We can use the full standard for three months, and after 3 months, reduce to the personal needs allowance. We maintain the case though. We do everything we can to keep the case, and do not ever want to let them go.

Q: What about the cases where the children are placed in foster care?

Mr. Schock: If the children are in foster care, it is different. Then, we close the TANF case. Pretreatment is a good place for the client to come to understand what will happen to their benefits, their children, and everything, but yet you haven't let go of them.

Q: I've read that there is a 5 percent national recovery rate for meth addiction after treatment. Are you seeing a higher rate in your services?

Ms. Moraghan: I just never give up on anyone. I agree that as a field, we haven't yet figured out meth. But we have to keep trying. I remember how a client came to me once and

said, "If only 3 percent get fixed, why try?" and I responded, "What if you're one of the 3 percent?" Part of why we're here today is because these challenges are not easy to confront. Substance abuse is a relapsing disease. We know that. But, we're coming up with strategies and we're succeeding more and more.

Q: What are your current caseload numbers?

Mr. Schock: In Cass County, TANF program managers currently hold between 40-50 TANF cases. We just drew down the total caseload to 65. We also try to maintain leaves in our unit and continue to provide post-employment services, which is where the other 20-25 cases come from.

Ms. Fry: In the JOBS program, our caseload is anywhere from 30-50. I think the exact number is 37.

Q: In North Dakota, will the TANF system attempt to adopt the drug opt out?

Mr. Hougen: There may be an effort soon. However, at this point, there is not proposed legislation. This is a good opportunity to speak with your individual legislators and express your concerns.

Dr. Rivera: While it is difficult to focus on past convictions, there are things we can do with present or quite recent convictions. We can train and educate our legal system. One option is to file routine appeals for TANF participants. The judge can reduce the felony down to a misdemeanor and add community service. We have the opportunity to educate our legal community about the ways they can help.

6.6 Putting the Pieces Together: A Case Study Exercise

Following the three consecutive presentations by Cass County staff, the presenters led the Roundtable participants in an interactive case study exercise that walked through an actual past case of the Cass pilot project. All participants were given a standardized case description to read and questions were posed to each of the eight service regions to address different aspects of the case including identification, screening, symptoms, work activities, child welfare involvement, and legal issues. See Appendix C.

7. RESPONDENT PANEL AND DISCUSSION

This session offered the opportunity for the national consultants at the Roundtable to reflect on the morning's presentation and case study. Ms. Mary Nakashian, Dr. Sushma Taylor, and Mr. José Rivera offered their thoughts. Ms. Nakashian elaborated the following points:

The co-located staff truly blurs the lines of who is a TANF worker and who is a JOBS worker. When I was here a year ago, I spent three days in the social services offices, and the distinctions between agencies and roles were very invisible to me. What Mr. Schock said about the perception of seamless integration is what I experienced.

In the job description of a case manager, they truly are reviewed on skills and responsibilities of case management and eligibility determination. It was refreshing to see that the job functions match the performance criteria.

For the other service regions in attendance, I can understand how it is daunting to see the polished Cass service package. But, it is important to keep in mind that you're learning about the product of multiple years of hard work. They went through a very tough journey to get where they are today.

On the issue of TANF eligibility and children in the child welfare system, my understanding is that TANF rules allow a State option to continue TANF for the mother of up to six months while children are in foster care, as long as family reunification is the goal.

Dr. Taylor added:

The co-location occurring in Cass County is very impressive, bold, and brave. It clearly removes many delays and barriers for clients to receive and access services. The cross-training efforts are also great as well.

There are other national studies that suggest a higher meth treatment efficacy rate. However, if the 3 percent success statistic is based on short-term programs, I can believe it. Meth treatment requires long-term sustained support to achieve results. I believe that we can achieve higher success rates with longer-term meth programs. Eighty percent of all admissions to my program (adults and children) are meth users. 100 percent of my adult admissions are meth users. At Center Point, we conducted a three year study on the graduates of our 180-day treatment program, and we found that after three years, 85 percent were still employed and 90 percent were not using drugs.

Greater involvement with local chapters of Alcoholics Anonymous and Narcotics Anonymous can be helpful to create small alumni associations and encourage peer-to-peer relationships.

Drop-in groups are another good option for those of you who have started pretreatment groups. Drop-in groups can occur for 2-3 hours per week. Participants with a higher degree of sobriety can act as peer leaders. Due to waiting lists for treatment programs, drop-in groups are a good temporary alternative.

Lastly, Dr. Rivera closed out the panel with a few short reflections:

Avoid thinking of screening devices as silver bullets. A more helpful viewpoint is to think of screening devices as referral devices.

In addition to screening devices, we should be thinking about the other things that we can do institutionally to assist the screening process.

Many agencies spend a great deal of time analyzing the weaknesses of their clients. However, a strengths-based approach helps our clients to understand their own strengths and assets and offers a new perspective for recovery.

8. CREATING A SOLUTION BY FUNCTIONAL AREA

During this breakout session, participants were re-seated by job function instead of regional location. Groups included TANF professionals, child welfare workers, and JOBS counselors. These groups were encouraged to discuss the challenges of substance abuse from the perspective of their functional area. Following the discussion, designees from each group reported the group's perspective to the broader audience to spark a group-wide discussion, moderated by Dr. Rivera. This section of the report describes the major themes that emerged from each group's discussions to illustrate the different perspectives of the different systems.

Major themes for the workforce development counselors included:

The expanding role of the JOBS counselor

The difficulty of identifying mental health issues without specific mental health experts to conduct intake and assessments

Substance abuse denial and the difficulty of confronting the denial

Collaboration with TANF and cross-training with social services

Transparency about protocols and informing the client of all that will be expected of them and sanctions for noncompliance

The transition to a strengths-based approach.

Major themes for the child welfare professionals included:

Strategies to confront the negative image of child protective services as "baby-snatchers"

Collaboration with JOBS services to provide life skills

Kinship care and support services

The transition to a single, unified permanency plan that incorporates elements of the employment plan and service plan.

Major themes for the TANF case managers included:

Strategies to communicate between substance abuse and mental health professionals

Managing expectations of relapse and incorporating those expectations into service plans

The impacts of substance abuse and child welfare issues on eligibility determination, and

Being proactive about cross-training and driving services forward.

Throughout the discussion, the national consultants and local representatives offered their insights on the specific challenges being enumerated by each group in true peer-to-peer fashion. Counties shared helpful tips and common barriers, Cass County staff reflected on their lessons learned, and the national consultants referenced examples from their work in other States.

9. CLOSING THE LOOP: INTEGRATING FAMILY-CENTERED SERVICES FOR TANF PARTICIPANTS WITH SUBSTANCE ABUSE ISSUES

Ms. Mary Nakashian presented during this session of the Roundtable and focused on the intersections between the systems of substance abuse, child welfare, TANF, and JOBS. Her presentation referenced her experiences working with the States of Colorado and Oklahoma on issues related to identifying substance abuse among TANF clients. To break her comments into two main themes, Ms. Nakashian highlighted "tools" and "teams" as the main tenets of her discussion about systems integration.

Tools

Ms. Nakashian emphasized that when using screening or assessment tools, systems should operate under the assumption of screening all participants instead of a selected few - what she referred to as the "rule it out" approach. This approach seeks to screen all participants and rule out substance abuse or mental health issues, which a screening process can confirm or dispute. Ms. Nakashian stressed that child welfare staff should screen for substance abuse in all cases, just as substance abuse providers should screen for child safety issues in all cases as well. One cross-disciplinary and common screening tool is also more preferable than multiple tools each being used by individual agencies. Ms. Nakashian believes in using a "community tool" that all agencies can use. Because each system should screen for a participant's possible

involvement with other systems, the use of a common tool enables all parties involved to speak from a common point of reference.

Because screening and assessment tools have both advantages and weaknesses, Ms. Nakashian advocated for the use of "multiple messengers" to obtain a piece of information. Screening tools are often blunt and generalized instruments, so as a result, agencies are advised to develop various strategies to acquire case information from multiple sources. The process of screening is sometimes mistakenly conceptualized as the use of a one-time tool. Rather, screening involves gathering multiple clues from a number of sources and piecing together a puzzle. One particular weakness of screening tools is that even the best instruments are only as good of the level of trust and level of dialogue between the interviewer and the client. Without sufficient trust or open dialogue to foster information sharing, screening tools may fall short of their intended benefit.

Teams

To provide a framework for this segment of her presentation, Ms. Nakashian expressed her particular preference for the statement, "Nothing about me, without me." In this sense, Ms. Nakashian emphasized the importance of including the family as much as possible in the process of service delivery. Service professionals are encouraged to think of the family as part of the service delivery team. The compilation of a list of family-focused team outcomes from a client-perspective is a positive step moving away from a system or an agency-focus on services. In Oklahoma, monthly meetings are held with all family members of a particular case to discuss progress and action steps. During these meetings, successes are celebrated and failures or relapses are addressed. Inviting the family to meetings also has the positive benefit of making the family feel welcome around agency staff and helps the family to see that "these agencies aren't necessarily the enemy." Most importantly, the integration of the family into the service delivery team helps to operationalize the notion of trust. Through meetings, visits, face-to-face exchanges, and dialogues, parties begin to trust each other to an increased extent.

Integrating Tools and Teams

Teams decide together on a course of action, which is informed by the information collected through tools. Consequently, the more comprehensive and widely shared the tools, the more comprehensive and better information the team will have to make wise decisions. The information obtained from screening and assessment tools, on its own, does not fully capture all the details and nuances of each family. Overall, both tools and teams are needed for effective service delivery and comprehensive service strategies.

10. REDEFINING TREATMENT AS A WORK EXPERIENCE

In this session, various speakers explored how TANF programs can collaborate with substance abuse treatment services in order to integrate vocational training and family support into the treatment continuum. Special emphasis was placed on innovative strategies to make activities that occur during treatment "countable" for purposes of TANF participation rates.

Dr. Sushma Taylor gave the bulk of the presentation by describing how her organization, Center Point, Inc., integrates countable TANF work activities into the treatment regimen. She discussed the various aspects of job readiness, training, and vocational services that are part of the services offered at Center Point. Many of these services were made possible by the receipt of a large Welfare-to-Work grant, which was awarded to Center Point in recent years.

Center Point obtains employment-related information about its residents through a battery of vocational tests. Needs assessments, written survey instruments, client interviews, client group discussions, a vocational choice survey, and a job readiness assessment are all examples of instruments that are used. This 4-6 hour assessment package provides a vocational aptitude score and a narrative diagnostic print-out about each resident. After the comprehensive assessment process, a wide variety of pre-employment services are offered addressing substance abuse, educational, vocational, and psycho-social issues. Following pre-employment services, residents are placed on one of three "tracks" based on their assessment and their progress during initial services.

Track I is entitled Job Ready and is designed for those individuals who could most likely get a job with relatively little effort. Dr. Taylor's goal is to place these Track I individuals in the job market within two weeks. Those on the Training Ready Track II require more intensive services before they will be ready for the job market. The Pre-Vocational Track III is reserved for the hardest to employ, such as those residents with learning disabilities, cognitive impairments, a history of long prison sentences, or an inability to read and/or write. Five career track options await those residents on Track III, which include culinary, home health care, child care supervision, maintenance, and clerical. Each track involves more than 520 hours of classroom training. For Dr. Taylor, these tracks are especially important because they teach a marketable skill and they provide referenceable job experience for the individual. For all her job placements, Dr. Taylor works with a group of more than 250 employers to find and obtain employment positions that have a considerable degree of upward mobility for her residents.

Dr. Taylor offered detailed descriptions of many of the services that Center Point can provide. Services offered at Center Point to help residents become job ready include:

Mock job interviews and Interpersonal skill development

Individual, group, and family counseling

Relapse presentation services focused on major relapse triggers (e.g., time, money, boredom, fatigue)

Adult education, G.E.D. courses, and college courses

Job search and job readiness training

Social skills training (e.g., learning to take supervision feedback, and criticism constructively)

Anger management and conflict resolution training

Personal hygiene and dress (i.e., how to groom for a job)

Self-esteem building (e.g., fostering hope and self-confidence)

Budgeting and money management training (e.g., weekly budgeting)

Family violence prevention.

Center Point also offers transitional housing to its residents. In this model, the program owns the facility and former residential clients live in the transitional facility as tenants. Rent prices are based as a percentage of income. The units are fully furnished with linens provided. Tenants stay from 12-24 months. The process of staying in an apartment and paying rent for an entire year helps to repair the damaged credit ratings of the residents.

11. A STRENGTHS-BASED PERSPECTIVE FOR SERVICE DELIVERY

During this session, Dr. Rivera offered numerous examples of ways that TANF, JOBS, substance abuse, and child welfare professionals could adopt a strengths-based approach for working with clients. Using an example intake orientation from the Texas Workforce Center in Amarillo, Texas, Dr. Rivera highlighted the importance of the language used to speak to clients about the services they will receive. Underscoring the significance of word choice and tone, he discussed the concept of "stairways to excellence" and introduced new language techniques into the intake process. Employing the use of positive and encouraging language early on in a conversation increases the likelihood that a client will "warm up" to their provider. Dr. Rivera encouraged the audience to identify frequently used words such as "barriers" that carry negative connotations and to replace them with more positive alternatives.

Dr. Rivera also introduced the notion of a strengths-based checklist to help clients to understand and identify their inner strengths that they already possess. See Exhibit III-8.

EXHIBIT III-8
STRENGTHS ASSESSMENT

- ***Connecting with others.*** I have a gift for making connections with people. I find friends easily, and enjoy being with people. _____
- ***Creativity.*** I'm good at art, dance, music, writing or some other creative pursuit. I like to play with imagination and possibility. _____
- ***Political action***. I try to make a difference in the larger world. I may help with advocacy (such as promoting the rights of women, lesbians, or children). I may volunteer in my community at a library or soup kitchen, for example. _____
- ***Attractiveness.*** I am physically beautiful or charming. People are drawn to me because they find me appealing. _____
- ***Sense of humor.*** I can find fun in almost any situation. I like to laugh and notice the quirks and absurdities in life. _____
- ***Survival skills.*** I survived painful life experiences, such as a dysfunctional family or child abuse. Or I may have completed schooling or a job that was difficult. I am a survivor. _____
- ***Persistence.*** I can follow through on commitments even when I don't feel like it. I have a sense of will and make an effort to improve things. _____
- ***Self-care.*** I take care of myself—eating right, exercising, annual check-ups, and taking care of my physical environment such as my home. _____
- ***Physical ability***. I'm good at sports or other physical activity (without being addicted to it). _____
- ***Social support.*** I have one or more people in my life who love me and genuinely want me to get better. I believe they'll help me when I ask, and be there emotionally when I need them. _____
- ***Helping others.*** I'm good at caring for others, such as children, pets, elderly, or others who need my help. _____
- ***Self-esteem.*** I have some positive feelings about myself. This may include pride in my achievements, valuing my personal qualities (e.g., honesty, integrity, warmth), or believing that I'm a good person. _____
- ***Spirituality.*** I am a deeply spiritual person. I sense larger forces and can tap into that positive energy. I may or may not be religious, but I have this gift of awareness. _____
- ***Intelligence.*** I "get it"—whether it's formal learning (mental intelligence), knowing how to relate to people (social intelligence), or dealing with feelings (emotional intelligence). I may have one of these strongly, or all of these somewhat. _____
- ***Ability to face my feelings.*** I can face feelings that are painful and deal with them. I may manage my feelings in a variety of ways—sometimes crying, thinking about them, or just letting myself experience them. _____
- ***Ability to communicate.*** I can say what I think and feel, without hurting myself or others. This is sometimes called "assertiveness"—expressing myself without being either passive (getting "walked on") or aggressive (attacking people). _____
- ***Financial resources.*** I have money available, which can help me obtain therapy and other resources for overcoming addiction. _____

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Overall, throughout the session, Dr. Rivera encouraged the audience members to conceptualize their role in service delivery through a slightly different lens that ennobles clients in a new way. He advocated for the use of words such as "excellence" when referring to a customer's potential. He also referenced Maslow's hierarchy of needs and presented the hierarchy in a new way, translated for a TANF customer. In showing this re-created diagram, Dr. Rivera stated that this new hierarchy can become a new paradigm for how public service agencies conceptualize their customers. See Exhibit III-9.

EXHIBIT III-9
A NEW VIEW OF OUR CUSTOMER

11.1 Questions and Answers

Q: What is your reasoning for the use of the word "customer" when referring to TANF clients? Do you see the word as more appropriate than "client?"

Dr. Rivera: The language of our business has changed recently. We moved from "welfare" to "TANF." We moved from "recipient" to "participant." The word "recipient" falls in line with notions of receipt, entitlement, or charity. However, "participant" refers to a player in a process that is bilateral in nature. Most specifically, the word "customer" conjures images of any service industry with common schemas that most everyone appreciates, such as "the customer is always right." By using the word customer, it reinforces to us that we are a customer service entity or that we are in the customer service business. However, none of this is to say that "client" is a bad or inappropriate word, although it does possess a different connotation.

Q: Can you suggest an example of a countable work activity that is included as part of 'treatment' on the treatment/self-sufficiency continuum?

Dr. Rivera: Good treatment prepares an individual for self-sufficiency, and there are ways that time in treatment can be countable. For an activity in treatment to be countable, it must meet three criteria: 1) the type and/or nature of the activity must prepare an individual for the workplace; 2) it must be pre-planned; and 3) it must be managed through case management so that it can be evaluated. Given these criteria, we can think of activities that occur during residential substance abuse treatment that can be countable. People clean, sweep, do dishes, or manage a cleaning team, often for an allotted period of time, or a shift. But remember, whatever the activity is, it must be pre-planned, countable, and case managed.

Q: What is an example of participation in faith-based organizations that can also contribute to countable work activities?

Dr. Rivera: When TANF participants work with a faith-based agency, they may help with a variety of activities that are included as part of a 'ministry.' If you remove the religious implications of ministry, these activities may include a great deal of community service, such as a visit to a nursing home, service projects for needy members of a congregation, etc. With innovative thinking, some of these activities can be considered countable, as long as you pre-plan it, count it, and case-manage it. Even if you consider outpatient treatment, such as coming in to a given organization for a set number of hours per week to obtain group counseling, there are innovative ways to derive countable work activities here as well. Maybe numerous participants all must come from rural areas, such has five TANF participants from a hundred square mile area. One person could be designated as the "outpatient treatment transportation coordinator." Their job would be to coordinate rides, account for everyone, make phone calls, notify others

when schedule changes occur, etc. This is an actual activity that helps offer skills for the workplace that is viable and countable. In general, I encourage you to think creatively and push the boundaries of your thinking as to what constitutes countable activity.

12. CASAWORKS

During this session of the Roundtable, Ms. Mary Nakashian gave a presentation on the CASAWorks program of the National Center for Addiction and Substance Abuse (CASA) to highlight another example of a substance abuse treatment program that integrates work. This program initially funded 11 communities from 1997-2001 to serve as demonstration projects to help policymakers understand what types of substance abuse programs work well in community settings. As part of the project, CASA contracted with selected community-based organizations to implement an idea related to substance abuse treatment and monitor/evaluate implementation. The majority of the organizations that were funded were substance abuse treatment centers, and one of the many requirements for funding was that the programs had to integrate work activities into their treatment regimen. The initial CASAWorks project was funded through the Robert Wood Johnson Foundation and other private donations.

Based on the lessons learned from the initial 11 demonstrations, CASA then designed a more evidence-based, protocol-driven substance abuse treatment program with a rigorous research design. As part of this new program, low-income families in two neighborhoods in East Harlem and the Bronx were assigned to either CASAWorks or to an alternate treatment setting. The University of Pennsylvania is currently conducting the evaluation of this program, which has been underway since 2003.

The CASAWorks program, in its current form, is a hybrid case management model that combines both strengths-based and intensive-services schools of thought. In essence, it is a program that integrates substance abuse treatment and job readiness skills to help participants find employment. To be eligible for the program, participants must be 18 or over, receiving or eligible to receive TANF, not receiving SSI or disability checks, and must have a substance abuse problem. The program has both family-focused and employment-focused goals for each participant. Through a phase-based intervention, services focus on substance abuse, mental health, employment, and parenting skills, with practice guidelines and a tailored curriculum developed for each of the four modules. In addition, the entire program is compliant with New York State's TANF rules.

Ms. Nakashian gave a detailed description of each of the four phases of service delivery as part of CASAWorks. A summary of the four phases is as follows:

Phase I – Generally occurs through month 1 of service delivery. Services focus on stabilization, detox, meeting acute needs, and developing a "change plan."

Phase II – Generally occurs in months two, three, and four of service delivery. Services focus on regular substance abuse treatment, stabilizing mental health, pre-vocational skills training, and developing a "job plan."

Phase III – Generally occurs in months four through seven. During this phase, the participant is actively preparing for employment, receiving job training, receiving parenting classes, and beginning to engage in work activities.

Phase IV – Generally occurs in months eight through twelve. During this phase, most participants are employed or at least job ready, and functioning well without barriers to employment. Community supports are also in place by this phase. A case manager helps the participant to stay in work for this four-month phase.

At CASAWorks, the participant spends some of each day in treatment, and some of each day involved in one of the four curricula, an activity which is counted as work. Ms. Nakashian closed her presentation on CASAWorks with a few final comments about the program. Although the model is resource-intense, it does not require a full-time employee for each job function. Also, the intervention can be housed and implemented at any suitable community-based organization.

12.1 Questions and Answers

Q: How many people are served at one time?

Ms. Nakashian: The program can handle 50-60 participants at one time, divided between two program locations. Per site, participant totals range from 25-30 at one time. There are two case managers at each site.

Q: Regarding job retention, how long does the case manager stay with the participant?

Ms. Nakashian: On paper, if the participant is working by month 8, the case manager would stay with them for four more months. However, my assumption is that the case manager will stay with the participant as long as they have the capacity. There are alumni groups for participants as well.

Q: If the participants show up for the program, do you find that they follow through with their commitment to the program?

Ms. Nakashian: Yes, we do. As with most any program, the first month of engagement is very hard. However, once they begin to regularly attend groups such as parenting skills, they seem to attend more regularly.

Q: Are services ever inpatient?

Ms. Nakashian: No. This is an intensive outpatient program, which translates to coming into the program several hours a day for several days each week.

Q: In terms of counting work activities, it is correct that Phase I is job readiness, and that the other three phases are filled with work activities?

Ms. Nakashian: Yes, that's largely the case. The New York Human Resources Administration does an assessment of all participants, and places them into one of three categories. In category one, you are exempt from work. In category two, a substance abuse problem is present but the participant is still required to work. In category three, a substance abuse problem is not even diagnosed. Most participants in our program fall in category two. For them, we have to create 35 hours each week of countable work activities and report that.

Q: What about child care?

Ms. Nakashian: It's an issue. The organization has limited onsite drop-in custodial care, however, they have made many arrangements with other community agencies, and it seems to work well.

Q: It seems like this model could be used for other barriers to employment such as depression, post traumatic stress disorder, or even domestic violence. Has this model been used in any of those areas?

Ms. Nakashian: I think the model could be very easily adapted to those areas as well. The model is appropriate for other challenges to employment.

13. ACTION PLANNING EXERCISE

This final Roundtable exercise focused on action planning so that participants could translate the knowledge gained in the workshop sessions to practical solutions in their local communities. See Appendix D. Led by Dr. Hercik and Dr. Rivera, this session facilitated a thinking process for participants to reflect on the main lessons they learned from the event on the

dimensions of the individual-level, the agency-level, and the community-level. Participants were given time to respond to worksheet questions individually, and then the responses were synthesized for the group. Major themes of the responses are reported in this section.

Common barriers to service improvement cited were:

Lack of funding

Negative attitudinal biases, preconceived beliefs, and resistance

Time and caseload constraints

Turf issues among competing agencies and silos

High and demanding current client caseloads

Lack of long-term inpatient treatment

Lack of community awareness and substance abuse education.

Common themes among individual-level action steps include:

Focus more on client strengths

Become more open-minded

Bring in TANF professionals sooner in the process to focus on work activities and reunification

Discover ways to merge the employment plan, treatment plan, and reunification plan

Inform co-workers of new information learned at the Roundtable.

Common themes among agency-level action steps include:

Implement a client satisfaction survey to help solicit feedback

Collaborate more closely with Human Services Center staff

Utilize lessons learned from the Cass County pilot in our county

Request the North Dakota Association of Counties to spearhead a legislative change effort

Request training in family development for all agency staff

Collaborate more closely with TANF, JOBS, and mental health staff

Strengthen the message our agency sends to our clients.

Common themes among community-level action steps include:

Hold community forums and community meetings on the impact of meth

Help the Department of Human Services, Human Services Centers, and JOBS program to work together to find a common goal

Identify more options for substance abuse treatment in the community

Help to secure more community support for meth awareness-raising efforts

Implement joint case staffing.

14. CLOSING REMARKS

As the final session of the Roundtable event, many of the presenters and initial welcoming speakers stated their closing remarks and offered words of encouragement to the participants to take the lessons learned here and act as catalysts for change in service improvement in their local communities. Kathy Hogan, John Hougen, Dr. Hercik, and Dr. Rivera all gave brief reflections on the value of the event and their hopes for the future.

At the conclusion of the Roundtable, Federal Project Officer John Horejsi thanked the participants for the contributions and energy. Mr. Horejsi encouraged the participants to build on the information presented at the meeting to improve services to customers in their home regions, to maintain a dialogue with one another and with their peers in other States, and to continue to use the Welfare Peer TA Network as a tool and asset in this important work.

Overall, the Welfare Peer TA Network was excited to have hosted this successful event and looks forward to future collaboration opportunities with TANF professionals in North Dakota. Others interested in further materials related to substance abuse screening and assessment, service integration, and work activities are encouraged to visit the Welfare Peer TA Network Web site, located at http://peerta.acf.hhs.gov

APPENDIX A:
AGENDA

Welfare Peer Technical Assistance Network

Substance Abuse–Challenges and Strategic Solutions

Fargo, North Dakota • September 27–29, 2004

AGENDA

Day One: Monday, September 27

11:30 – 12:30 PM **Registration**

12:30 – 1:15 PM **Welcome and Introductions**
Thomas Sullivan, Regional Administrator, ACF Region VIII
John Hougen, TANF Administrator, ND Department of Human Services
John Horejsi, Federal Project Officer, Welfare Peer TA Network
José Rivera, J.D., Project Director, Welfare Peer TA Network

Federal and State representatives will welcome participants and provide a brief overview of the Welfare Peer TA Network and the goals of the roundtable. Participants will be seated by Region. The regions will be asked to spend five minutes focusing on their region's desired goal or outcome from this program. A spokesperson for the region will then introduce the region, the team and their desired outcome.

1:15 – 1:45 PM **Setting the Context**
José Rivera, J.D., Welfare Peer TA Network
Jeanette Hercik, Ph.D., Welfare Peer TA Network
Mary Nakashian, M.A., Consultant

Many TANF participants and their families are deeply affected by issues related to substance abuse. This introductory session will help to put the issue of substance abuse in a broader context. One such context is the reality that substance abuse rarely occurs absent some preceding or subsequent problem or issue. Another is the fact that systems which address substance abuse are related to and dependent upon systems that address issues such as TANF, child welfare, substance abuse/mental health and workforce development. Yet another context is one that reflects the strength and power associated with the process called recovery.

1:45 – 3:15 PM **Inventory of Substance Abuse Challenges and Community Assets**
José Rivera, J.D., Welfare Peer TA Network
Participants will be engaged in a facilitated discussion to identify North Dakota challenges and issues associated with substance abuse which impact the ability of local offices to move participants from TANF to work as soon as possible as well as the strengths in each regional district to meet the needs of TANF families.

3:15 – 3:30 PM **Break**

3:30 – 5:00 PM **Causes, Symptoms and Treatment of Addiction**
Sushma D. Taylor, Ph.D., Center Point, Inc.
Mary Nakashian, M.A., Consultant

The session will focus on understanding the science of and the differences among substance use, substance abuse and substance use disorder. The goal of this session will be to help participants understand not just what addiction is, what treatment does but also how to harness the energy associated with recovery in order to move TANF participants in recovery to self sufficiency.

5:00 – 5:30 PM **Day 1 Wrap-up and Day 2 Preview**
José Rivera, J.D., Welfare Peer TA Network

Day Two: Tuesday, September 28

8:00 – 8:30 AM **Reflections on Day 1**
José Rivera, J.D., Welfare Peer TA Network

Participants will be asked to briefly summarize their thoughts from the prior day's session and share any concerns about the current day's agenda.

Substance Abuse–Challenges and Strategic Solutions

Fargo, North Dakota • September 27–29, 2004

8:30 – 10:30 AM

Case Management Strategies: Supporting Substance Abuse Treatment
Sidney Schock, Carey Fry, Kathleen Moraghan, Cass County, ND
Mary Nakashian, M.A., Facilitator

In this session, participants from Cass County will describe their work in the pilot demonstration project, its achievements and recent recommendations and implementation strategies. Actual tools will be shared. Following the presentation and time for questions and answers, participants will engage in a case study exercise. Information on the case study will be provided in advance. The case study will allow the district teams to explore individual perceptions about substance abuse, identify particular challenges, and strategize solutions together.

10:30 – 10:45 AM

Break

10:45 – Noon

Respondent Panel and Discussion
José Rivera, J.D., Welfare Peer TA Network
Cass County Panel
Sushma Taylor, Ph.D., Center Point, Inc.
Mary Nakashian, M.A., Consultant

Participants will have the opportunity, in this session, to ask questions or discuss issues flowing from the case study and the panel presentation.

Noon – 1:30 PM

Creating a Solution by Functional Area and Roundtable Discussion
José Rivera, J.D., Welfare Peer TA Network
John Hougen, Facilitator

During this breakout session, participants will be re-seated along functional lines (TANF, Job Service, Child Welfare and Substance Abuse) to discuss the challenges of substance abuse from the perspective of their functional area. Team designees will then state the challenges and opportunities from each group's individual perspective and report the paramount problem and one proposed solution.

1:30 – 2:15 PM

Closing the Loop: Integrating Family Centered Services for TANF Participants with Substance Abuse Issues
José Rivera, J.D., Welfare Peer TA Network
John Hougen, Facilitator
Mary Nakashian, M.A., Consultant

Building on the previous session, the discussion will focus on the intersection and interdependence of TANF, Job Service, Child Welfare, and Substance Abuse Treatment. Particular attention will be paid to identifying challenges to serving families with multiple needs under (potentially) competing program requirements. This session will also focus on the challenges associated with moving individuals in recovery into the workplace and working with their families to advance family reunification and/or stabilization.

2:15 – 2:30 PM

Break

2:30 – 3:30 PM

Redefining Treatment as a Work Experience
José Rivera, J.D., Welfare Peer TA Network, Facilitator
Mary Nakashian, M.A.
Sushma Taylor, Ph.D.

Panelists will explore how TANF programs can collaborate with substance abuse treatment services in order to better integrate vocational training and family support into the treatment continuum. Special emphasis will be placed on ways to make activities in the treatment continuum "countable" for TANF participation purposes. The panel will look to the treatment community to devise ways that they can re-frame work activities in treatment and TANF/Child Welfare participants will be asked how these new definitions can further their performance goals. The panel will also examine how the faith community can become an integral part of the countable work experience by using the work done as ministry as countable work experience.

3:30 – 4:30 PM

Exercise and Roundtable Discussion
José Rivera, J.D., Welfare Peer TA Network, Facilitator

Each participant will be asked to look at the work they do and "create" some ideas or strategies for using the Power of Recovery and the activities of treatment as countable activity or as a vehicle for enhancing or promoting family stabilization. These unsigned "suggestions" will be collected and a sample of them will be read out loud and discussed by all present.

4:30 – 4:45 PM **Day 2 Wrap Up and Day 3 Preview**
José Rivera, J.D., Welfare Peer TA Network

Day Three: Wednesday, September 29

8:00 – 8:30 AM **Reflections on Days 1 and 2**
Evaluation of Program

8:30 – 10:00 AM **Putting the Pieces Together: Strategizing Solutions for Your Region**
José Rivera, J.D., Welfare Peer TA Network

During this session, participants will work in their Regional teams to apply the ideas and insights from the previous two days. Participants will focus on developing an Action Plan, with tangible goals, strategies and benchmarks. (Templates will be provided).

10:00 – 10:30 AM **Action Planning: Bridging the Gap**
José Rivera, J.D., Welfare Peer TA Network

Building on the previous session, working groups will share their Action Plans. Other working groups will offer support, suggestions, lessons learned and recommendations, as appropriate. Discussion will include returning to previously articulated challenges and initiatives for guidance and closure. Ultimately, a list of challenges, targeted milestones, and promising practices will be developed.

10:30 – 10:45 AM **Break**

10:45 – 11:15 AM **Action Planning: Bridging the Gap (continued)**
José Rivera, J.D., Welfare Peer TA Network

11:15 – 11:30 AM **Closing Remarks**
John Hougen, TANF Administrator, ND Department of Human Services
John Horejsi, Federal Project Officer, Welfare Peer TA Network

APPENDIX B:
PARTICIPANT LIST

Substance Abuse—Challenges and Strategic Solutions

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APPENDIX C:
CASS COUNTY CASE STUDY

APPENDIX C

Case Study – Ann Jones

Ann is a 23-year old white single female in her seventh month of pregnancy. She reports having completed the tenth grade and not currently in school. Her work history consists of day labor jobs. Her mother has had custody of her two other children, ages four and two, for the past 1 ½ years.

August: Ann volunteers for JOBS upon baby's reaching three weeks of age. She denies any drug or alcohol problems; claims having never been through treatment, not attending any aftercare programs; no history of domestic violence. She feels she is suffering from post-partum depression. Ann is required to attend GED and engage in work experience.

October: Ann's testimony to JOBS counselor that she has bipolar disorder as well as a history of drug and alcohol abuse in Colorado results in Referral to MH. Ann meets with Kathy and testifies to: prior use of cocaine, marijuana, and alcohol; multiple criminal convictions (possession of stolen property, possession of marijuana), with jail-time served for non-payment of child support; current use of 12-24 cans of Mountain Dew per day as well as two to three pots of coffee.

November: Ann fails to comply with JOBS requirements (work experience) and is sanctioned.

December: After missing an earlier (November) appointment, Ann again meets with Kathy. Ann complains of suffering bipolar disorder and requests medication. Ann reports mood fluctuations, increased grandiosity, varying sleep, increased distractibility and racing thoughts. During the meeting she gives conflicting reports about her drug usage, first denying any use, then admitting to using on a regular basis. She reports having been seen by an addiction counselor for meth use; admits she lost her children 1½ years previous due to a failed u.a. Ann refuses to do a urine drug screen, claiming she would "....test positive for marijuana." She said she'd be willing to have a drug/alcohol evaluation. CD evaluation conducted; mood stabilizer prescribed; advised to reduce caffeine consumption; case management referral made.

December: Ann's behavior is very erratic. She frequently calls her JOBS Counselor and Program Manager stating she wants to close her case, then calls a short time later wanting to leave it open. Admission to her case manager that she's been smoking pot is quickly followed by a request that the case manager write a letter to the court asking that Ann be excused from paying child support as she is currently participating in treatment program. The JOBS Counselor, Program Manager, and Kathy communicate almost daily.

December: A referral is made to Child Protective Services. Kathy arranges for Ann to attend pre-treatment while JOBS requires that she attend the Career Building Workshop. Ann either fails to attend the Workshop or leaves early, citing illness (vomiting), court hearing, doctor appointments, or WIC appointment. When in the Workshop, she is disruptive, sleeps during class, interrupts the trainer, or leaves the classroom while presentations are being conducted.

January 8, a.m.: During pre-treatment group, Ann denies drug use, then tests positive for meth and marijuana. During a meeting with Kathy she reports having Hepatitis C and claims needle marks discovered on her arm are a result of a blood draw at the clinic. Call to Ann's doctor reveals no history of Hepatitis C or history of blood draws.

January 8, p.m.: Ann reports to her Program Manager that the Police found drugs and paraphernalia in her home and that "... a friend who was staying there" sold drugs out of her home.

January 9: The Fargo Police Department, along with Child Protective Services, take Ann's child into protective custody. Ann's daughter is five months old, weighs 25 pounds, cannot roll over, and can barely move when she is lying down. Ann is adamant when voicing intent to comply with the treatment plan "... and stay clean so I can get my child back."

January 20: Ann enters residential treatment program; altercations with the staff are frequent and animated, and Ann is soon kicked out for failing to follow rules which she feels are "..... unfair and too restrictive". .

January 31: Ann's TANF case closed due to non-receipt of Monthly Report; no eligible child in the home.

February: Ann jailed for Felony possession with intent to deliver. She chooses to stay in jail rather than post bond.

March: Ann pleads guilty to 2 Class B Felonies (possession); Class C Felony (paraphernalia); Class A misdemeanor (marijuana); serves 90 day in jail; 21 months supervised probation; drug evaluation, mandatory treatment, random u.a.

Today: Ann is in residential treatment facility. Her two children still reside with their grandmother who reports that she is "...doing very well"; her youngest daughter remains in foster care.

APPENDIX C (CONT.)
KEY QUESTIONS

1. What signs and symptoms in that month indicate possible methamphetamine use?

2. During the course of Ann's involvement with TANF, she is required to attend GED and engage in work experience. When she fails to do so, she is placed in the Career Building Workshop and Pre-treatment as well as other appointments at the Mental Health Center.

   What other options/activities would be available/utilized in your region for Ann?

3. In December, a report was made to Child Protective Services (CPS).

   What information at this point would lead you to believe that the child may be at risk?

   Would you expect that a referral for CPS would be done in your region under similar circumstances?

4. In December, the team members communicate "almost daily" about Ann.

   If this client was in your region, what level/frequency of communication could or would take place?

5. What role does the legal system play in this case?

6. Is this case a success story? Why or why not?

APPENDIX D:
ACTION PLANNING WORKSHEET

Welfare Peer Technical Assistance Network
Maintaining the Momentum
September 29, 2004

Thank you for participating in this program and using your knowledge and experience to teach and learn from your colleagues both within your agency and within your partner agencies.

As we review the progress of the last couple of days, we (the program planners and presenters) believe that the impact of the presentations and the dialogue affect three spheres: you, the individual; your agency; and your community of stakeholders and potential partners. With that in mind, we ask you to answer the following questions about what actions you might take in the next 90 days:

1. Identify something which you will take away from this program which will result in changes in the way you, as an individual, act or behave as a TANF, JOBS, Child Welfare or Substance Abuse Treatment Professional or will maintain the momentum obtained through this program:

   How do you measure success on this activity:

2. What actions will you undertake or recommend undertaking within your agency/unit as a result of this meeting:

   How do you measure your success on this activity:

3. Finally, what actions would you recommend being undertaken in your community as a result of this meeting:

How do you measure your success on this activity:

4. What are the obstacles which might prevent your success in any of the above areas?

Name: _____

Agency: _____

APPENDIX E:
EVALUATION SUMMARY

APPENDIX E:
EVALUATION SUMMARY

Welfare Peer TA Network
Substance Abuse - Challenges and Strategic Solutions
Evaluation Summary

At the conclusion of the Roundtable, participants were asked to evaluate how well the Welfare Peer TA event met their expectations and needs. Participants were first asked to rate the extent to which they agreed with a series of five general statements about the Roundtable on a 5-point scale, where 1 = Strongly Disagree and 5 = Strongly Agree. Each of the five statements and associated average scores are presented in the below chart.

Statement	Average Score
Conference planners adequately prepared me for the meeting by providing clear written and verbal communication regarding the meeting's purpose and expected outcomes.	3.9
Conference planners handled the preparation, arrangements, and scheduling of the event in a timely, courteous, and competent manner.	4.6
The speakers were thorough in the subject areas presented.	4.1
The speakers engaged the audience and facilitated interactive discussions.	4.4
The information will be useful to me/my staff in developing new approaches to addressing the problem.	4.2

Additionally, participants were asked three open-ended questions about their reflections on the Roundtable and their future technical assistance needs. These questions and representative responses received are presented below:

What did you find most useful about attending this Roundtable (i.e., any immediate or long-term benefits to you/your staff that you anticipate as a result of attending this Roundtable)?

I gained a better understanding of the TANF and JOBS program and their connection with my area of child welfare

The strategies and practices occurring in other areas of the State

Discussing ways to work as a team in order to best serve the client

Heightened appreciation of the vital need to work together to define manageable and effective service plans that supports a goal shared by all

Helpful hints about incorporating a strengths-based approach

Provided alternative approaches to consider and use when treating substance abusers in my practice

How to build coalitions

What issues would you have liked to have had more discussion about at the Roundtable?

The relationship between child welfare and substance abuse

TANF and kinship care

Safety issues for workers dealing with Meth-addicted clients

How addiction affects children

More detail and elaboration about the stages of treatment and recovery

More information on service integration

Coalition-building

In which areas, of those covered, would like to receive additional technical assistance?

The science and behavioral implications of substance abuse addiction

Assistance in how to build cross-disciplinary service teams

How to integrate a mental health component into TANF and JOBS services

Best practices information on successful substance abuse treatment centers that integrate work activities

Supportive services for non-custodial parents

The Welfare Peer TA Network is a service of the Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services. The contractors supporting the Network are Rivera, Sierra & Company, Inc. and Caliber Associates, Inc. under Contract No. HHSP23320042907YC. For further information, please contact José A. Rivera, Project Director at 301-881-4700 or jrivera@riverasierra.com.